THE BOOK WAS DRENCHED

UNIVERSAL
LIBRARY
OU_164319
UNIVERSAL
LIBRARY

THE NATIONAL INSTITUTE OF
ECONOMIC AND SOCIAL RESEARCH

Economic and Social Studies

I. Studies in the National Income, 1924–1938.
By A. L. Bowley, Sc.D.

II. The Burden of British Taxation.
By G. Findlay Shirras and L. Rostas.

III. Trade Regulations and Commercial Policy of the United Kingdom.
By the Research Staff of the Institute.

National Health Insurance

A CRITICAL STUDY

BY

HERMANN LEVY

CAMBRIDGE
AT THE UNIVERSITY PRESS
1944

CAMBRIDGE
UNIVERSITY PRESS
LONDON: BENTLEY HOUSE
NEW YORK, TORONTO, BOMBAY
CALCUTTA, MADRAS: MACMILLAN

All rights reserved

Nunc autem Deus sic ordinavit,
ut discamus alter alterius onera portare.

De Imitatione Christi, Lib. I. Ch. XVI.

There is one lesson at all Times and Places,
One changeless Truth on all things changing writ,
For boys, girls, men, women, nations, races,—
Be fit—be fit! And once again, be fit!

RUDYARD KIPLING, *A Preface.*

To

DONALD TYERMAN

in gratitude for his unfailing assistance and advice

and

TO THE MILLIONS OF WORKERS

covered by the National Health Insurance Acts,
in the hope that it will further their interest

this book is respectfully
dedicated

CONTENTS

PART I. *THE NATIONAL HEALTH INSURANCE SCHEME AND THE SUBSEQUENT LEGISLATION*

Preface PAGE ix

Chapter

I. Beginnings 1
II. The doctor's case 15
III. The Royal Commission 23

PART II. *THE SCOPE OF NATIONAL HEALTH INSURANCE*

IV. Categories of insured persons 38
V. Deficiencies in the scope of insurance 43

PART III. *BENEFITS*

VI. General Classifications 53
VII. Special benefits 58

PART IV. *CASH BENEFITS & THE ECONOMIC CONDITION OF THE WORKER*

VIII. The flat-rate system 61
IX. Insufficiency of additional benefits and other resources 70
X. National Health Insurance and the workers' budget 77

PART V. *MEDICAL BENEFIT & MEDICAL TREATMENT*

A. General medico-social aspects

XI. The socialization of medicine 92
XII. Types of medical benefit 95

B. The Doctor

XIII. The doctor's service 102
XIV. The doctor's remuneration 122
XV. Specialist treatment 137
XVI. Dental and ophthalmic service 153

C. Hospitals and other Institutions

XVII. National Health Insurance and the organization of hospital service 161
XVIII. Deficiencies of hospital service 167

PART V. Medical Benefit & Medical Treatment *continued*

D. Pharmaceutical Benefits. Nursing. The Role of the Insured

Chapter		PAGE
XIX.	Medicines and appliances	185
XX.	Nursing	200
XXI.	The role of the insured	203

PART VI. *THE ADMINISTRATION OF NATIONAL HEALTH INSURANCE*

I. Approved Societies

XXII.	Some general problems	211
XXIII.	No profits. Democratic contro	215
XXIV.	German and British systems	227
XXV.	Surplus and benefits	238
XXVI.	Financial shortcomings	243
XXVII.	Social effects of, and recommendations for removal of, inequalities of benefit	252

II.

XXVIII.	Insurance Committees	266

III.

XXIX.	The relation between National Health Insurance and other statutory social insurance schemes	276

IV. The Economic side of Administration

XXX.	The expense ratio	289
XXXI.	Economy through control	302

V.

XXXII.	The territorial system	316

PART VII. *CONCLUSIONS AND RECOMMENDATIONS*

XXXIII.	The failure of National Health Insurance	330
XXXIV.	Reform	341

POSTSCRIPT

The Beveridge Report and Sickness Insurance 351

Bibliography 357

Index 363

PREFACE

This book on National Health Insurance follows the Author's publications on "Industrial Assurance" and "Workmen's Compensation" written in collaboration with the late Sir Arnold Wilson, M.P. The author deeply appreciates that his investigation can be printed and published in these days of paper and labour shortage. He owes much gratitude to the National Institute of Economic and Social Research, which sponsors this enquiry, and he wishes to include in his expression of thanks a tribute to the courteous and skilful help given to him by the Secretary of the Institute, Mrs F. S. Stone and her staff. The author is also greatly indebted to Mr Donald Tyerman who has assisted him in shaping the manuscript and who contributed to the final wording of the text by much suggestive and fruitful criticism.

The book was finished by the end of the year 1942. Were it not for the war it would have been published in the second half of 1943. Its final conclusion coincided with the publication of the Report by Sir William Beveridge; it was still possible to insert some references to this classic Report and to add a Postscript explaining where and why the author's views differ fundamentally from the plan suggested by Sir William. It was, however, not possible to provide, as the author had wished, an Appendix with documentary matter and statistical tables. The latter have, in a shortened way, found their place in the text itself. Nor was it possible to deal with the elaborate and, indeed, thought-provoking literature which was published in 1943 in connection with the Beveridge Report. But readers will find a list of the most important of these publications, so far as they relate to National Health Insurance problems, in an addendum to the Bibliography.

The system of British sickness insurance differs very markedly from the methods and the administrative organisation which were applied abroad. The author has tried to describe these differences and to analyse their causes. In view of the Beveridge proposals and the coming White Paper on the medical services it may be expected that the whole face of National Health Insurance in Britain, as we have known it now for more than thirty years, will be fundamentally altered. "National Health Insurance" may disappear altogether as a separate branch of Social Insurance;

sickness insurance may become, even to a larger extent than unfortunately it is already to-day, mere machinery for the payment of cash benefits, unrelated to and separated from the obligation of a comprehensive medical treatment and restoration to working capacity of the insured person. Before deciding on such a course which would deprive sickness insurance of its task of contributing progressively to the improvement of the Nation's health, the conclusions at which the author has arrived as to how, against the background of existing international experiences, National Health Insurance could be retained, though fundamentally reformed, might, as the author hopes, prove of some value.

RICHMOND (SURREY) HERMANN LEVY
15 *January* 1944

PART I. *THE NATIONAL HEALTH INSURANCE SCHEME & THE SUBSEQUENT LEGISLATION*

CHAPTER I. BEGINNINGS

Much remains to do, and in the coming years much may be done, but here at least is a beginning made on a broad and comprehensive plan.' DAVID LLOYD GEORGE 1912

IT is not within the scope of this investigation to describe in full the social, political and economic controversies which characterized the introduction of National Health Insurance under Part I of the National Insurance Act, 1911 (1 and 2 Geo. 5, c. 55). The struggle was one of the liveliest and hardest ever fought out, both inside and outside Parliament; and the creator of the new system, Mr Lloyd George, expressed the hope that the 'campaign against poverty, squalor and disease' would evoke 'the same patriotism that is always ready to leap to the call of external danger'.[1]

The question of compulsory insurance naturally brought to their feet all those who still believed in the gospel of non-interference and economic liberalism and in leaving the care for the contingencies of life to personal thrift. The first Old Age Pensions Act, it is true, had been in existence since 1908. But its provisions did not touch the masses of people which would be brought within the scope of 'interference' by the new scheme, nor did they interfere so drastically as the Health Insurance scheme which laid down the duties as contributors of all the people who were to be concerned, as employers or workers. The insurance 'card' alone was a sensational innovation for the British people, and a particular affront to those who were ready to protest against the imposition of disagreeable 'clerical' work. The compulsory insurance of domestic servants appeared to many as an abominable intrusion by the State into the Englishman's home.[2] The general public was inclined to agree with the sophisticated views proclaimed in the *Report on Old Age Pensions* of 1898, signed among others by such erudite people as Sir Edward Brabrook and Sir Alfred Watson: 'We consider that State aid cannot be justified unless it is limited

1 Cf. in the preface to Sir Leo Chiozza Money, *Insurance* v. *Poverty*, 1912, p. 8.
2 Cf. J. H. Clapham, *An Economic History of Modern Britain*, 1938, p. 425.

to aiding the individual when circumstances beyond his control make it practically impossible for him to save from his own earnings an adequate provision for old age.'[1] But what were 'circumstances beyond his control'? What was 'practically' impossible? What was an 'adequate' provision? This and similar Reports never took pains to inquire into such 'details', and for many opponents of the health scheme of 1911 the same old catchphrases were as alive as ever. Other objections sprang from very definite materialistic motives. During the passage of the Insurance Bill through Parliament various bodies with different vested interests became alarmed lest their rights and privileges should be interfered with. The doctors were afraid of too much official control and too little remuneration; the friendly societies were anxious to protect the position of their members; the commercial insurance companies demanded admission in the scheme; and representatives of the women's organizations concerned themselves with women's interests to the exclusion of every other consideration. 'Some attempt was made in the Act to unite these various interests, but Parliament left its work in this direction unfinished, and assigned it to Commissioners to complete', writes Dr Brend.[2] The Commission, consisting among others of representatives of the British Medical Association, of insurance companies, of the friendly societies and of women's organizations, was an attempt to reconcile the conflicts. But the influence of these interests on the structure of the new legislation and its administration remained powerful; and it was certainly not lessened by choosing Commissioners to represent them within the administrative authority itself. The important fact is that the agitation of certain material interests, seriously concerned about the structure of the proposed measure, had a very definite influence upon its final shape. As Mr J. L. Smyth of the Social Insurance Department of the Trades Union Congress put it a few years ago when interrogating a witness before the Royal Commission on Workmen's Compensation:[3] 'There were interests powerful enough to force their way into the scheme, although it had never been intended that they should be in it?' It was the intention of the scheme originally—and claimed on its behalf by no less an authority than the Act itself—that the prevention of ill-health should be the

1 Cf. *Report on Old Age Pensions*, 1898, p. 13.
2 Cf. W. A. Brend, *Health and the State*, 1917, pp. 220 sqq.
3 Cf. Royal Commission on Workmen's Compensation (from now quoted as Hetherington Commission), Evidence, 1939, Q. 1464.

chief vested interest of the nation, and that all other vested interests should be subservient to that.

It seems almost miraculous in view of the many powerful opposing interests that an Act of this kind could have emerged at all. What is necessary for the purpose of this investigation is to analyse how far the structure and administration of the Act, which still remains the foundation of sickness insurance in this country, was evolved from a well thought-out plan and how far from amendments to meet the wishes of interests outside the sphere of its originators.

It is generally accepted that the ideas of the National Health Insurance scheme of 1911 were deeply influenced by the tragic revelations of the Poor Law Reports—Majority and Minority—of 1909 and by the German example of national sickness insurance. The introduction of the scheme actually followed a recommendation by the Royal Commission on the Poor Laws that medical assistance should be organized on a provident basis, and that an insurance scheme should be set up to provide some form of cash benefits for persons incapacitated from wage-earning, rather than that such persons should be driven to seek Poor Relief.[1] This recommendation was a flat confession that neither the Poor Law nor the organization of friendly societies, clubs and trade unions had been able to deal satisfactorily with the effects of sickness among the humbler classes on poverty and the effects of poverty on sickness. The existing system of relief as divided between the 'voluntary agencies' and the two distinct 'public authorities dealing with the sick poor', the Destitution Authority and the Local Health Authority, had proved to be insufficient as a whole and full of deficiencies in particular. The Minority Report of the Poor Law Commission dealt very fully with the shortcomings of the friendly societies; it stated: 'To quote the words used by a medical witness, himself a Poor Law Guardian, "the clubs are a failure, both for the patients and for the medical men".'[2] This criticism was merely incidental to what the Report had to say about the general insufficiencies of sickness relief.

The truth that disease creates poverty had been recognized and enunciated many decades before; Sir Edwin Chadwick had been the first to state this truth and prove it by detailed investigations, and it was, as John J. Clarke remarks,[3] the basis of the Poor Law

1 Cf. Hetherington Commission, *Memorandum of the Ministry of Health*, p. 150.
2 Cf. *Minority Report* (Fabian Society edition), 1909, p. 256.
3 Cf. John J. Clarke, *Social Administration*, 1922, pp. 261–2.

health activity of 1838. The complementary truth, the same writer observes, that poverty creates disease, was a more recent discovery, and owed its acceptance to the development of interest in general social reform rather than to any activities primarily concerned with health itself. The Reports of the Poor Law Commission constituted an outstanding landmark in this awakening. While the Majority and the Minority Reports analysed different causes and recommended different remedies, the whole Commission united in condemning the operation of the Poor Law, and almost unanimously advocated a clean sweep of Poor Law principles. It was decided that the whole province of social reform relating to poverty, its causes and effect, needed to be dealt with on principles wholly different from those of the Poor Law.

'It was natural, therefore, that the National Health Insurance Act, 1911, should turn definitely and finally away from the Poor Law principle, and in its new endeavour to break the vicious circle, should take the great voluntary thrift organizations as a model for a new system', writes Clarke. The first assumption, that it was natural to break away from the Poor Law, is not unjustified. But the assumption that it was similarly natural to model the new system on the voluntary thrift organizations is quite unwarranted. It has had far-reaching consequences, for the entire system of National Health Insurance still rests upon the association of the so-called 'thrift institutions' with sickness insurance. That such a step was at all necessary is denied by Dr Brend. 'When the Insurance Act was under consideration,' he writes,[1] 'an opportunity existed of sweeping away the stigma by incorporating the Poor Law medical system into a general public medical service, but unfortunately the opposite step was foolishly taken, and Poor Law authorities were rigidly excluded from those with whom Insurance Committees[2] might make arrangements for sanatorium benefit. Then, after emphasizing the stigma of pauperism, the Insurance Act provides no alternative but the Poor Law infirmaries for many thousands of tuberculous insured persons.'

There can be no doubt that the supporters of the National Health scheme were very much aware of the grave deficiencies and shortcomings of the system of friendly societies and other voluntary sickness benefit institutions. They knew the Poor Law Reports which, in particular, had dealt with the disappointing medical efficiency of the system. Sir Leo Chiozza Money wrote:[3] 'The State Health Insurance system works through the existing

1 Cf. Brend, *loc. cit.* pp. 294–5. 2 See below, p. 17. 3 Cf. *loc. cit.* p. 118.

voluntary thrift institutions, and permits voluntary institutions to be formed to carry out its provisions. No other course could have been adopted. If we can imagine for a moment the field of action cleared of all existing Friendly Societies, legislation for Health Insurance would have been exceedingly simple, and a lucid and logical system of local organizations could have been formed to carry out its beneficent provisions. We can imagine the whole working population naturally grouped in Local Sickness Funds, democratically governed, and including in their scope all the workers under a certain income limit, irrespective of age, occupation or health. A Bill to create such a system would be a comparatively simple piece of legislation.' This was not a flattering comment upon friendly societies to which, however, Mr Lloyd George, who prefaced the book, had seen no objection. 'But it was impossible', continues Sir Leo, 'to secure a clear field of action'; and he even attempts a 'salto mortale' by adding: '. . . it is quite impossible even to wish that the field was clear. Existing Friendly Societies and Trade Unions have done great things for the working population.' He tries to explain the inclusion of the thrift institutions into the scheme by arguing that 'Friendly Societies in the past have been too much neglected by the Legislature. They have received a little assistance, but for the most part have been left to blunder along in honest ignorance, which is often as fatal to their members as wilful dishonesty.' Apparently the financial deficiencies of the friendly societies, made good by State help, and their other shortcomings, regulated by State control, were regarded as the new safeguards against the old system of *laissez-faire.*

In criticizing the attitude of the sponsors of the Bill as rash and unconsidered, one must remember that the opposition from all quarters up to the very last moment forced them into a 'now or never' policy. On 4 December 1911 *The Times* could report that the 'vigorous opposition to the servant's tax continues and there are signs of increasing discontent, not only among trade-unionists and the industrial section of the community, but on the part of other classes, including women teachers and lecturers. Members of Parliament continue to receive a very large number of letters protesting against the Bill. . . the general Federation of Trade Unions is promoting among the affiliated societies throughout the country organized opposition to the denationalization of the Government scheme, to which objection is taken on the grounds of expense and difficulties of administration, and on account of

its tendency to separate English, Irish, Scotch and Welsh trade-unionists into separate camps.' In the same issue of the paper, Prof. A. V. Dicey wrote from Oxford: 'The repeated changes in the Bill are its condemnation. I doubt if two men in or out of Parliament could be discovered who can understand the contents of the Bill or predict its working.' How little the Bill was favoured, even by those who might have been expected to be most fully conversant with it, may be gathered from a speech made by Mr Philip (later Viscount) Snowden to the Fabian Society on 28 July 1911.[1] He was indignant that workmen should have to pay insurance contributions and the State only £5,000,000 of the £25,000,000 to be raised. 'The Bill', he said, 'would be a tax on the starvation of the people, a pettifogging, meagre, meddlesome, inadequate and ineffective way of dealing with conditions which were a grave menace to the community.' The fate of the Bill seemed to be imperilled by the attacks of those who found that it gave too little as well as by the attacks of those who thought that it gave far too much.

In these circumstances it is not surprising that the sponsors of the new scheme were driven to court the support of the great and politically powerful institutions which had in the past administered health benefits. When Mr Gladstone introduced his Post Office Annuities, in the face of no less opposition than Mr Lloyd George encountered fifty years later, he met with strong protests from the friendly (collecting) societies, which waited on him and 'appealed' to him 'not to interfere with private trade and enterprise'. But he did not give way. As he explained to the House of Commons, he did not consider many of these societies qualified to say: 'Do not enter into this field, it is occupied already.'[2] The situation was not entirely dissimilar in 1911; but, while Mr Gladstone was able to carry his scheme through, Mr Lloyd George and his supporters saw no way out of their difficulties but to reach an accord with the existing institutions and to bring them into the scheme by giving to it a shape suited to their demands.

The friendly societies, so far as they did sickness business, were afraid that they would lose it if a centralized State scheme administered by the State were introduced. More positively, they wished to profit by an extension of their activities if sickness insurance by becoming compulsory was to embrace many more millions of people. The friendly collecting societies together with

1 Cf. *The Insurance Mail*, 19 Aug. 1911.

2 Cf. *H.C. Debates*, 7 March 1864, p. 1555 and 11 April 1864.

the industrial assurance companies were startled by the prospect that, as it appeared for a time,[1] Mr Lloyd George might include burial benefit with sickness benefit as in the German scheme.[2] Two outstanding concessions were to be made to bring these interests into the National Health scheme and to secure their support for the whole measure.

1. The activities of the existing voluntary associations and institutions were combined with the scheme by means of the so-called *Approved Societies.*

2. Burial benefit was excluded from the provision for sickness insurance.

The first concession is of crucial importance; it was instrumental in the construction of the administrative machinery of National Health Insurance as it still exists. The second concession represents the omission of a benefit which in most countries is included in national sickness insurance. If it had been included in the National Health scheme of 1911 it would have meant a great improvement in the benefits, but no change in the structure of the scheme—though it would certainly have resulted in the disappearance of the system of industrial assurance.

The introduction of the system of approved societies was a recognition of the fact that the administration of sickness benefits by voluntary and entirely private institutions had failed. The new scheme was based upon the principle that there must be control over the insurance carriers, which would now be responsible for serving about ten million persons hitherto uninsured, as well as those already insured by existing voluntary agencies. The aim of the new scheme, 'to convert uncertainty into certainty, insecurity into security', as Mr Lloyd George once expressed it, could only be attained by new principles and new methods of administration. The basis of the new scheme was that two conditions as to the insurance carriers were to be strictly upheld:

1. The society was not to be carried on for monetary profit.
2. It must be subject to the absolute control of its members.

For friendly societies in general these rules already existed, although the framers of the new scheme might have been well advised to investigate how far the representation of members in societies which had been 'commercialized' and centralized had

1 Cf. Wilson and Levy, *Industrial Assurance,* 1937, pp. 74–5.

2 Cf. also G. B. Wilkie, in a leaflet (edited by R. H. Burgess) of the Insurance Guild journal, *Nationalization of Insurance,* 1931, p. 36.

become a dead letter. The first condition raised obvious difficulties in the case of insurance offices, which wished to be brought within the scope of the Act, but which would be excluded because they were private companies working for profit. The device of the approved society was the way out; and approved societies were formed as separate units or sections by those insurance offices entrusted with the administration of cash benefits under the Act; they became the insurance carriers. Had this way out not been found, the life assurance companies would have been excluded 'a limine' as, in fact, they had no members at all, but only customers, that is, policy-holders.

The same way out was found for the 'collecting societies'. Obviously they could not be placed in the same category as the friendly societies proper. The so-called 'book interest' made their agents 'capitalist' administrators. This interest is the right of an agent, or in the case of his death of his legal personal representative, to nominate his successor; in more direct terms it is the right of an agent to sell his 'book'.[1] The National Health Insurance Act, therefore, extended the obligation to form separate approved societies, if they wished to do sickness business under the Act, to these 'friendly societies' as well.

The case of the trade unions was no less difficult. Even in the eyes of their ardent supporters, trade unions were not well fitted to do insurance business on modern actuarial lines. Their customary method of doing sickness insurance without insurance reserves resembled the methods of the primitive sharing-out clubs. Moreover, trade unions have other definite objects which take precedence over that of health insurance. It was just as necessary in their case as in that of the collecting societies to detach sickness insurance from any preoccupation with other purposes. So, in the case of trade unions as well, the formation of approved societies was made a condition of entering the new scheme. The smallness of many trade unions was not an obstacle to their forming approved societies. The Act allowed small societies, whether friendly societies or trade unions, to become approved, on condition that they pooled a proportion of their risks by association with other societies. The trade unions expected that from the many millions

1 The Committee on Industrial Assurance (Cohen Committee) of 1933 described this particular feature of friendly collecting societies as securing to the agents of the societies 'the capitalized value of the excess of the agent's commission over the market value of the services he renders'. Cf. *Committee on Industrial Assurance Report*, 1933, pp. 22–3.

of compulsorily insured persons they would gain millions of new members;[1] and trade-union membership did in fact greatly increase during 1912–14 as a result of the National Insurance Act, which brought many thousands of recruits to the approved society sections of the unions. But an effort to centralize trade-union activities under the Act failed. In 1911, the General Federation of Trade Unions formed an approved society with the object of relieving the separate trade unions, and notably the thousands of small ones, from the onerous task of administering the Act separately. But the venture attracted only a few thousand members.[2] There was another advantage which accrued to the trade unions: up to 1911 most of them had a common fund, which was used for general management and the provision of strike pay and also, in many cases, for sick pay, unemployment benefit and, sometimes, burial money. Thus, the general fund was in many cases liable morally, though not legally, to the members of the unions for sick pay and unemployment benefit. Under the National Insurance Act these liabilities were now undertaken by the State, which provided new reserve values[3] for the purpose of giving sick pay and so relieved the funds of trade unions which became approved societies from the sick-pay liabilities which they had hitherto borne, and so set free a part of those funds for strike pay and trade disputes, etc.[4]

Far more than the unions, it was the friendly societies which directly benefited from the Act of 1911 and its health insurance provisions. To understand this the actuarial position must be considered. Every worker compulsorily insured by the Act entered insurance at the same flat rate of contribution; every worker aged 16 to 65 years of age was treated as though 16 years of age, and this was accomplished by drawing upon the entire insurance fund in order to create for each person over 16 a reserve fund such as he would have accumulated if he had been contributing ever since he was 16. By this means, the whole of the insured were made 16 years of age for insurance purposes. When the member of a friendly society became compulsorily insured under the Act, he was furnished with a new insurance reserve, and for the purpose of National Health Insurance no longer needed the existing reserve which he had built up by his own savings; this reserve was

1 Cf. Chiozza Money, *loc. cit.* p. 136.

2 Cf. S. and B. Webb, *History of Trade Unionism*, ed. 1902, pp. 495 and 555.

3 See next paragraph.

4 A. S. Comyns Carr, W. H. Stuart Garnett and J. H. Taylor, *National Insurance*, 1912, pp. 33–4.

released. The friendly society was entitled to recast its finances in view of this, and could make a scheme either increasing the benefits to its members without increasing their subscriptions or reducing their subscriptions—or combining both methods. What happened was that by the Act the liabilities of friendly societies were reduced at a stroke by £10,000,000 or more.[1] In view of the very insecure financial conditions of the smaller societies, this 'windfall' may well have been for many societies an eleventh-hour salvation.[2]

Commenting on this point Sir Leo Chiozza Money declared: 'It will be seen how substantially the existing members of solvent Friendly Societies stand to gain.' But the Act found the majority of the small friendly societies insolvent. 'It puts them on their feet again', commented Sir Leo,[3] 'by giving new reserve funds to their members under the equalization of age provisions. Having put them on a sound basis, the Act keeps them solvent by submitting them to an expert supervision which allows them freedom for good while denying them freedom for bad management.' The National Health Insurance Act was frequently blamed for reducing independent saving by compulsion and State aid. It was seldom observed that State help had actually become a dire necessity because of the financial shortcomings of so many of these 'self-supporting' institutions.

The life assurance offices which had no members also gained. Under the National Health scheme, industrial assurance companies were enabled to combine their business of funeral insurance (coupled with endowment policies) with that of sickness insurance by forming approved societies. They were the 'other interests' which broke into a scheme intended for friendly societies and trade unions.[4] A dramatic struggle between the Government and the

1 Cf. Chiozza Money, *loc. cit.* p. 135 and Joseph L. Cohen, *Social Insurance*, 1924, p. 34.

2 It should be noted that under the National Insurance Act, the Government undertook the payment of two-ninths of all benefits, and two-ninths of the cost of management expenses. But, for some eighteen years, a sum equal to the parliamentary grant had to be set aside for the accumulation of a reserve fund, in order to provide the benefits for those entering above the age of 17 at the same rate as for those entering at 16. For the first eighteen years of insurance, therefore, the person entering into insurance at the age of 16 got no direct benefit from the parliamentary grant, but the wholesale contribution of 7*d.* provided by himself and the employer was available to pay for his benefits and the cost of their administration. Cf. also Comyns Carr, Garnett and Taylor, *loc. cit.* pp. 100 sqq.

3 *Loc. cit.* p. 69. 4 Cf. Hetherington Commission, Evidence, 1939, Q. 1463.

industrial assurance companies ended in the complete victory of the companies. It may be asked what business interest the industrial assurance companies had in mind when they asked to be admitted to the National Health scheme as insurance carriers by being allowed to form approved societies? Approved societies were non-profit-making institutions, while life assurance companies were not. Few people at the time were bold enough to suggest outright what the advantages of their inclusion into the scheme might be to these companies when viewed from the angle of their entire business organization. In a House of Commons debate, however, Mr Ramsay Macdonald quoted passages from insurance journals which explained with some frankness how non-profit-making health insurance work would help agents to get more profit-making industrial assurance business and how, when canvassing for approved societies, they could at the same time see that during sickness life assurance premiums did not run into arrears.[1] He observed: 'To have a man who comes in with his ten shillings to the sick person who is insured on a life policy through him and who deducts from the ten shillings, while he is handing it over, his weekly premium on his life policy, is not an operation which is going to benefit the man so much as the company.'

To-day the financial importance of National Health Insurance business to life assurance companies by the formation and management of approved societies is no longer denied. The Report of the Committee on Industrial Assurance in 1933 drew particular attention to the point.[2] It stressed the fact that it had been 'much impressed' by the evidence, given from first-hand knowledge, by witnesses representing the National Amalgamated Union of Life Assurance Workers. 'These witnesses, speaking very frankly, said that the payment of National Health Insurance benefits, "especially maternity benefit", was of great assistance to them in canvassing industrial assurance policies.' The Report added that, when it was realized that 40 % of the men and women who were contributing to the National Health Insurance Acts are members of approved societies associated with industrial assurance offices, 'the significance of the statement will be appreciated'.[3] Industrial

1 Cf. *H.C. Debates*, 6 Dec. 1911.

2 Cf. *Committee on Industrial Assurance Report*, 1933 (Cohen Report), pp. 42–3.

3 Cf. also Cohen Committee, 1933, Evidence, Q. 4775; cf. also as to the same point L. G. Horsefield, *Practical Methods in Industrial Assurance*, 1935, who draws the particular attention of life assurance agents to National Health Insurance as 'one other source of prospects'. Cf. also W. Hardy Wickwar, *The Social Services*, 1936, p. 144: 'When an ordinary industrial insurance company

assurance companies and collecting societies must see that their agents, in spite of the tremendous competition among the men, who sometimes take to this job as the last chance of a disappointed life, get something like a minimum living. If the commission on industrial assurance, in many districts, does not suffice for this, there remain the emoluments from other branches, and in particular from National Health Insurance. If this source of income did not exist, the insurance offices would be obliged either to pay higher commissions or see their staff reduced.[1]

The original opposition to the Bill offered by the life assurance companies had been mainly directed against the inclusion of burial benefit in national health benefits. Clause 30 of the original Bill authorized the application to additional benefits of any surplus which might be found on the quinquennial valuation of the assets of approved societies. This might have meant burial benefit. The amended Bill expressly excluded burial money from benefits.[2] This arrangement was reached after a strong agitation on the part of the companies.[3] When the struggle was over, *The Insurance Mail* asserted that the Chancellor of the Exchequer now had the support of 100,000 practical insurance men and 'need fear no threats'.[4] On the second reading of the Bill, Mr Lloyd George paid high tribute to the offices which, he said, were managed 'with great skill by means of consummate business ability'. He did not say so because 'he wanted to buy off their opposition', but because 'he wanted their help'.

The list of those who might become insurance carriers under the National Health scheme, once the limitation to friendly societies and trade unions had been discarded, was not restricted to insurance companies only. Anybody was entitled to make an application to become an approved society, and on receiving

thought it good advertisement to act as an approved society, and good business to get a treasury grant towards its over-head expenses, it had to imitate the friendly society in making no profits in this department of business. . . .'

1 Mr J. A. Jefferson explained at the General Meeting of the Britannic Assurance Company on 21 March 1941 that the minimum wage for collecting of £3 now guaranteed for full-time agents should be viewed in the light of his possible further income from other sources, among them those 'in connection with National Health Insurance'; cf. *The Times*, 24 March 1941, p. 9.

2 Cf. Section 37 (3): 'No surplus and no part of any surplus shall be applied for the purpose of paying any benefits payable on death or any benefits other than one or more of the additional benefits specified in Part II of the Fourth Schedule of the Act.'

3 Cf. Wilson and Levy, *Industrial Assurance*, pp. 74–81.

4 Cf. *The Insurance Mail*, 28 Oct. 1911.

approval—dependent mainly on the conditions already stated—to undertake the business of health insurance. A wide field was now open: the Act contemplated the recognition of Employers' Superannuation or Provident Funds; societies of this kind were to be approved, although the employer was entitled to representation (not exceeding one-quarter of the whole) on the committee of management, if, in addition to the contributions which he was bound under the Act to pay, he made himself responsible for the solvency of the funds or was substantially liable to supplement the benefits.[1] As matters developed, the administration and organization of an approved society might now be linked up with an ordinary friendly society or a trade union, no less than with a sharing club, a co-operative organization or a federation of one kind or another.[2] The decisive point is that the retaining of the friendly societies and trade unions as insurance carriers and the widening of the list of such carriers without any other consideration than that of their financial safety and non-profit-making organization and democratic management gave to the administration of British National Health Insurance its fundamental character. Insurance carriers might have been formed exclusively on, say, a territorial or an occupational basis. Their operations may be related to a village, town or county; and their membership may be limited to certain occupations or creeds. But their administration is vested, as far as friendly societies are concerned, in approved societies affiliated to centralized societies. Finally, the different approved societies vary between very wide extremes in size, from a few dozen members to some millions.[3]

As compulsion was not applied to the joining of an approved society, provision had to be made for those not joining one. Under section 42 of the Act persons not being members of an approved society became 'deposit contributors'. Their contribution, together with the employer's contribution, is paid into the Post Office Fund and they are allowed to draw upon that fund when qualified for benefit to the extent of their credit and two-sevenths more—the balance being the contribution paid by Parliament. This applied not only to persons who by their own wish did not join an approved society, but also to those who were unable to obtain admission to an approved society on account of

1 Cf. Comyns Carr, Garnett and Taylor, *loc. cit.* pp. 8–9.

2 Cf. *Memorandum by the Ministry of Health to the Hetherington Commission*, section 33.

3 Cf. Hetherington Commission, p. 153, as to the requirement possibly made: the Rechabites will not take anybody who is not an abstainer, cf. *ib.* Q. 1236.

the state of their health. Thus the principle of voluntarism still further increased the already existing variety and multiplicity of insurance carriers. A system was adopted which, 'by a typical incorporation of the voluntary with the statutory',[1] contrasted sharply with the much studied German system with its State-organized territorial sickness funds (local and rural) and its uniformly organized occupational funds. It may be that in Germany the survival of guild institutions, mainly in mining, formed a link between the old and the new by providing the pattern for a corporative organization.[2] In England, such traits of industrial organization had entirely disappeared, and their idea had been replaced by an almost unshakeable belief in the financial and social efficiency of friendly societies and trade unions. Clapham declares that 'imaginative British statesmen, now having the power, were eager to experiment in all forms of national insurance without damaging the structure and effectiveness of Societies or the Unions', and that 'their piecemeal, empirical methods were what their nationality and their political environment dictated'. But it can be seen from Sir Leo Chiozza Money's valuable analysis of the German system, and the remarks on this system contained in Mr Lloyd George's preface,[3] that the English legislators were aware of the differences between their 'system' and the German one. It was probably no sentimental inclination to individualism and voluntarism, nor an over-estimate of the efficiency of the friendly societies, which produced the approved society idea. The struggle between Mr Lloyd George and the life insurance companies should not be forgotten. It was the vested interests which shaped the scheme.

The object of this chapter was not to describe even summarily the various features of the National Health scheme under the National Insurance Act of 1911. Subsequent chapters will deal in detail with the particular parts of the provisions such as premiums, benefits, expenses of administration, the special medical sides of the schemes as administered by the insurance committees, and other features as they present themselves to-day. The general effect of the scheme, compared with the situation existing before 1911, is that the health insurance of certain classes was from then

1 Cf. Clapham, *loc. cit.* p. 424.

2 Cf. Chiozza Money, *loc. cit.* pp. 49–50.

3 Cf. the whole chapter v and Preface, p. 8: 'it was from Germany that we who were privileged to be associated with the application of its principles to the United Kingdom found our first inspiration, and it is with her experience before us that we feel confident in the future.'

on compulsory; that sickness (cash) benefit as well as medical benefit was granted; and that employers and employees and the State shared in the financial support of the scheme. The fundamental feature of the scheme is the particular shape given to its administration by the provisions for insurance carriers. It is to this basic administrative characteristic that most of the criticism relates at the present time; and to it, perhaps, most of the deficiencies of the system are traceable. Friendly societies and life assurance offices were called to administer a scheme which was to be free from 'profit-making'. The fact that the friendly societies had entirely lost their original associative character, and in fact had become a fair copy of private businesses, was not taken into account. Indeed, under the pressure of powerful interests, no choice was left than to compromise. The approved societies and the insurance committees, administering medical benefits, were the essence of the compromise. The risks, so it seemed, were properly fenced. So originated—historically and politically—the British system of National Health Insurance. On these fundamental foundations it still rests.

CHAPTER II. THE DOCTOR'S CASE

'Commisisse cavet, quod mox mutare laboret.'[1] HORACE.

THE first important opposition to the administrative structure of the National Health Insurance legislation of 1911 came from the medical profession. The issue as represented mainly by the British Medical Association may thus be summarized.[2] The Report made by the Association in 1905 had exposed grave evils in regard to contract practice, especially in regard to the remuneration of doctors by friendly societies and clubs, evils which directly affected the adequacy of medical benefits to the sick. It was not pretended that the profession was not partly to blame for many of the abuses of the medical services administered under society rule, which drifted by want of foresight and common discipline into underpayment. But it must be taken into account that the doctors as a body were far more the victim of the unfavourable circumstances

1 'He is wary of doing what he soon may labour to undo.'
2 Cf. Comyns Carr, Garnett and Taylor, *loc. cit.* pp. 57 sqq.

of their trade, such as over-competition, than of their own mistakes. As the organization of the profession improved, the British Medical Association decided to make a vigorous attempt to put an end to the defects of the existing system, and the Contract Practice Committee of the Association[1] obtained the approval of the representative meeting, which on all questions of policy was the authoritative body of the Association, to a scheme for establishing what was called a Public Medical Service, to be organized by the profession itself. Administration of the medical side of the insurance scheme by the medical profession itself would have meant an entirely different development of the entire scheme. But, while some local medical services were actually started by the medical profession itself, the general carrying-out of the scheme was interrupted by the appearance of the Poor Law Commission Reports. The British Medical Association decided to oppose the suggestion made by the Minority Report that a unified medical service should be established under the control of the county and county borough public health authorities.[2] Comyns Carr, Garnett and Taylor explain this attitude—which was in some contrast to the profession's desire to see a uniform medical service established—by reference to the fear felt by the British Medical Association that 'the Minority's proposal for a system of whole-time medical officers could not for long be confined to the poorer classes, and that a free medical service open to all might result, which would cut the very foundation of private practice'. Moreover, no very cordial relations had existed for some time between general practitioners and the public health authorities, and the profession in general was opposed to any system that gave the Medical Officer of Health anything like a controlling influence in a service which would be largely concerned with domiciliary medical attendance. But the Majority Report, too, was not what the doctors wanted. It recommended an extension of the contract system of the clubs. The British Medical Association therefore decided to stick to their

1 'Contract Medical Practice', in *B.M.J.* 22 July 1905—Special Number.

2 *Minority Report of the Poor Law Commission*, ed. 1909, p. 285: 'The need for a Unified Medical Service'; also p. 293: 'that we therefore agree with the responsible heads of the four Medical Departments. . .in ascribing the defects of the existing arrangements to the lack of a unified Medical Service based on Public Health principles'. Then follows the recommendation of a Unified Medical Service, organized in districts of suitable extent under the Medical Officers of Health, Hospital Superintendents, School Doctors, District Medical Officers, Workhouse and Dispensary Doctors and Medical Superintendents of Poor Law Infirmaries.

scheme for a Public Medical Service which, if introduced, might have shaped some sort of provident medical service administered by doctors, and might very well have revolutionized private practice among the lower working classes.

The sudden appearance of the National Insurance scheme again interrupted the British Medical Association's plans. It now seemed necessary to strive to save as much as possible of the principles laid down by the British Medical Association in regard to the reorganization of the medical service. Six 'cardinal points' were evolved and submitted to the Chancellor of the Exchequer. They demanded:[1]

1. Income limits for those entitled to medical benefits.
2. Free choice of doctor by all patients, subject to the consent of the doctor called in.
3. Medical benefit to be administered by insurance committees and not by friendly societies.
4. Special provisions as to the methods of remuneration of medical practitioners by the insurance committees.
5. Further special provisions as to medical remuneration for the duties to be performed, and other conditions of service.
6. Adequate representation on various committees and among the insurance Commissioners.

Of these demands probably the most important administratively were those relating to the administration of medical benefit by the insurance committees. The other points were not less open to discussion or dispute. But the question of the fees to be guaranteed to the profession was a matter of bargaining rather than of principles. Similarly, the question of an 'income limit' point did not raise issues of principle, for it was evident that the scheme should not apply to all income categories. And the 'free choice of doctor' principle was accepted almost without reservation, on the ground, no doubt, that to compel any person to be insured and yet to compel him to have as his medical attendant one whom he might distrust, would be unreasonable.

Thus it was two points relating to the administration of medical benefits by insurance committees (3) and the representation of the medical profession on these committees (6), the points which went to the heart of the administrative structure of the scheme, which were most important. A lively discussion had gone on between the medical profession and the friendly societies. Most

1 Cf. also W. A. Brend in *Lancet* of 10, 17, 24 Feb. and 2 March 1912.

of the dividing (share-out) societies had assented to the transfer of medical benefit to the insurance committees; but the feeling in favour of retaining administration in their own hands was so strong in many of the great friendly societies, such as the Manchester Unity and the Foresters, that the Government decided to leave the question to the House of Commons. Accordingly Dr Addison, M.P., acting on behalf of the British Medical Association, proposed an amendment to the effect that medical benefit should in all cases be administered by the insurance committees. This received the personal support of the Chancellor and was carried by a very large majority, 387 to 15. The argument which probably carried greatest weight with the House was the 'urgent need for uniformity in the medical service, which could hardly have been attained if every approved society had adopted its own methods'.[1] The supporters of this amendment would be surprised to see that, in spite of it, the great diversity of medical benefits remains one of the most difficult problems after thirty years of experience.

What happened was that the medical profession, having won its victory, was disappointed by two intrusions into the unrestricted administration of the medical service by the insurance committees as envisaged by the British Medical Association. One was due to the acceptance of the so-called 'Harmsworth amendment'. This was introduced by Mr Harmsworth, member for Luton, primarily to protect the vested interests of medical institutes. Medical institutes were affiliations of friendly societies; they provided general domiciliary medical attendance and were staffed mostly by salaried whole-time medical officers. In 1912 there were about 100 medical institutes comprising approximately 300,000 members, and the medical profession was not happy about the way in which some of these institutes were run.[2]

The second intrusion that disappointed the medical profession was much more disquieting. It affected the composition of the insurance committees. Originally, the profession had devised a scheme under which the administration of the medical side of National Health Insurance would be entirely entrusted to the doctors. Then, it was expected that the system of administering medical benefit by means of insurance committees would be a fair

1 Cf. Comyns Carr, Garnett and Taylor, *loc. cit.* p. 61 sqq.

2 By the Harmsworth amendment and section 15 (4) of the Act it was made possible for at least the existing institutes to carry on—though a safeguard against abuse was included by the conditions, first, that treatment must be approved by the insurance committee and the insurance Commissioners and, secondly, that the free choice of doctor by the patient was not to be impaired.

compromise with the plan of control by doctors. But the final arrangement was a great disappointment. Insurance committees were to be appointed in every county or county borough, the number and method of appointment to be settled by Commissioners. Each committee was to contain not fewer than 40 and not more than 80 members, of which three-fifths were to be representatives of insured persons, drawn partly from approved societies and partly from deposit contributors, in proportion to the respective numbers of their members. The whole organization of insurance committees and approved societies (the latter administering sickness benefit) was to be supervised and directed by the insurance Commissioners, who enjoyed very wide powers. There were four sets of insurance Commissioners co-ordinated by a joint committee under a chairman, the first chairman in 1912 being the Under-Secretary to the Home Office. In both bodies, the insurance committees and the insurance Commissioners, the doctors had expected to get a larger share of representation. On the insurance committees, the medical profession could, as Comyns Carr, Garnett and Taylor put it,[1] 'not reasonably expect' more than enough representatives to voice its opinions in matters relating to the profession or to public health; and at the request of the British Medical Association the number of medical representatives was increased above the proportion originally envisaged, so that in a committee of 40 at least 4 must represent the medical profession, in a committee of 80 at least 6, and in a committee of 60 or upwards at least 5. In every case these were to be directly elected by the local profession itself. But the medical profession had expected more.

The medical profession was not less dissatisfied with the Commissioners. In 1917, Dr Brend vigorously criticized the composition of the Commission as offering much too little scope for comprehensive and decisive medical representation. 'No objection could be taken to the composition of this body', he wrote,[2] 'from the point of view of reconciling or representing divergent interests concerned, but it is important to note that the course adopted involved sacrificing any idea of making the Commission authoritative in public health questions. Not one of the members, however eminent in other directions, would claim to have had any special experience in Public Health Administration, or special knowledge of its more scientific problems; yet they were called upon to administer an Act which touched Public Health questions

1 Cf. *loc. cit.* p. 62.

2 Cf. Brend, *loc. cit.* p. 221.

in every direction, and one which, so far from providing a fully worked-out scheme, left to the discretion of the Commissioners many matters of the greatest importance.'

It is from this angle that the medical profession held that the Act of 1911 did not fulfil its promises. 'It is not surprising that under these circumstances the Commissioners have never regarded themselves as forming a Public Health Authority. This is clear from their administrative actions and utterances. They have devoted their energies mainly to creating the machinery for enforcing insurance; they have been satisfied with mere names, as for instance "Domiciliary benefit" in place of an efficient system of treating tuberculosis; and they have neglected almost entirely those provisions of the Act which demanded scientific knowledge or were of a preventive character.'[1] The same criticism was applied to the insurance committees:[2] 'Insurance Committees still have power to make reports on the health of the insured persons and are also required to provide lectures on health; but in actual working, the time of these bodies has been so fully occupied by administrative details, that their Public Health functions have been almost entirely unexercised.'

It is true that the duties of the Commissioners were only partially concerned with medical matters. Shortly after the passing of the Act it was found that their powers of control were too limited and in the Act of 1913 (3 and 4 Geo. 5, c. 37) provision was made enabling insurance Commissioners to withdraw approval from a society on account of maladministration of its affairs, where it appeared expedient in the interest of the members of the society to do so.[3] The Commissioners were up to their eyes in economic, financial, actuarial and legal matters. Little room was left for the conception of a constructive health policy.

In 1919 the Commissioners were succeeded by the Ministry of Health, which became the central authority for the administration of the Act in England (in Scotland the administration of the Act was supervised by the Scottish Board of Health, but the National Health Insurance Joint Committee was composed of representatives from England, Scotland and Wales and Northern Ireland). But the insurance committees remain; and the conditions of representation complained of by the doctors still exist.

1 Cf. Brend, *loc. cit.* p. 221. 2 Cf. *ib.* p. 223.

3 Cf. also *Report of the Royal Commission on National Health Insurance*, Cmd. 2596, 1926, p. 109. The Report will from now on be quoted as *N.H.I. Report*, 1926.

The medical profession is represented,[1] but it has in no way a decisive voice.

It can be understood why the medical profession was dissatisfied with the organization of National Health Insurance when the Act is contrasted with the expressed aim of the profession to create a uniform national medical service. But the doctors did not realize that the measure was not one of National Health but of National Health Insurance. They took too literally the claim of its promoters that it would be good for the nation because it would greatly improve the nation's health.[2] Mr Lloyd George certainly stressed this point very much. It was only natural that he should lay emphasis upon the improvement in health to be expected from National Health Insurance. It was an argument which nobody could resist in good faith, and was very powerful in breaking down the stand made against State insurance by vested interests. Dr Brend and others, in criticizing the Act for not carrying with it a comprehensive, uniform scheme for health improvement, entirely overlooked that the object of the Act was in the first instance 'to provide insurance against loss of health'. It was the outcome of the fact that voluntary mutual efforts had not secured this social and economic provision at all adequately. The Act was only in the second instance 'for the Prevention and Cure of Sickness'; and this was certainly expected to be the indirect effect of the Act resulting from its primary object of insurance, to secure the means upon which the poorer individual should be able in times of the contingency of sickness to rely, instead of seeking Poor Relief or deliver himself to neglect of his health, disastrous to himself and dangerous to his fellow-creatures.

Doctors resented, in particular, the fact that the proposal contained in the original Bill for the establishment of a 'Local Health Committee' in each county and county borough had been dropped. Each committee was expected to consider 'the needs of the county and county borough with regard to all questions of public health, and may make such reports and recommendations with regard thereto as it may think fit'. Mr Lloyd George attached much importance to the possible activities of these bodies; he had in mind that they might serve as local or district health committees

1 Cf. N.H.I. Act, 1936, 26 Geo. 5 and Edw. 8, c. 32, section 91.

2 In this respect a group of British investigators was much impressed by the progress achieved in Germany; cf. National Health Insurance, Medical Benefit under the German Sickness Insurance Legislation, Cmd. 6581; also Brend, *loc. cit.* pp. 217–18.

which would view the new measure mainly from the point of view of the improvement of the medical service.[1] But the local health committees were replaced by the insurance committees. The name 'local health committee' disappeared. The duty to 'consider generally the needs of the county or county borough with regard to all questions of public health' was no longer required. The insurance committees had power to make reports on the health of insured persons and were also required to provide lectures on health. But they were not what the medical profession had envisaged. They were not medical committees but insurance committees; they were burdened with a great variety of non-medical tasks. Dr Brend gave expression to the doctors' dissatisfaction in drastic terms; it gives a clue to the attitude of medical men, then and now, towards National Health Insurance administration:[2]

'. . . in actual working, the time of these bodies has been so fully occupied with administrative details, that their Public Health functions have been almost entirely unexercised. Where Local Health Committees might have been making exceedingly valuable investigations into infant mortality, adulteration of food, bad housing, atmospheric pollution, prevention of tuberculosis, etc. Insurance Committees have spent their time in preparing and maintaining registers and panel lists; in discussing such questions as to whether doctors may write "Rep. Mist." instead of a prescription; in negotiating with chemists over the costs of drugs; in keeping voluminous accounts; and in deciding the maximum number of eggs or pints of milk which may be given under "domiciliary treatment" to a person in an advanced stage of phthisis.'

Such criticism ignored, or at least underestimated, the difficulties of a mere administrative and financial kind which faced the insurance committees and their strict responsibilities. How little doctors were able to perceive the economic and administrative responsibilities coupled with the new Statute became evident when Dr Brend regretted that medical benefit had not been left with the approved societies.[3]

The same conclusions, with criticisms not unlike those of Dr Brend, though reached from a very different angle, were stated in a book written by the only English economist who has made a special study of social insurance, Joseph L. Cohen. He sharply attacked the system of approved societies as it had developed under

1 Cf. *H.C. Debates*, 4 May 1911.
2 Cf. Brend, *loc. cit.* p. 223.
3 Cf. *loc. cit.* p. 223.

the Statute.[1] One of the first to do so, he drew attention to the great disparities between the benefits granted by the multifarious approved societies; and he spoke of 'deeper objections' than that:[2] 'Where they administer the Act there is a lack of democratic interest with over-lapping of societies and inefficient management, and individuals who happen to join a society with a large number of bad risks are differentiated against. It needs a costly supervision by the State to prevent abuses. It leads to a maximum amount of friction with the doctors and the State. After thirteen years of experience it may be definitely declared that the "approved society" has been tried and found to be inefficient for the task. It certainly cannot be used as a machinery for administering a comprehensive unified system of social insurance.' This dictum may have been influenced by the author's desire to have all social insurance schemes, Burial Insurance, Old Age Pensions, Industrial Accident Insurance, Unemployment Insurance, brought into one unified relation to National Health Insurance. He may have asked too much from approved societies, just as Dr Brend expected them to do things which they were not able to perform. But the point is that within a very short time of the introduction of National Health Insurance, the most important part of the scheme, relating to the insurance carriers, had become open to considered criticism.

CHAPTER III. *THE ROYAL COMMISSION*

'States are great engines moving slowly.'
FRANCIS BACON, *Advancement of Learning*, Bk. II.

THE ROYAL COMMISSION which Cohen had advocated was appointed in the same year, on 11 July 1924. Its scope was confined to the National Health Insurance scheme as introduced in 1911 and amended by various measures up to 1922; and it was asked to report 'what, if any, alterations, extensions and developments should be made in regard to the scope of that scheme and the administrative, financial and medical arrangements set up

1 Cf. Joseph L. Cohen, *Insurance against Unemployment*, 1921; idem, *The Future of Unemployment Insurance*, 1922; idem, *Insurance by Industry Examined*, 1923; idem, *Workmen's Compensation*, 1923; idem, *Social Insurance Unified*, 1924, pp. 31 sqq.
2 Cf. *Social Insurance Unified*, pp. 35–6.

under it'. This Commission, with Lord Lawrence of Kingsgate as chairman, was composed of members with wide knowledge in administrative matters, such as Sir John Anderson, one of the Under-Secretaries to the Home Department, while for the actuarial side of the enquiry there were Sir Alfred Watson, the Government's actuary, and Mr Besant, President of the Institute of Actuaries; and for the medical side Sir Humphry Davy Rolleston, President of the Royal College of Physicians. Prof. Alexander Gray, who had written an important study on certain aspects of National Health Insurance, supporting a closer co-ordination between the Unemployment and National Health Insurance schemes, was also appointed.[1] The Commission began work on 17 July 1924. A great wealth of evidence was published in this and the following year, based on memoranda handed in by Government Departments and representative bodies of all kinds, which were published in separate Appendices of the Evidence. A separate actuarial Committee under the chairmanship of Sir Alfred Watson was appointed by the Minister of Health on the request of the Royal Commission, to assist in the enquiry into the financial and actuarial complications of the problem. Interest in the proceedings of the Royal Commission was surprisingly great. The weekly reports enjoyed a considerable sale, which reached a weekly average of as much as 600 copies.[2] A Majority Report and a Minority Report were finished by the end of February 1926, and together with that of the Actuarial Committee were published in 1926. It is to these valuable Reports and to the Minutes of Evidence and Memoranda that any investigation of National Health Insurance must look for much of its material.

The Royal Commission was not the first enquiry into the workings of the scheme since its inception, though it was the most important. Certain aspects of the working of the Statute had been investigated earlier. Two of these investigations should be placed on record. The first was the Committee which sat under the chairmanship of Sir Claud Schuster in 1913–14. It was appointed because of allegations that excessive sickness claims were being made on the funds of the approved societies. The Report gives an interesting account of the working of the societies at the outset of the scheme, but its results, overshadowed by the last war, have little bearing upon present-day conditions. The other enquiry of importance was that of 1916, which dealt with the

1 Cf. Alexander Gray, *Some Aspects of National Health Insurance*, 1921.
2 Cf. *N.H.I. Report*, 1926, p. 2.

finance and administration of the approved societies; and the amending Act of 1918 was much influenced by the labours of this Committee.

The labours and findings of the Royal Commission of 1924–25 into the development of National Health Insurance have two distinct aspects. On the one hand, the Royal Commission did review very closely the various arrangements made by the existing legislation for the different benefits provided under the scheme, such as cash benefits, medical benefits, maternity services, dental and other benefits; it analysed the scope of the legislation and the possibilities of its extension; it carried its study into neighbouring fields, such as Workmen's Compensation; and dealt fully with the intricate actuarial and financial details of the scheme. On the other hand, the Royal Commission did not make any systematic review or critical synopsis of the administrative system on which National Health Insurance had been based, in order to test its effectiveness during its first twelve years. The Royal Commission did not give anything like a clear and exhaustive picture of the material forces and ideologies which had led to this particular system, to the exclusion of other alternative systems. It did not confront the English system of sickness insurance with that of other great industrial nations, although the material to do so was placed at its disposal—and although the original framework of the scheme had been largely designed on a foreign model. The arrangement of the various sections of the Report does not indicate any desire to analyse the system of administration as distinct from the technical details. The question of financial resources and the approved society system, for instance, were considered as separate problems, while the problem of insurance committees, which played so important a part in controversies about the administration of the scheme, was discussed among other 'major problems' in quite a different place. First, approved societies are dealt with in several chapters in great detail; then the Report returns to the same problem later on under the heading of 'miscellaneous questions' affecting these bodies. There is no evidence of any plan to get down to the roots of the matter and to examine the 'system' of sickness insurance in England really methodically and comprehensively. It may be that their terms of reference, which spoke of the 'alterations, extensions or developments' to be made, and cautiously added 'if any', discouraged the Commissioners from scrutinizing the edifice too closely.

Nevertheless, the Report did contain much evidence as to necessary changes in administration. It is significant that a great deal of space was devoted to approved societies, more space in fact than to any other single subject. At the time the Royal Commission began its sittings, there were 1192 approved societies in Great Britain, of which 31 were societies with branches, the total number of these branches being 7226. 'That this leads to overlapping, unnecessary competition and waste, and avoidable administrative expenses is commonly agreed', wrote Joseph L. Cohen.[1] As the Royal Commission observed, 'the main ground on which the Approved Society system, as it now exists, has been attacked by many witnesses who gave evidence on the subject' consisted in 'the serious inequalities of benefit to which the system gives rise'. But apparently this did not in the least inspire the Commission with the idea that the system should be altered; on the contrary, the Commission held that such differences in benefit, and even in regard to the security of the benefits, conformed well with the measure of individual liberty of choice conceded by the Statute:[2] 'Under the present system an insured person is free to choose the Society to which he shall belong, and if he selects a Society which proves to be relatively unsuccessful and, as a consequence, unable to provide substantial additional benefits, he is, to some extent, responsible for the unfortunate position in which he finds himself.'

Apparently the Commissioners thought that the choice of an approved society by a workman was on all fours with, say, the choice of a new business connection by a merchant. They do not seem to have reflected at all on the fact that it was difficult, if not impossible, for a workman to ascertain beforehand the necessary facts about the financial status and security of an approved society—although the Commission itself had found it necessary to be assisted by actuarial and financial specialists in these matters. Nor did the Commissioners take into consideration under what conditions of persuasion—and by what dubious methods of canvassing—some societies obtained their members. The Commission was content to record that the word 'National' had never been interpreted to mean 'uniformity'.[3] It did not occur to the Commissioners that lack of uniformity can mean two very opposite things. It may mean a deliberate differentiation of administration which may be necessary in order to suit different conditions:

1 Cf. Cohen, *Social Insurance Unified*, p. 32. 2 Cf. para. 251.
3 Cf. para. 250.

health insurance finance might be handled differently, for instance, in industrial and rural districts, or ordinary rates of contribution might be different for employed and voluntary contributors, and so on. But it may also mean merely that differences are due to differences in the efficiency of administration; and in this case it might be regarded as the responsibility of legislators to see that the higher standard is made general. The Commission did not see it so; it made no proposals which might have gone beyond the task of 'mitigating inequalities of benefit'. It even pretended that 'on a cold analysis' the inequalities could be justified. The fact escaped the Commissioners' notice that it was precisely the gross inequalities under the system of sickness insurance before 1911 which led to the necessity for the National Health Insurance scheme in the first place. It had been expected that every individual would be fully protected by the uniformity of the new system; and it should have been clear to the Royal Commission that the Act of 1911 was thus far from securing its end.

Another point of outstanding importance suggested, or should have suggested, the same conclusion. The National Health Insurance scheme had been drafted on the principle that approved societies should be ruled by the members themselves in a 'democratic' way; and, as we have seen, the legal and statutory safeguards had been carefully drafted. There were no exceptions, and industrial insurance offices, being private undertakings, had to set up particular non-profit-making sections to comply with this principle. But the evidence given to the Royal Commission revealed the fact that democratic representation and control by members existed 'on paper' only. The Majority Report found it necessary to state:[1] 'We have had ample evidence that in some of the largest Societies associated with Industrial Assurance Companies there is no effective means whereby the members could exercise control over the affairs of Societies, whilst in many other Societies [!!] where the rules do contain provision for enabling such control to be exercised, the vast majority of members, mainly no doubt by reason of indifference or apathy, do not avail themselves of their opportunities and evince little or no interest in the affairs of their Societies.'

Thus history was repeating itself. Decades before the passing of the Act of 1911 friendly societies had ceased to be associative bodies ruled by their members; in fact they were not distinguishable from any commercial undertaking in their administration.

1 Cf. section 231.

The Act of 1911 was intended to create organization of genuine mutual and associative administration. By 1924–25 it was evident that it had failed.

The Minority Report strongly emphasized the two points of criticism about approved societies which stood out in such strong contrast to the expectations of the framers of the legislation. It declared:[1] '. . . we are definitely of the opinion that the wide disparity in valuation results was not contemplated by Parliament, and that the complete lack of any real opportunity for membership control, affecting over half of the insured population, has rendered almost negligible a feature of the system to which Parliament attached a very great importance'.

The Minority Report bluntly stated[2] 'that the Approved Society system is a hindrance to the development of a complete public health policy', 'that the intentions of Parliament as to the control of Approved Societies by their members have not been realized', 'that it is undesirable to retain Approved Societies any longer as the agencies for the distribution of cash benefits to insured persons', 'that Local Authorities could and should take the place of Approved Societies as the bodies through whom sickness and disablement benefit should be administered'.

But the Majority Report did not draw conclusions like these from the evidence offered. It actually recommended the continuation of the system of approved societies:[3] 'that the Approved Society system as a means for the administration of cash benefits of National Health Insurance should be retained'. But, cautiously, it added: 'that this question might have to be reconsidered in the event of fundamental changes being made in the system of social insurance'.

This was an easy way to escape the difficulties of a clear-cut decision. It was an easy way to avoid proposals which would have entailed an entirely new drafting of the administration of the scheme. Committees on matters of social reform not infrequently avoid the necessity of tackling the fundamental defects of a scheme by declaring that they have been empowered to deal with the defects of the existing scheme, but not to propose any radical alteration in the system itself. The Holman Gregory Committee on Workmen's Compensation, which sat five years before the Royal Commission on Health Insurance, withdrew to exactly the same line of non-interference with the existing 'system' and merely recommended a number of scanty measures to 'miti-

1 Cf. *Report*, p. 304. 2 Cf. *Report*, p. 327. 3 Cf. *Report*, p. 277.

gate' glaring evils.[1] The Royal Commission on National Health Insurance considered fully those aspects of the scheme which it thought to represent 'certain major problems'. One of these, the 'transfer of powers and duties of Insurance Committees to the Local Authorities', led to a recommendation which, if approved by the legislature, might have given a very different aspect to the administrative system of National Health Insurance. But it was never carried into effect.

A valiant attempt to secure a radical alteration of the administrative system on which National Health Insurance had been built was made in a reservation by Sir Andrew Duncan and Prof. Alexander Gray.[2] They drew attention to 'the lack of co-ordination in our social services'. 'We desire', they said, 'to point out the inconvenience and by implication the waste which it occasions.' They realized that, in considering the overlapping of various services, such as Poor Law Relief, Old Age Pensions, Health Insurance, Unemployment Insurance and Widows' Pensions, they were not 'within our Terms of Reference'. But they felt bound to express their opinion, 'realizing that the problems of Health Insurance are closely interwoven with wider questions, from which, in fact, they cannot be divorced'. Sir Andrew Duncan and Prof. Gray limited their reservation to the question how far National Health Insurance legislation could have been better devised to bring about an improvement in public health and how this aim could be effected in the future by an improvement of the scheme. They doubted whether the machinery in operation was at all capable of such improvement.[3]

It is a matter of controversy how far National Health Insurance was meant to have an outstanding direct influence on health improvement, or how far it should, in the first instance, only protect the lower classes against destitution by ill-health or, by treating sickness at the proper moment and with correct and sufficient means, avoid more ill-health and more sickness as a consequence of neglect through lack of means. The Commission, indeed, by its terms of reference might have felt constrained not to enter this field of thought at all, nor was it their task to draft a better plan for co-ordinating all schemes connected with national health. The Majority Report had not entirely ignored the fact that more

1 Cf. for details, Wilson and Levy, *Workmen's Compensation*, vol. I, p. 225 and whole chapters VII–XI.

2 Cf. *Report*, pp. 292 sqq.

3 Cf. para. 10 of the Reservation, *Report*, p. 297.

co-ordination of the health services, including National Health Insurance, was desirable in view of the aim to secure more effective 'prevention of sickness and the improvement of health'. But neither the Majority Report nor the two Commissioners in their Reservation drew the conclusion, as the Minority Report very decidedly did, 'that this is impossible while one essential health service is left unattached'; nor did they agree to the 'substitution of Societies under appropriate Local Authorities, which would apparently be the County Councils and County Borough Councils, for the present system of Approved Societies'.

So the harvest that might have been expected from the Royal Commission in fundamental administrative reforms was small indeed. That very real dissatisfaction with the scheme has not ceased since the publication of the Commission's evidence and Report was revealed later by the famous three-volume investigation made by Sir Arthur Newsholme and published in July 1931.[1] This was the conclusion at which the author arrived about the administrative complications of National Health Insurance in Britain and the efficiency of the scheme, viewed from the medico-economical standpoint:

'Apart from the restricted and unequal extensions of medical benefit provided by those Approved Societies which possess available surplus funds—and not completely supplied even by these exceptional Societies—medical benefits under National Health Insurance are incomplete in certain respects:

'1. There is no provision for treatment in hospital, or alternative treatment at home, for serious operations or other conditions requiring expert medical service.

'2. Apart from limited consultations possible with regional medical officers, who may be described as generalized specialists, there is no provision under the Act for consultation as to diagnosis for obscure cases of disease, or for treatment of eye, ear, throat, gynaecological or other cases needing special diagnosis and treatment.

'3. There is no provision for pathological and physical aids (X-ray examinations, etc.) in the diagnosis of disease and guidance as to its treatment (in 1914 national funds had been set aside for providing facilities for insured and non-insured alike, apart from insurance organization, but the War intervened. At the same

1 Cf. Sir Arthur Newsholme, *International Studies on the Relation between the Private and Official Practice of Medicine*, vol. III, 1931, pp. 142 sqq.

time funds were allotted for providing specialist help for insured persons, but this also fell through, on account of the War).

'4. There is usually no provision for nursing the sick. Insured persons, like others of limited means outside the insurance scheme, depend on voluntary and official hospitals, and on the Queen's Nurses and County Nurses' Associations.'

This was a sad indictment from one of the most authoritative of medical experts. The enquiry made in 1937 by Political and Economic Planning came to precisely the same conclusions. The Report had a remarkable reception in the press and with the public, though, as a matter of fact, it was not much more than a summary of the investigation made in 1924–25 and both Reports, mainly the Minority Report.[1] The Political and Economic Planning Report did not spare its criticism of the approved societies. But it did not occur to the authors, or did not impress them sufficiently, that the system of approved societies was in fact *the* British 'system' of administration. Political and Economic Planning started its Report with the preliminary statement that 'the administration of the National Health Insurance scheme is carried out by the Ministry of Health, the Department of Health for Scotland and the Welsh Board of Health, and assisted by local inspectors, by those bodies controlling the medical side of the scheme, by the Government Actuary as regards valuations, by the Treasury as regards the audit of the insurance funds'. But all these activities and duties of State departments and officers do not touch the actual administration of the scheme; they merely represent the controlling or supervising power, which surrounds and fences the actual administrative machinery.[2] The basic fact is that administration is definitely vested in the approved mutual benefit societies, managed by representatives of insured persons, and by insurance committees consisting mainly of representatives of societies and doctors.[3] Apart from this perhaps rather formal point, the position of the approved societies was well understood by Political and Economic Planning. The multiplicity of the societies, their overlapping, the inequalities of the benefits provided, the insufficiency of benefits, the lack of proper administra-

1 In 1939 a 6*d.* volume on *Britain's Health* was published by S. Mervyn Herbert, based on the P.E.P. Report. Lord Horder wrote a preface to this interesting condensed study.

2 Cf. *P.E.P. Report*, pp. 199–200.

3 This is definitely stated in I.L.O., *International Survey of Social Services*, Geneva, 1936, p. 359, which is based upon official information (see p. viii) or approval.

tion by members—all these complaints were once more set out with greatest clarity. Yet this cardinal deficiency was not made the central point of attack by Political and Economic Planning. Instead, the Report described the deficiencies and gaps in the medical service offered under the National Health Insurance scheme in order to demonstrate its weakness in the framework of national health services in general.[1] The inherent imperfections of the administration of National Health Insurance were not checked against other systems and other administrative possibilities for the health insurance of the poorer classes. The suggestion of a 'public medical service'—which, of course, implies a method of dealing with the contingency of sickness quite different from the insurance method—was the only alternative that the Political and Economic Planning Report considered, and rejected. The possibility of introducing a different method of health *insurance* administration was not discussed. The recommendation of the Minority Report of 1926 that, by stages, the work of the approved societies should be taken over by the county councils and county borough councils was mentioned but not discussed. But attention was called to the fact that, in 1933, the Irish Free State Government had passed an Act, by which a unified society was set up for nearly all insured persons, while the system of approved societies, which had existed there on the British lines, had been abolished.

The Political and Economic Planning Report did a valuable piece of work in reminding the public, politicians and social reformers once more that, in spite of the labours of the Royal Commission of 1924–25, and their Report of 1926, nothing had been changed; nothing had been done to meet the complaints which had never ceased to accompany the working of the 1911 scheme since its inception. In effect, the friendly societies' system, in spite of so many of its failures, had been reinstated when National Health Insurance was created; the system of private insurance, represented by industrial insurance companies, had, by a clever evasion of the original intention of the legislators, been incorporated into the scheme—with safeguards for the insured. Disappointment with the scheme had never been absent from its very first years. If, after the findings of the Royal Commission in the twenties, the books by Joseph L. Cohen and by Sir Arthur Newsholme, the Political and Economic Planning Report of 1937 and a host of other criticisms, some erudite writers

1 Cf. *P.E.P. Report*, pp. 211 and 229.

can still claim that 'the final success of the scheme was made possible by the action of the large industrial assurance companies and collecting societies who formed separate societies for National Health Insurance purposes',[1] one is left with the sad feeling that, in C. F. G. Masterman's words, 'the surface view of society is always satisfactory'.[2] It is always impressive to state with an array of figures, setting out annual contributions and benefits, and payments and reserve funds which run into millions of pounds, what a 'social service' is doing. What it has not been doing is always more difficult to state. But sufficient is known to make quite plain that the National Health Insurance scheme has not achieved 'final success'. When the Bill had had its third reading in 1911 an economic journal of authority wrote:[3] 'No doubt this scheme will be amended in many ways as experience brings its lessons. It is too large and too ambitious, but we hope, and are inclined to think, that in the end it may yield a balance of good.' The deficiencies which the *Economist* foresaw materialized to a far greater extent than was expected; but the amendments of the Act between 1911 and to-day have been relatively few and of a secondary nature.

Of the more important amending Acts passed between 1911 and 1940 that of 1913 (3 and 4 Geo. 5, c. 37) should be mentioned first. The immediate purpose of the Statute was to make provision by Exchequer grant for the additional cost of medical benefit. At the same time, the opportunity was taken to give effect to a certain number of minor amendments the need of which had been disclosed in the early period of the working of the Act. Among others the Act provided for an increase of the fees payable to the doctors. Temporary war-measures relating to soldiers and agricultural workers were enacted in 1914 and 1916; in 1915 and 1917 Statutes were passed to effect an adjustment of the benefit payable to discharged soldiers in receipt of total disability pensions at the highest rate.

Much more important was the National Health Insurance Act of 1918 which followed the Report of the Departmental Committee on Approved Society Finance and Administration under the chairmanship of Sir Gerald Ryan, F.I.A. The Committee had issued three reports and the provisions of the 1918 Act were based upon its recommendations.[4] Simplification was effected by the abolition

1 Cf. W. J. Foster and F. G. Taylor, *National Health Insurance*, 1937, p. 2.
2 Cf. C. F. G. Masterman, *Condition of England*, ed. 1910, p. 133.
3 Cf. *Economist*, 9 Dec. 1911, p. 1201.
4 Cf. Foster and Taylor, *loc. cit.* pp. 168–9.

of certain special classes of insured persons, who were thenceforth to be treated as ordinary insured persons; the date of termination of insurance was definitely related to the date of cessation of employment; and provisions relating to the position of women who marry were enacted. The financial provisions of the 1918 Act were even more important, greatly strengthening as they did the financial structure of the scheme. The Women's Equalization Fund was also set up. To this fund were carried the grants made by Parliament, and the fund was distributed among societies on a capitation basis, according to the number of married women among their members (the fund was abolished in 1922). A series of important actuarial movements in the legislation were also effected.[1] The primary object, however, was to strengthen the financial position of the weaker societies. It was with this object that the Central Fund and the Societies' Contingencies Fund were created. The revenue of these 'protective' funds was obtained by diverting a portion of the sums retained out of the weekly contributions for the redemption of reserve values. Provision was also made for the pooling of the contingencies funds of small societies—the whole measure, indeed, being an ample proof that administration by the insurance carriers had been coupled with many disappointments not foreseen in 1911.

Of the later measures, two passed in 1919 and 1920 were occasioned by changing economic conditions. The first raised the limit for the insurance of non-manual workers from a maximum rate of remuneration of £160 a year to £250 a year; the second increased the rates of contributions and of benefits. An Act of 1921 diverted a part of the contribution retained by the Minister of Health to the benefit funds of societies, to enable an increase to be made in the amount available for expenditure by insurance committees on administration; while an Act of 1922 made provision for additional payments to insurance committees for the cost of medical benefit. In 1921, the National Health (Prolongation of Insurance) Act was passed with the object of preventing certain persons from passing out of insurance through unemployment; it was made necessary by the increasing prevalence of unemployment.[2] The Act was a temporary measure, and was kept in force each year by the Expiring Laws Continuance. It finally lapsed in 1928, when other steps were taken to prevent unemployed persons from passing out of insurance.

1 Cf. Foster and Taylor, *loc. cit.* pp. 5 and 171; see also p. 198.
2 Cf. *Royal Commission Report*, p. 6.

Inevitably the constant addition of unco-ordinated pieces of legislation added considerably to the difficulties of administration, which were already large and increasing; and it was of material advantage when, in 1924, the whole of the existing legislation relating to National Health Insurance (with the exception of certain temporary provisions) was consolidated in the National Health Insurance Act, 1924, which came into force on 1 January 1925.[1] In the meantime, the Royal Commission had begun its work. While their labours, as embodied in the Majority and Minority Reports, published in 1928, did not lead to any fundamental alterations of the scheme, a large number of new measures followed the consolidating Act of 1924.[2] In 1925 there was the Widows', Orphans' and Old Age Contributory Pensions Act. From 4 January 1926 all those insured under National Health Insurance became insurable under the Pensions Act, and combined contributions in respect of both schemes became payable. This linking of the two schemes had for its object merely administrative convenience, and for all other financial purposes they remained entirely separate. Old age pensions under the Pensions Act did not begin until January 1928; and from that date the upper age-limit for sickness and disablement benefits under the National Insurance Act was reduced from 70 to 65. This lowering of the age enabled a reduction to be made in the contribution applicable to National Health Insurance. Then, in 1926, the Economy (Miscellaneous Provisions) Act brought a reduction in the State contribution, from two-ninths of the sum expended in benefits and administration to one-seventh in the case of males and one-fifth in the case of females.

The National Health Insurance Act, 1928[3] effected considerable changes in the scheme as consolidated by the 1924 Act, which was later entirely repealed. The chief alterations were in the duration of insurance. The free period following the cessation of insurable employment was considerably extended, under certain conditions. The Act of 1928 contemplated putting a definite term to the extension of insurance, following cessation of employment—the unemployment problem loomed more and more in the background of National Health Insurance provisions as it became more

1 14 and 15 Geo. 5, c. 38.

2 In describing the main outline of this legislation we follow, except where stated otherwise, the description given by Foster and Taylor, *loc. cit.* p. 6 sq. and *passim.*

3 18 and 19 Geo. 5, c. 14.

widespread during the 'Great Depression'. The 1928 Act also made changes relating to the insurance of married women and to their benefits. Other alterations dealt with certain of the obligations of approved societies; the avoidance of loss of benefit because of delay in giving notice of incapacity; and arrears of contributions. From 1 January 1929 the Scottish Board of Health ceased to exist, and its powers and duties were vested in the Department of Health for Scotland. The National Health Insurance and Contributory Pensions Act, 1932[1] provided for the reduction of rates of benefit for women and amended the provisions of the principal Act which related to transfer and reserve values and arrears. This Act also made important amendments regarding the duration of insurance, which were made necessary by the expiry of legislation dealing with the prolongation of insurance for unemployed persons. From 1935 the provisions relating to the duration of insurance were placed on a more permanent basis, and were no longer subject to temporary prolongation as had remained the case under the 1931 Act; this was effected by the National Health Insurance and Contributory Pensions Act of 1935.[2]

The changes made by this Statute were important. It was necessary, *inter alia*, to make special provision for the group of about 200,000 persons who had suffered prolonged unemployment and lost their title to all health insurance benefits. The Act also made provisions for excusing in full all arrears due to genuine unemployment—a reform which, in view of approved societies' finance, would not have been possible but for an improvement in the state of employment conditions, for the extra annual burden upon societies on account of the concession made since the National Health Insurance of 1928 had mounted to £2,000,000 by July 1932.[3] The Act of 1935 set up an Unemployment Arrears Fund from which societies would be recouped for the extra cost of writing off arrears. Further alterations were made in the relations of approved societies to institutions maintained out of public funds; and in the conditions laid down for 'proof of incapacity'.

It is apparent from all these measures that the consolidating Act of 1924 had hardly been in force ten years when a flood of new enactments dealing with important details of the entire scheme made another consolidating measure necessary. This came with the National Health Insurance Act, 1936.[4] The Act came

1 22 and 23 Geo. 5, c. 52. 2 25 and 26 Geo. 5, c. 44.
3 Cf. *Annual Report of the Ministry of Health*, 1936, p. 190.
4 26 Geo. 5, and E. 1, Edw. 8, c. 32.

into force on 1 January 1937; it is the foundation of present National Health Insurance legislation (and will be quoted by us subsequently as the National Health Insurance Act).

The list of amendments, however, was not exhausted by this extensive consolidating measure. From April 1938, under the National Health Insurance (Juvenile Contributors and Young Persons) Act, 1937, the National Health Insurance scheme was extended to apply to a limited extent to boys and girls who, between school leaving age and 16, were engaged in employment in respect of which they would be fully insured if they were over the age of 16. The only benefit to which these boys and girls became entitled, however, was medical benefit. Thus, the Acts passed since the original introduction of the National Health Insurance scheme in 1911 make an impressive list. Yet in all these, many of them of great importance, there was no attempt to alter the basis of the original legislation, which has remained almost intact. This would not be surprising or discouraging, if the scheme had worked well. Actually, the same serious complaints about the defects and deficiencies of the scheme and its administration were made right from the start as have been voiced in recent years. It is this fact that makes the volume of amendments considerably less impressive. In many respects they were merely palliatives when, according to a widely held opinion, more fundamental and far-reaching remedies were imperatively needed.

The British system of health insurance was not the outcome of an impartial choice from the many possible alternatives of the most appropriate scheme. The existing institutional framework had to be taken into account whatever its merits. Vested interests were to be consulted and their support secured. Public opinion, unprepared for the first great step, had to be won over by deference to susceptibilities which bore no relation to the real objectives of health insurance. All these circumstances were the 'imponderabilia' which the originators of the scheme were neither able to foresee nor bold enough to ignore; and the same traditional institutions, vested interests and public prejudices have still to be reckoned with to-day.

PART II. *THE SCOPE OF NATIONAL HEALTH INSURANCE*

CHAPTER IV. CATEGORIES OF INSURED PERSONS

'Long experience shows that human needs refuse to be completely covered by any classifications; we are constantly coming upon some new complication of distress which calls for all the ingenuity of experts if it is really to be met.'

MRS BERNARD BOSANQUET, *Rich and Poor*, 1899.

NATIONAL HEALTH INSURANCE covers two distinct categories of insured persons:

1. Compulsory contributors.
2. Voluntary contributors.

Compulsory contributors are persons between the ages of 16 and 65 gainfully occupied in certain classes of employment:

(*a*) In manual labour, or

(*b*) If not in manual labour, persons paid at a rate of remuneration of not more than £250[1] a year (unless especially excepted).

All such persons are compulsorily insurable. There are seven classes of employment under the Act, of which the first, employment in the United Kingdom under a contract of service or apprenticeship with money payment, is the most important. The other classes are employment under contract on British ships; employment as an outworker (i.e. a person who works at home or in his own workshop on articles or materials given to him by an employer); employment in plying for hire (for instance, taxi-cab drivers); employment in the Forces of the Crown, other than in commissioned ranks; employment in the United Kingdom in manual labour under a contract of service for the purpose of any trade or business; and the employment of certain masters or seamen on ships, who are remunerated by a share in the profits or gross earnings of the vessel. The last two classes were made compulsorily insurable by the National Health Insurance Act of 1928, following a recommendation of the Royal Commission. The Commission had received evidence that the ordinary test of con-

1 Increased to £420 from 1 Jan. 1942.

tract was not fulfilled in the case of certain classes of persons, who, although undoubtedly members of the wage-earning classes, could not be said to be employed under the ordinary relationship of master and servant, as for instance tree fellers, stone breakers, market porters and the like. Doubtful cases of this character were constantly arising for investigation by the Ministry of Health, and the question frequently turned on 'fine distinctions in the facts, or in the way the facts were presented'.[1]

Prior to 1928 (when contributory old age pensions first became payable to persons between 65 and 70) the age limits for compulsory insurance had been 16–70; since 1928, the range has been 16–65. Cash benefits now cease to be payable at the age of 65, but medical benefits and additional treatment continue until death. There were in Great Britain, in 1937, approximately 1,325,000 insured persons over the age of 65. The scope of the scheme was not inconsiderably enlarged by the National Health Insurance Act of 1937 relating to juvenile contributors and young persons. This Act came into operation on 4 April 1938; and meant that 717,000 juvenile contributors were entitled to medical benefit at the end of the year.[2]

Certain classes of employment are excepted from insurance.[3] They include those where employment is otherwise than in manual labour if the rate of pay exceeds £250[4] a year. Apart from this, the principal exceptions are certain employments under the Crown or public authorities; specified classes of teachers; and employees of railway and other statutory companies where the Minister certifies that the terms of employment are, on the whole, not less favourable than the corresponding benefits conferred by the Act—a reservation which corresponds to the contracting-out schemes in the Workmen's Compensation scheme. Employment of wife by husband and of husband by wife is also excepted; and there is a safeguard against members of family business concerns acquiring the status of insured persons by reason of their employment in the business.[5] There are further excepted persons in so-called 'subsidiary employments'. These employments are subject to special regulations which define the circumstances in which they are excepted or included as insurable. There are further excepted

1 Cf. *Royal Commission Report*, paras. 464–6 and p. 274.
2 Cf. *20th Annual Report of the Ministry of Health*, London, 1939, p. 138.
3 Cf. N.H.I. Act, 1936, First Schedule, Part II.
4 See footnote on p. 38.
5 Cf. for further details, the Act itself and Foster and Taylor, *loc. cit.* pp. 12–13.

employments where the employment is casual or where an agent is paid on commission, while mainly dependent on his earnings from some other occupation. Such exceptions are customary in all sickness insurance schemes. As the International Labour Office observes: 'the list of authorized exceptions may seem long and likely to weaken the general formula of compulsory insurance for wage-earners. Happily, experience has shown that this is not so. In fact, the groups and occupations which are exempted in countries where the Conventions apply form a fairly small percentage of the total wage-earning population. Moreover, improvements in the administrative practice of insurance institutions are steadily reducing the gaps in the scope of compulsory insurance.'[1] Great Britain, which ratified the Draft Convention (No. 24) concerning sickness insurance for workers in industry and commerce and domestic servants on 1 November 1935, does not lag behind other nations in regard to the scope of sickness insurance.

A distinction must be drawn between persons exempted and persons excepted from sickness insurance. Special provision has been made to allow a person, who would ordinarily be compulsorily insurable, to be exempt from the payment of his share of contributions (the employer's share still being payable). These are persons who come within the category of those employed within the meaning of the Act, but who, under the provision of section 5, have obtained certificates of exemption from the Minister. Among the grounds entitling persons to such exemption are the following: if the person is in receipt of a pension or an income of not less than £26 a year, not dependent on his personal exertion; or if he is ordinarily and mainly dependent for his livelihood on some other person or on the earnings derived from a non-insurable occupation. Exempt persons are entitled, subject to the satisfaction of certain prescribed conditions, to medical benefit only.[2]

The scope of sickness insurance seems clearly defined and to follow out the intention of the legislation to cover the greater part of the working-class population. But, inevitably, there are doubtful cases on the borderline. Questions as to whether any particular employment is within the meaning of the Act or whether any particular person is employed within the meaning of the Act are determined by the Minister of Health subject to an appeal to

1 I.L.O., *The International Labour Organization and Social Insurance*, Geneva, 1936, pp. 47–8.

2 See Act, section 34 (3).

a judge of the High Court on any question of law.[1] In a recent case, the question was whether a professional football player whose salary exceeded £250 was not 'employed by way of manual labour', so as to bring him within the exception of Part II of the First Schedule of the 1924 Act relating to 'Employment otherwise than by way of manual labour and a rate of remuneration exceeding in value £250 a year'. Roche, J. (King's Bench Division), giving judgment, referred to his own judgment given in another case where he had said 'the test is whether the work with the hands is the essence of the work, or whether it is some other power or quality in the employment which is the essential matter'. In the present case, he observed, a professional footballer 'is essentially a person who works with his acquired or inherited skill for play, fortified and improved by continuous instruction, study and practice'. It was held that his employment was 'not by way of manual labour' and that he was therefore not insurable under the Act.[2] Other recent decisions have been that a scenic artist employed by a firm of providers of theatrical scenery and furniture was employed by way of manual labour, that certain trawler skippers at Ramsgate were employed otherwise than in manual labour; and that a preacher in charge for the Presbyterian Church of England was not employed under contract of service.

There are voluntary contributors apart from the compulsory employed contributors. Voluntary contributors are insured persons, who have been employed and insured for 104 weeks; if such a person gives notice within a prescribed time after ceasing to be insurably employed, he becomes a voluntary contributor. Since the Contributory Pensions scheme of 1926 came in force, the total number of voluntary contributors has considerably increased. Prior to that Act it was not more than 45,000; now there are over 600,000 voluntary contributors—which is, however, only a relatively small percentage of the compulsory contributors. Voluntary contributors pay the whole of the contribution, and this is reduced by 3*d.* a week where the contributor is not entitled to medical benefit, owing to his income from all sources exceeding £420 per annum. The regulations regarding voluntary con-

1 Cf. Foster and Taylor, *loc. cit.* p. 13. A large number of decisions, together with reports of cases which eventually have been decided by the Courts, have been collected in an official volume called *Memoranda and Decisions* (Sept. 1931), and in supplements to this volume at later dates.

2 Cf. *in re* National Health Insurance Act, 1924: *in re* Professional Football Players' Association (1934, 2 K.B. 265).

tributors[1] not inconsiderably widen the scope of sickness insurance. Apart from the categories of workers out of employment, all persons in any excepted employment,[2] where the Minister is satisfied that in the special circumstances they should be allowed to contribute voluntarily, may do so. A man who, not being insured for the purposes of the Widows', Orphans' and Old Age Contributory Pensions Act, 1936, marries a woman who is insured for the purposes of the Act, and by or in respect of whom 104 contributions have been paid under the Act, may also, if he gives notice within the prescribed time after marriage, become a voluntary contributor.

The question of the determination of insurability was discussed before the Hetherington Commission on Workmen's Compensation in 1939. Very many cases of painful and protracted litigation arise constantly under the Workmen's Compensation procedure. National Health Insurance, however, unlike Workmen's Compensation, is supervised by a Government Department, and the decision of the Ministry is certainly looked upon as disinterested. Mr E. G. Bearn, Deputy of the Controller of Health Insurance, explained to the Royal Commission on Workmen's Compensation that the difficulties of determining the National Health Insurance status of 'certain persons employed by way of manual labour under a contract for service'[3] have been overcome by High Court decision.[4] The procedure of appeal to the Ministry to decide insurability under the scope of the Act is much used; approximately 500 cases are decided annually by the Ministry, but only a few—two or three in a year—go to the High Court, a result highly satisfactory compared with the cases arising annually out of difficulties of defining the scope of cover under the Workmen's Compensation Act.

1 N.H.I. Act, 1936, Part I, section 3. 2 See p. 39.

3 Cf. Act, Schedule I, Part I (*f*).

4 Cf. Hetherington Commission, A. 1143: 'It was thought right that persons whose economic status was very similar to that of the ordinary workman, but who could not come within the compulsory scheme because it was not possible to establish that they were subject to right of control and day-to-day supervision, should nevertheless be included. The hedger or ditcher was near the economic status of the ordinary farm labourer, and some of these contractors for the cartage of stones to the ordinary worker.'

CHAPTER V. DEFICIENCIES IN THE SCOPE OF INSURANCE

'There is no mortal whom sorrow and disease do not touch.'
Euripides, Fragments, No. 757, quoted by Cicero, *Tusculanae Disputationes*, Bk. III, c. 25.

As a result of the successive enlargements of the scope of National Health Insurance, the estimated number of persons entitled to benefits under the Acts has continuously increased. For Great Britain it was given as 13,689,200 men and women in 1914.[1] Ten years later the figure had risen to over 16,000,000 and a decade later to over 18,000,000; 19,000,000 was passed by almost 200,000 in 1936.[2] In more detail the figures for England present the following picture:

	1938	
	Men	Women
Approved societies	10,544,000	5,686,000
Navy and Army Fund	136,000	—
Deposit contributors	133,000	145,000
Exempt persons	6,000	5,000
Persons over 65	914,000	267,000
Total	11,733,000	6,103,000

It will be noticed that approved societies take the overwhelming majority of every class of insured. But their share of the total has decreased since the first years of the scheme. In 1914, of 13,689,000 insured no less than 9,173,000 men and 4,019,000 women were insured through approved societies. At the end of 1938 of 17,836,000 insured 10,544,000 men and 5,686,000 women belonged to approved societies, though the figures for women since 1922–23 are not 'strictly' comparable with the earlier figures. Male deposit contributors[3] declined from 245,000 in 1914 to 133,000 in 1938. But female deposit contributors increased from 96,800 to 145,000. To the large increase of voluntary contributors since 1926 and their present approximate number we have already referred.

Any international comparison, owing to the lack of comparable

1 The figures were not complete, as the number of persons over 70 years of age was not known.
2 Cf. *Statistical Abstract for the U.K.*, 1938, p. 83.
3 Insured persons who either have not elected to join a society or whose application has been rejected, become deposit contributors.

figures, must be dated back to 1933. Roughly, the picture is as follows:[1]

Country	Total population	Number of insured at end of 1933
Great Britain and Northern Ireland	46,000,000	17,707,000
Germany	65,000,000	18,540,348
France	41,000,000	16,004,880
Sweden	6,200,000	1,229,364
Denmark (sickness funds)	3,500,000	2,409,474
Switzerland	4,000,000	1,841,896
Italy	41,651,617	1,317,895
Japan	29,200,000	1,720,199
Czechoslovakia	14,700,000	2,063,396

The table is in no way intended to suggest exact international comparisons. Such comparisons are not possible, because in the various countries the schemes are of a different character. Figures for the United States are not available for purposes of comparison as the sickness benefit schemes in that country are not governed by any special legislation, and there can be no question there of a general national scheme of sickness insurance. Similar circumstances explain the absence of figures for Canada. Japan introduced an extended scope of sickness insurance in 1934 on a compulsory basis (the first compulsory scheme was introduced in 1922). It may rightly be asked whether a truer comparison could not be got by a comparison in relation to the total insured, not of the total population, but of the total number of gainfully occupied persons in different countries. But these rough comparisons serve their purpose. They show that, under the present British legislation, the statistical scope of health insurance certainly does not lag behind its scope in other countries, and in industrial countries in particular. In continental Europe Switzerland appears to have achieved the most comprehensive scheme. Compulsory sickness insurance has, in some cantons, been widely extended beyond the usual scope; some cantons have even made health insurance compulsory for school children, and the ambit of voluntary insurance under various schemes is also wide.[2] It is in Switzerland that the proportion of the population insured against sickness almost reaches 50 %. But even this achievement is not substantially better than the position in Britain. Even so, this does not mean that there is no scope for further extensions in Britain. The exten-

1 The figures are compiled from the *International Survey of Social Services*, vols. and II, Geneva, 1936.

2 Cf. *International Survey of Social Services*, vol. II, pp. 430–3.

sions generally discussed affect dependants, and in particular married women. The problem of married women enters into National Health Insurance in various ways. There is the question of maternity benefit, which will be analysed in the chapters on benefits, as well as the problem of a general extension of insurance to dependants. Maternity benefit has received the particular attention of legislation, from the inception of the scheme, in regard to gainfully occupied women who, after marriage, cease to be employed. But it has been always a matter of some difficulty.[1] The first arrangements were complicated and unsatisfactory, and were the subject of amendments after the Report of the Departmental Committee on Approved Society Finance and Administration in 1916. The position under the present legislation is briefly this: a woman member of an approved society who is an employed contributor under the age of 65 and who marries and has ceased, within twelve months after the date of her marriage, to be a person whose normal occupation is employment, ceases to be entitled to the ordinary benefits of the Act; but she is not entirely uncovered. She becomes entitled to special benefits (so-called Class K benefits) as and when they are transferred to a special class. A woman voluntary contributor, however, who is a member of an approved society ceases immediately on marriage to be entitled to pay further contributions.

The Majority Report of 1928 discussed various proposals for the extension of the scope of insurance to married women not gainfully occupied, of which the proposal for a free year's insurance was the most important. The Report did not find the recommendation suitable, but made recommendations of its own, which led to the granting of the special Class K benefits.[2] For a period of two years from the date of her marriage, the Act now treats[3] a woman who, until her marriage, was normally occupied as if she were an insured person. But, on transfer to class K, she is entitled to certain benefits.

It is singular that married women are expressly excluded from becoming voluntary contributors to health insurance when they can do so for pensions insurance (section 127 (2)). A married woman may, however, if her husband dies while she still is an insured person, become such a voluntary contributor if otherwise eligible. The proposals to open voluntary contributorship to married women were not discussed in the Majority or Minority

1 Cf. *Royal Commission Report*, 1928, pp. 214 sqq.
2 Cf. Foster and Taylor, *loc. cit.* pp. 7, 106 and 107. 3 Cf. section 126 (1).

Reports of the Royal Commission. The National Union of Societies for Equal Citizenship pleaded for inclusion. Mrs Hubback, giving evidence, agreed that 'the provision of special benefits for unemployed married women goes some way, but you may have a woman marry late in life. She will have made contributions during a great number of years, and I think she should have an opportunity of becoming a voluntary contributor in order that she should remain insured during the rest of her life, if she wishes to make the payments.'[1] The chairman saw insuperable 'administrative' difficulties in applying the test of incapacity for work in the case of a married woman whose normal occupation is looking after her home. Sir Walter Kinnear made a strong appeal, as Controller of the Insurance Department of the Ministry of Health, for voluntary insurance not to be extended beyond its existing scope.[2]

If dependants were included in the Health Insurance scheme the position of unoccupied married women would at once be changed. Such inclusion, particularly for medical benefits, has frequently been urged during recent years. The Departmental Committee on the Scottish Health Service wrote in 1936: 'The statutory provision for general medical attendance should be extended to include dependants of insured persons and, so far as practicable, others in similar economic circumstances, and all statutory provision for general medical attendance should be co-ordinated.' The British Medical Association wrote in 1929: '. . . medical benefits of the present National Health Insurance Acts should be extended so as to include the dependants of all persons insured thereunder and entitled to medical benefit.' These views were endorsed, or repeated, by the British Medical Association in April 1938.[3] The dependants of persons at present insured constitute the great majority of those in the same economic class not covered by the existing medical service. But, as the British Medical Association rightly observes, there remains a considerable number of persons not included in this group, such as persons over 70 in receipt of non-contributory pensions, and those in uninsurable occupations with incomes below a certain limit (see above, p. 39) together with their dependants, as well as the dependants

1 The deficiencies of N.H.I. as regards married women have been aptly treated in the *Report on Social Insurance and Allied Services* (Beveridge Report), 1942, pp. 49–51.

2 Cf. Royal Commission, Evidence, QQ. 22, 986–9, 23,398, 23,404–6.

3 Cf. B.M.A., *A General Medical Service to the Nation*, April 1938, pp. 15–17.

of those in the Defence Services who at present receive only maternity benefit. The British Medical Association considers it desirable to include these groups in any extended medical service in order that it may be available to everyone in the economic group within the £250 limit.

Another problem is that of the smaller independent business man. The present legislation is based on the principle that its services should be restricted to people in gainful employment and not apply to 'independent' workers. In fact, the small trader, viewed from an economic and sociological angle, and not from the narrow one of legal and statutory definition, is in no different position from the employed worker. Charles Madge, commenting upon an interesting statistical enquiry, refers to a sample of seventy-two trader families interviewed in Bristol, of which not less than thirty-five had 'an income and standard of living which corresponded roughly with that of the working-class A (over 30*s*. per head weekly) income, while seven seemed nearer to the working-class B (under 30*s*. per head weekly) income'.[1] In 1930 an investigation conducted by the Home Office and the Ministry of Labour reported that in Birmingham, with a population of 950,000, there were some 21,000 retail shops of which no less than 75 % were of the family type, employing no assistants except the members of the family. Other big provincial towns showed similar results.[2] L. E. Neal suggests that more than half of the existing retail shops, and possibly as many as two-thirds, may be of a family type; the number of retail outlets in England and Wales has been estimated at 575,300 in 1931; of these 80–90 % may be assumed to belong to the small independent type.[3] Many of this class of tradesmen are in hardly less 'proletarian' circumstances than workers, and they share with them the risk of suddenly reduced income and the chance of unforeseen destitution. They are not in a position to lay much aside for long periods of sickness; and they can hardly be expected to do so voluntarily, as experience shows that they are likely to 're-invest their surplus earnings in their business or shop'—while even more since the War 'every penny is being used to lay in stocks'.[4] When heavy sickness comes upon them or their dependants there is little money available for

1 Cf. Charles Madge, 'The Propensity to Save in Blackburn and Bristol', *Economic Journal*, Dec. 1940, p. 440.

2 Cf. *Report of Select Committee on Shop Assistants*, 1930, vol. II, *passim*.

3 Cf. Lawrence E. Neal, *Retailing and the Public*, 2nd ed. 1933, pp. 5–6; Henry Smith, *Retail Distribution*, 1937, pp. 35–6.

4 Cf. Madge, *loc. cit.* pp. 440–41.

proper and adequate domiciliary medical care. The British Medical Association therefore suggested that they should be included in an enlarged system of National Health Insurance by means of contributions from them and the State.[1]

If inclusion of dependants in National Health Insurance meant that dependants of male workers or employed females would partake of the medical benefits to which they are entitled in case of sickness, this could be regarded as merely a widening of the benefits granted to those whose living has to be provided for by insured persons. If, however, the extension could be arranged so as to include dependants as additional insurers, this would certainly be a considerable enlargement of the insurance scheme itself. The cantons of Soleure and Valois in Switzerland have made insurance compulsory for children or school children.[2] In Denmark, the voluntary sickness scheme has a similar wide range of insurers; admission to full membership of a recognized sickness fund (i.e. to insurance with a right to benefit by the State subsidy) depends on the fulfilment of conditions which do not lay down that the insured person must belong to the working classes, though if not, he must be in similar economic circumstances and 'without means'—that is, he must fall into the income and property limits which are determined every third year by the Minister of Social Affairs.[3] A married man's membership of a recognized sickness fund does not automatically entail the insurance of his employed wife, who must join separately to acquire the right of benefit; while children under 15 years, on the other hand, including adopted children, are insured if their parents belong to a sickness fund. These arrangements, which combine voluntary with compulsory insurance in a somewhat singular way,[4] account for the high percentage of insured persons in Denmark. Here the scope of the scheme is enlarged by throwing it open to a wide circle of insurers, and not merely by enlarging the benefits of the already insured to cover provision for relatives and dependants.

By distinguishing between these two methods of extending the scope of insurance, a problem of far-reaching importance becomes visible. If health insurance is accepted as relating exclusively to

1 Cf. *loc. cit.* p. 13. 2 Cf. *International Survey of Social Services*, vol. II, p. 431.
3 Cf. *ib.* vol. II, pp. 131–2.
4 The Act does not make it compulsory for anyone to become a full member of a sickness fund or of a sickness benefit society. But every Danish citizen between 21 and 60, who is not a full member of a recognized sickness fund or sickness benefit society, is bound to become a contributing member of a recognized sickness fund, provided that he satisfies certain conditions.

the wage-earners within certain income limits, any enlargement of its scope to other persons—whether unemployed married women, or children or dependants—is contrary to this principle. Such apparently is the opinion of the International Labour Office.[1] This means that, if unoccupied persons were to be included, the inclusion should be done by extending the benefits of the occupied insured. If, however, the inclusion is so done by making these new classes separate and individual insured persons, then National Health Insurance would evolve from a scheme of workers' health insurance to one approaching far more the conception of a general service to all citizens who cannot afford complete and proper treatment. This apparently is the ideal of the British Medical Association;[2] it is a high ideal and one which conforms with the traditional aims of the medical profession. But this could not be achieved in this country without fundamental changes in the administrative machinery and, particularly, in the functions of the present insurance carriers.

It should not be concluded, however, that it is therefore impossible to include insurance for dependants in the existing National Health Insurance scheme. This, unfortunately, was not the conclusion of the Royal Commission of 1924–25 when they reported in 1926. On the one hand, the Royal Commission satisfied itself that the inclusion of dependants—by which the Report meant the inclusion for medical benefits of uninsured wives of insured men and children up to the age of entry into insurance—would mean that 20,000,000 people more would have to be brought under the provisions of the scheme, at least for medical benefit, 5 million people more than the insured population at that time.[3] This was apparently regarded as distorting the original intention of the Act. On the other hand, the Commission felt bound to observe that the 'effect of including the dependants in the medical scheme of the present Insurance Scheme might be to impede or postpone any ultimate unification of health services'. It quoted in particular the view of Mr Brock, speaking for the

1 Cf. *The International Labour Organization and Social Insurance*, 1936, p. 46: '. . . insurance laws and regulations . . . are definitely intended to cover wage-earners as a whole, or at least all those with small means. This aim was taken into account by the Conference, which recommended that sickness insurance should include within its scope, without discrimination as to age and sex, every person who performs work by way of his occupation and under a contract of service or apprenticeship.'

2 Cf. *A General Medical Service*, pp. 17 and 47.

3 Cf. Evidence, QQ. 2576 and 2581; also *Report*, p. 163.

Ministry of Health, that 'extension of medical benefit to dependants would be less logical and probably less satisfactory than the establishment of a public medical service at the expense of local funds'. And the National Conference of Friendly Societies, in their Memorandum,[1] expressed the view that 'the best way of organizing the provision of medical treatment is to merge all existing forms of public medical service (including medical benefit under the N.H.I. Acts) into one National Medical Service, thereby creating one unified organization for the prevention and cure of disease'. The Commission thought that, in view of such definite statements by important bodies, 'the matter should be left over to be considered with any wider proposals for reorganizing the health services of the community which may commend themselves to later students of the problem'. The result, here as elsewhere, was that nothing was done. Twelve years have passed since the Royal Commission's Report was published; while no real improvement in the position of dependants has been effected, the creation of a national health service, which would make the inclusion of dependants in National Health Insurance unnecessary, is yet far away from realization. Adherence to the ideal of a national health service has become an excuse not to make smaller reforms which would be, at least, of some use to the neglected class of dependants. The Royal Commission did not find it necessary to consider the system of 'family assistance' of the German empire. Nor did they consider the very interesting proposals for 'family insurance' put forward by the late Joseph L. Cohen two years before the publication of their Report.[2]

The relation between National Health Insurance and the Workmen's Compensation Acts is rather complicated.[3] It should be understood that Workmen's Compensation in this country applies only to compensation for loss of earning. It is in no way, directly or indirectly, connected with the cure or reconditioning of the worker injured by industrial accident or disease, largely because industrial accident insurance in Britain was not drafted in close collaboration with other social insurance schemes, but was regarded as being merely a necessary improvement of the narrow limitations of Employers' Liability.[4] The injured worker receives

1 Cf. Royal Commission, Appendix XXVI, pp. 35–7.

2 Cf. Joseph L. Cohen, *Family Income Insurance, a scheme of Family Endowment by the method of Insurance*, with a preface by Eleanor F. Rathbone, London, 1926.

3 See chapter XXIX for the difficulty of evaluating certain benefits, etc.

4 Cf. Wilson and Levy, *Workmen's Compensation*, vol. I, pp. 45 sqq. and chapter III: From Employers' Liability to Workmen's Compensation.

cash compensation under the Acts, and, when the National Health Insurance scheme was drafted, it was calculated that friendly societies, which had hitherto provided such cash benefits in the form of sick money, would now be relieved from this obligation in the cases of injured workers—at least so far as such benefits would not have exceeded the compensation payments. The exclusion of compensatable illness from the National Health Insurance scheme enabled the rates of contributions to be lower than they otherwise would have been.[1] But, for medical treatment, the injured worker is fully dependent upon the National Health Insurance scheme. It might, therefore, be expected that every worker covered by the Workmen's Compensation Acts would necessarily be covered by the National Health Insurance scheme. This, however, is not the case. A reason is that, while National Health Insurance has a £250 pre-war income limit, resulting from the distinction between manual and non-manual labour and other exceptions, under Workmen's Compensation any person is covered who has entered into, or works under, a contract of service or apprenticeship with an employer, whether by way of manual labour, clerical work or otherwise—with the exception of certain classes expressly excluded by the Act, and not so far-reaching as the exceptions under National Health Insurance.[2] For persons not employed in manual labour the limit is £350. The number of employed persons who are covered by the Workmen's Compensation Acts but are not compulsorily insured under the National Health Insurance Acts cannot be precisely estimated; but, according to an official statement in the House of Commons,[3] is thought to be approximately 900,000. Of this number, probably some 250,000 are voluntary contributors, leaving 650,000 not covered by National Health Insurance. Of this number roughly 300,000 would be non-manual workers earning between £250 and £350 and therefore excluded from National Health Insurance,[4] but not from coverage under Workmen's Compensation legislation. The remainder would be employed persons earning under £250 a year who are exempted from National Health Insurance

1 Cf. Royal Commission on Workmen's Compensation, 1939, Evidence, p. 158.

2 Cf. Workmen's Compensation Act, 1925, 15 and 16 Geo. 5, c. 84, section 3.

3 House of Commons, 20 April 1939; statement made by Sir Samuel Hoare in an answer to a question.

4 The war-amendment provisions of N.H.I. (see p. 38 above) will lessen this number.

owing to the terms of their employment. It is to be hoped that in the future, by the consolidation and unification of the entire structure of the social insurance services, such discrepancies will disappear. Meanwhile, it would be expedient to draw the two schemes nearer together and to squeeze out the existing anomalies of their scope.

PART III. *BENEFITS*

CHAPTER VI. GENERAL CLASSIFICATIONS

'There is a strong element of tragedy in all human illness, in the pain of the sufferer, and in the anxiety surrounding him. But this is purely a sentimental consideration as compared with the stern economic necessity that arises when the breadwinner himself falls victim to disease.' I. M. RUBINOW, *Social Insurance*, 1913.

WHILE the scope of a social insurance scheme mainly indicates its numerical or quantitative significance, the benefits indicate the personal or qualitative significance of the scheme for insured persons. We have seen what an important role the question of scope played during the initial struggle for the inception of health insurance. To bring more than 10,000,000 people under a safe insurance cover at a single stroke was one of the strongest arguments put forward by the supporters of the Bill of 1911. Since then the scope has widened. Almost 20,000,000 people in Great Britain are now entitled to its benefits. But in the matter of benefits the reverse has been the case. The process of extending and intensifying the benefits under National Health Insurance has hardly begun.

The problem of benefits is particularly significant in health insurance. In many insurance schemes the problem of benefits has an easy and almost mathematical solution. In the case of burial insurance, for instance, as administered under industrial assurance, the payment at death to cover funeral expenses may be strictly defined and calculated; people may insure to get what they consider a 'decent funeral', which may cost £15, £20 or more, and they will receive in benefit exactly what they have expected to get. The same applies to the insurance of houses or furniture; the premium paid is expected to provide a certain well-defined benefit. But in the case of health insurance, the position is very different. The object is to relieve workers and persons of small means in time of illness. It is a twofold object in this case. The first object is to provide a cash benefit to indemnify the insured against at least some part of his lost earnings during illness. The second object is to provide the insured with the means of reacquiring health. And it is extremely difficult to define, calculate and fix benefits in order to secure these two very different aims.

Compensation for 'loss of earning capacity' under Workmen's Compensation gives rise to many technical and legal difficulties and even inconsistencies; but, theoretically at least, it deals with calculable factors. But the case of health insurance, with regard to both sickness and medical benefit, is much more difficult. From sickness benefit, the worker who falls ill expects to receive enough in cash to enable him to sustain existence, from the point of view of his budget, as if no contingency had occurred. The person who insures his furniture against fire expects to be enabled to replace it by the compensation paid. Here the difference begins. Compensation payments must depend upon the amount of premium paid. It will be necessary at a later stage in this book to ask how far the worker by contributing more to the scheme, or how far by a greater contribution by the State and by the employers, health insurance could be made more effective. The fundamental question, of course, is how far the contributions paid by workers represent the limit of their capacity. The point is that, while higher contributions might be necessary, from an insurance standpoint, to enable the insured to sustain his existence, such higher contributions might not be socially, economically or politically practicable. Yet the aim to enable him to do so still stands, and cannot be set aside. Here is a basic difference between health insurance and fire insurance.

What is the basis of sickness benefit under the present scheme? Sickness benefit might aim at compensating the worker in case of illness for the loss he incurs through illness and for as long as the illness lasts; in such case he would receive the equivalent of his wages throughout his illness. The benefit would then obviously enable him to maintain his usual standard of living. Alternatively, sickness benefit can aim at enabling the sick worker to secure a minimum of existence during the period of his incapacity; in this case, there will be a flat rate of benefit for all insured persons, irrespective of earnings. As the International Labour Office has emphasized, 'only the system of benefit varying with wages can secure that the sick person will be relieved in proportion to his resources and standard of living',[1] and this is the method that has been adopted in most compulsory insurance schemes. It is, however, not the English system, which fixes[2] sickness benefit as a flat rate of 15*s.* a week for men, 12*s.* a week for unmarried women and widows and 10*s.* for married employed women, with

1 *International Labour Organization, etc.*, p. 49.

2 As from January 1933 until January 1942.

smaller amounts for those who have not been insured for 104 weeks and paid contributions respectively.

The recommendation of the League of Nations that[1] '. . . the statutory scale should ordinarily be fixed in relation to the normal wage which is taken into account for the purpose of compulsory insurance, and should be a substantial proportion of such wage, regard being had to family responsibilities' exhibits a wide conception of the cash benefit provision. It conceives the sick worker not only as a wage-earner, but as the breadwinner of a family, and emphasizes that full compensation for loss of earnings increases in importance with family responsibilities. The aim thus becomes to include the wage-earner's dependent family under sickness insurance—which at least, in part, has been done in the modern sickness insurance of some countries.

In the case of sickness benefit, a cash payment, there would be no difficulty in working out exactly the compensation needed for earnings lost—if this were set by legislation as the standard. The matter is far more complicated as regards medical benefits, and the discussion and controversy about National Health Insurance has centred on these. Medical treatment and cure cannot be assessed like a money payment designed to compensate for a known amount of lost earnings. Whether the sick worker will actually get the medical 'benefit' which he expects from his insurance, that is, whether he will be actually restored to health, so far as this is humanly possible, depends on a number of very heterogeneous factors.

1. It depends, first, on the standard and level of medical science and practice. The diffusion of modern and sometimes costly methods of cure and treatment, of surgery and reconditioning, varies widely from country to country. The application of scientific, medical and pathological progress may be hampered in a country by prejudice, by a lack of quick adaptation to new methods or by administrative deficiencies. To-day the usefulness of sanatorium treatment, though 'the sanatorium system is still in process of evolution and its different phases are reflected in the after-care movement', can hardly be disputed.[2] The progress in this matter, which derived its first decisive impetus from the National Health Insurance scheme of 1911, belongs to the great

1 Following the 10th Session held in 1927, Recommendation No. 29, sub II. Benefits, A. Cash Benefits.

2 Cf. E. Brieger, 'After-Care and Rehabilitation', *British Journal of Tuberculosis*, Oct. 1937, Special Supplement, Part I: The Evolution of the Sanatorium System, p. 7 and *passim*.

assets of medical development in Britain since those days.[1] Here, then, it was health insurance legislation which paved the way for general improvement in a medical sphere to be extended from the insured worker to the uninsured tubercular patient at a later date, i.e. by the Public Health (Tuberculosis) Act of 1921. The efficiency of medical benefit in obtaining the recovery of the sick insured person must, however, depend upon the general medical arrangements and institutions which can be used for the benefit of the insured population—though improvements under insurance administration can sometimes be themselves the starting-point for an improvement of the medical services. The General Medical Service for the Nation envisaged by the British Medical Association[2] would certainly enlarge greatly the possibilities of medical benefit under National Health Insurance. As the British Medical Association states, the 'health services, each good in itself, have grown up or been established in a piecemeal, independent, more or less haphazard fashion, and in consequence there is much overlapping and unnecessary complication and confusion, while there are yet large gaps in the provision needed in a reasonably complete service'. The general structure and efficiency of the medical service of a nation must necessarily influence medical benefit under any health insurance scheme.[3]

2. Legislation may limit the extent of medical benefit. On legislation and statutory medical benefits depends how far the

1 *P.E.P. Report*, pp. 285–7.

2 *Loc. cit.* pp. 3sqq., and Medical Planning Commission, *Draft Interim Report*, 1942.

3 A similar effect on general health conditions might have been achieved if in the sphere of fractures certain measures of rehabilitation and reconditioning of the injured worker had found its way into legislation. Perhaps if, in this sphere, a Lloyd George had had the chance to raise his voice—even taking into account some propagandistic exaggerations—a rehabilitation service would have been instituted; it would have led to the creation of those model fracture clinics which for the wide sphere of all persons injured by accidents was so urgently recommended by the British Medical Association and the Inter-Departmental Committee on Rehabilitation which referred to the long and encouraging experiences of Boehler's Clinic in Vienna (cf. *Interim Report of the Inter-Department Committee on the Rehabilitation of Persons Injured by Accidents*, 1937, pp. 6–7, and *Final Report*, 1939, p. 6; British Medical Association, *Report of Committee on Fractures*, reprint Feb. 1935, pp. 18–19). Here, Britain was lagging behind by not exploiting on a large scale medical discoveries which, if properly put into practice, would have greatly enlarged the possible ranges of medical benefit. As a matter of fact, the most progressive development of rehabilitation in the U.S.A., as practised in New Jersey, had its origin in some sporadic English experiments which, after the Great War, were investigated by American legislators (cf. Royal Commission on Workmen's Compensation, 1939, Evidence of Mr Henry H. Kessler, M.D., Medical Director of the New Jersey Rehabilitation Clinic, Q. 6111).

sick worker is actually given the possibility to make use of the existing medical facilities, may it be treatment, institutional care, reconditioning services, medicines or appliances. There are certainly wide differences in regard to such provisions between the various countries. Medical benefit is influenced by the intention of the legislators, which may be either to provide to the insured every possible medical assistance or to limit the benefit to certain services likely to restore his health but not all that medical treatment and care could bestow. The National Health Insurance Act of 1911, in a phrase which permits a great variety of interpretations, provides that the insured person shall 'receive adequate medical treatment and attendance'.[1] The Commissioners who had to decide upon the interpretation of the phrase gave it, in Dr Brend's words, an 'exceedingly narrow meaning', by defining the scope of medical treatment as 'such treatment as is of a kind which can consistently with the best interests of the patient be properly undertaken by a practitioner of ordinary skill and competence'. Dr Brend observed that 'specialist services and institutional treatment are by far the most crying needs among the working classes, and no system can be "adequate", in any ordinary sense of the term, which does not provide these'.[2]

The positive problem of medical benefit, as distinct from cash benefit, is fundamentally affected by the relation of health insurance to the general medical services of the nation. It was from this point of view that doctors like Brend attacked the provisions for medical benefit under the National Health Insurance scheme. It is to its credit that the medical profession, at so early a date, recognized the dangers to any national health scheme if one of its most important components was actually allowed and expected, by statutory provision, to limit the scope of medical treatment. There can be no doubt that there has been a kind of competitive development between cash benefit and medical benefit. In the words of the International Labour Office:[3] 'When sickness insurance funds were first set up, their main purpose was to pay sick persons who were unable to remain at work a cash benefit, and they paid relatively little attention to medical treatment. Slowly but steadily their views have changed and their work has taken a new turn. The principal object is to restore health and working capacity, and first place is given to medical, surgical and pharmaceutical benefits. The function of compensation is giving way to that of restoration.'

1 Cf. section 35 (2). 2 Cf. Brend, *loc. cit.* pp. 224–5.
3 Cf. *International Labour Organization, etc.*, pp. 50–51.

CHAPTER VII. SPECIAL BENEFITS

'The maintenance of a healthy and vigorous labour supply is of capital importance not only for the workers themselves, but also for communities which desire to develop their productive capacity.'

General Conference of the International Labour Organization of the League of Nations, 1927.

THE benefits which under the British National Health Insurance scheme have been superimposed upon its basic cash and medical benefits are called additional benefits. Their purpose is to give some elasticity to the services in cash and kind provided in return for insurance contributions.

One special benefit, which is properly treated apart from these, is maternity benefit. This is, for insured women (whether married or not), a recognition of the necessity of treating confinement like sickness, though it was regretted at an early date 'that it has not been found possible to make some provision that there should be entire cessation from work by pregnant women, at any rate for some weeks before confinement'.[1] Maternity benefit may be considered as being the first step in the English legislation towards enlarging the scope of benefits from the point of view of the family. For it is a special feature of maternity benefit that it is paid, not only in favour of an insured woman, married or unmarried, but also of the wife of an insured man, or, where the child is a posthumous child, of a widow, even if not insured in her own right. The statutory provision goes even further. There is what is called 'second maternity benefit'. If husband and wife are both insured, and there are the necessary qualifications for maternity benefit under the insurance of each, benefit is payable in respect of both insurances, from both the husband's and wife's society. The benefit paid by the wife's society is the second maternity benefit. If the husband, being a deposit contributor, is entitled to reduced maternity benefit, then the wife, being qualified under her own insurance, is entitled to receive from her own society, in addition to the benefit under her own insurance, a sum representing the difference between the ordinary maternity benefit (which is £2) and that payable in respect of her husband's insurance. Here, at least one step has been taken by the English scheme towards what the International Labour Office has described as 'sickness insurance becoming a family matter'.[2]

1 Cf. Comyns Carr, Garnett and Taylor, *loc. cit.* p. 89.
2 Cf. *International Labour Organization, etc., loc. cit.* p. 52.

A wide range is covered by the additional benefits proper, which are tabulated in the Third Schedule of the Statute, and now comprise seventeen different payments. These benefits play a most important and much disputed part in the English scheme. In general, it may be said that they bear eloquent witness to the inadequacy of the basic benefits under the Act; and they direct the way in which any surpluses that may be at the disposal of the insurance carriers may be used for the immediate benefit of the insured—as distinct from the indirect benefit which would arise from, say, the strengthening of the reserves. The additional benefits are expressly limited to those set out in the Schedule. The first three benefits are known as cash additional benefits.[1] They are distinguished from 'treatment' additional benefits. But it is a condition of both that the insured has first to spend a waiting period as contributor. The first three additional benefits relate to an increase of sickness and disablement benefit; to the shortening of the period which must elapse before sickness payment begins (which is normally the fourth day after the start of the incapacity); and to an increase of maternity benefit. The other additional benefits are designed to mitigate special circumstances: as when the insured is convalescent after some disease or disablement; when he is in want or distress; when he cannot attend work on account of infection; when certain repayments of contributions are due to him; when payments for medical or surgical advice, for dental treatment, to hospitals or convalescent homes have to be made. Payments in the form of such benefits may also be made for the provision of premises suitable for convalescent homes and the maintenance of such homes. They may be made for the whole or part of the cost of medical and surgical appliances (other than dental and optical appliances and those provided as part of medical benefit); for ophthalmic treatment (other than provided as part of medical benefit); or to charitable institutions in respect of the treatment of members required for the prevention or cure of disease.

The last of the seventeen benefits gives permission to enlarge the list 'by such other additional benefits, being of a character similar to that of any of those hereinbefore mentioned as may be prescribed'.

This list of additional or special benefits is characteristic of a system of sickness insurance which first limits its statutory benefits

1 Cf. the very lucid description of this matter in Foster and Taylor, *loc. cit.* pp. 171 sqq.; also Ministry of Health, *National Health Insurance*, Memorandum 239, 1938, pp. 19–20.

to a certain minimum and then tries by *ad hoc* arrangements to enlarge their scope or efficiency. How far these permissive powers have or have not been made use of is one of the most critical problems in National Health Insurance. The extent to which they are used depends on the administration and finance of the individual insurance carriers, a fact which is fundamental in any examination of the system and practice of approved societies.

The list of benefits, cash and medical, basic and additional, makes apparent the two very different functions which the National Health Insurance scheme attempts to fulfil. Cash benefits are a category of insurance; medical experts who assert that the object of the scheme is the improvement of the nation's health tend to forget this. Even if the real aim were the prevention of sickness, so far as possible, and the treatment and restoration of the sick, available to every citizen as a great national service, the necessity would remain to safeguard the wage-earner and his family against the risk of losing his income during illness and exposing his family and dependants to starvation and destitution. That this safeguard can best be secured by levying contributions from those in good health to compensate those who happen to become the victims of sickness, with additional aid from the contributions of employers and the State, is obvious. Moreover, this method of income insurance, by preventing destitution, goes far to prevent further ill-health; to the merely economic function of cash benefit is added one of medical importance. But directly and mainly the medical importance of the scheme rests with the second category of benefit, the medical benefit. It depends upon the scope, adequacy and efficiency of medical benefit, not only whether the insured can expect physical restoration, but also whether and how far the financial burden of compensation for loss of earnings, to himself, his employers and the State, can be limited. This interlocking between medical and cash benefit should not be overlooked. The more effective the scheme is medically, in physical terms, the less costly it will be financially, in terms of cash. It is doubtful whether the present system of health insurance has sufficiently recognized this vital interconnection and how far medical benefit under a system of sickness insurance is the best method of attaining this end. It is tragic that this matter tends to be treated as a conflict between purely medical ideals, on the one hand, and social, political and economic ideals, on the other. This is the conflict that stood at the cradle of National Health Insurance; and after thirty years it has not yet been settled.

PART IV. *CASH BENEFITS AND THE ECONOMIC CONDITION OF THE WORKER*

CHAPTER VIII. THE FLAT-RATE SYSTEM

'. . . it cannot but be good for the commonwealth to shield from misery those on whom it so largely depends for the things that it needs.'

POPE LEO XIII, *Rerum Novarum*, Encyclical Letter, 15 May 1891.

CASH BENEFITS, under National Health Insurance, consist of sickness benefit and disablement benefit. Sickness benefit is paid periodically during incapacity for work caused by some specific disease, or bodily or mental disablement, of which notice has been given. Payment ordinarily begins on the fourth day of incapacity and continues for a period or periods not exceeding 26 weeks in all. When sickness benefit is ended, disablement benefit begins. It is a permanent cash payment. In other countries it is usually called pension or rent and, if not embodied under a sickness insurance scheme, is provided for by special schemes such as the German worker's invalidity insurance law which forms part of the law of pensions and orphan's insurance.[1] Disablement benefit in Britain, being part of the National Health Insurance scheme, is a continuation of periodical payments at a lower rate in respect of incapacity after the period of sickness benefit has been exhausted. Sickness and disablement benefits are both paid by the approved society of which the insured person is a member.

An insured person is not entitled to sickness benefit until a certain waiting period has been passed; 26 weeks of insurance must have elapsed and 26 weekly contributions must have been paid. For disablement benefit the insured person must have been insured for 104 weeks, and 104 weekly contributions must have been paid. An insured person who falls into arrears of contributions is penalized by the reduction or suspension of ordinary health insurance benefits—other than medical—unless he makes a payment to his society to cover his arrears within an allotted time. The appropriate payments and penalties are fixed by regu-

1 *Reichsversicherung*, Book IV, Invalidenversicherung.

lations made by the Health Insurance Joint Committee; and arrear notices giving particulars are issued by the societies. Benefit may also be reduced when a member has failed to pay a levy imposed by his society to meet a deficiency in its administration account. Special rules apply to unemployed members who may prove 'genuine unemployment' and so get their arrears not counted for the period of their unemployment.

The ordinary basic rates of sickness benefit are 15*s.* a week for men, 12*s.* for unmarried women and widows and 10*s.* for married women.[1] But, until a person has been insured for 104 weeks and 104 weekly contributions have been paid in respect of him, benefit is paid at a reduced rate; 9*s.* for men and 7*s.* 6*d.* for women. The normal rate of disablement benefit is 7*s.* 6*d.* a week for men, 6*s.* for unmarried women and widows and 5*s.* for married women. When an insured person who has received sickness benefit in respect of an illness recovers from that illness and again falls ill within twelve months of his recovery, the second illness is treated for cash benefit purposes as a continuation of the first. Benefit is, therefore, payable from the first day of the second illness, and the illnesses are reckoned as one in calculating the 26 weeks of sickness benefit. Special provisions relate to workers who have been injured by industrial accident or disease, who are entitled to claim and receive cash compensation under the Workmen's Compensation Act or under the Employers' Liability Act, 1880 or at Common Law or under various Injuries in War (Compensation) Acts. In these cases sickness or disablement benefit is payable only if the normal weekly rate of benefit exceeds the weekly value of any lump sum paid under these Acts or at Common Law as final compensation or damages. The general rule is that the injured worker gets sickness benefit under the Workmen's Compensation legislation, while he gets medical benefit under National Health Insurance. The distinction between sickness benefit, payable to injured workers under Workmen's Compensation rules, and medical benefit under National Health Insurance is not an exceptional feature of the British insurance system. In Germany, where under Workmen's Compensation, in principle, both cash benefit and medical care are provided, the injured worker gets sickness benefit as well for the first 26 weeks. Sickness benefit is half his wages, payable for the first 45 days of disability by the approved society (Krankenkasse), while cash benefit under Workmen's Compensation is 66⅔ % of his pre-accident earnings, which

1 Increased by 3*s.* a week on 1 Jan. 1942.

he gets when the first 26 weeks of injury are over.[1] This arrangement in Germany should not be overlooked, for it is sometimes contended that the division of benefits between National Health Insurance and Workmen's Compensation in Britain, and their inequality, is due to the fact that Workmen's Compensation preceded National Health Insurance.[2] In Germany, the basis of 66⅔ % of pre-accident earnings (annual wages) under Workmen's Compensation was decided upon as distinct from the 50 % basis of the basic daily wage under sickness insurance. There are some logical grounds for making this distinction. The intention is apparently to grant the heavily injured worker a larger benefit than the worker more lightly injured or struck by illness in the normal circumstances of life.

Under the latest British legislation National Health Insurance has been obliged to take over sickness benefit for the industrially injured in cases 'where an award of compensation or damages has been made in favour of an insured person, and the payment cannot be recovered by reason of the insolvency of the employer or other person liable'.[3] This amendment followed a recommendation made by the Royal Commission of 1926. Because of the difference between compensation benefit and sickness benefit under National Health Insurance the injured is thus reduced to the lower standard of the latter—although the new legislation means a great improvement in view of the worker's insufficient security under a non-compulsory Workmen's Compensation insurance scheme.

The sufficiency or insufficiency of National Health Insurance benefits may be judged by comparison with other social services—though such comparisons do not touch the root of the problem, which is the adequacy of the benefits by absolute, not relative, standards. While under National Health Insurance the sick insured person gets a flat rate sickness benefit, under Workmen's Compensation a flexible scheme of payments is intended to compensate the injured worker for the loss of earning capacity. When his earnings are more than 50*s.* a week, he is entitled to get 50 % of his average weekly earnings before the injury—in case of both total or partial disablement—with a maximum of 30*s.* If his

1 Cf. for particulars, Wilson and Levy, *Workmen's Compensation*, vol. II, pp. 99–100 and the evidence of Oberregierungsrat Lauterbach before the Royal Commission on Workmen's Compensation, Evidence, 21 July 1939, in particular QQ. 6349–62.

2 Cf. Royal Commission on Workmen's Compensation, Mr Hackforth's evidence, QQ. 1585–90.

3 Cf. N.H.I. Act, 1936, section 51 (I) (*a*).

earnings have been less than 50*s.* a week, he gets a higher percentage of compensation, amounting to 74 % of the difference between his earnings before and after the accident, and remaining at 75 % where pre-injury earnings were less than 25*s.* a week. But the proportionally higher percentages paid for compensation only begin to become effective with the lower wage-earners, so that actually the lower pre-injury earnings have been the nearer compensation draws to the National Health Insurance cash benefit; and, even with a pre-injury income of 25*s.* a week and compensation at 75 %, it does not touch the 15*s.* (now 18*s.*) limit of statutory National Health Insurance benefit.

Before the Royal Commission on Workmen's Compensation, in 1939, Mr Hackforth expressed the view that National Health Insurance and Workmen's Compensation payments should, in theory, not differ, since injury in the course or out of employment did not in any way differ from the regular contingency of sickness; the very principle of Workmen's Compensation had been (in contrast to Employers' Liability) not to pre-suppose any fault or negligence on the part of the employer himself.'[1] But Mr Hackforth's argument does not appear to be quite watertight. Although the negligence factor may be ruled out as regards Workmen's Compensation, it must be taken into account that the worker exposes himself by his work to particular risks. It is for this exposure to unavoidable risks that compensation for injury has been granted. If a worker breaks a leg while at work—though the cause may be quite unrelated to any particular act of negligence on his part or on that of the management—it is supposed by the law that such an accident might not have happened if he had not been at work. A worker breaking his leg in his private garden is, on this ground, treated differently as regards cash benefits from the worker who breaks his leg while at his work.

While the differences between National Health Insurance benefits and those paid under Workmen's Compensation are in the main a matter of principle, the discrepancies between National Health Insurance and Unemployment benefits have had a very undesirable effect in practice. The ordinary pre-war benefits under Employment Insurance are definitely higher than National Health Insurance cash benefits. The matter was amply discussed before the Royal Commission of 1924–25. Sir Walter Kinnear, then Controller of the Insurance Department of the Ministry of Health, agreed that there had been complaints from insured persons who

1 Cf. Royal Commission on Workmen's Compensation, Evidence, Q. 1594.

had been unemployed for long periods and fallen sick.[1] As Sir John Anderson intimated, the higher rates of unemployment benefit tended to affect the working of National Health Insurance 'adversely', and even the legislation alleviating the position of the unemployed in cases of arrears[2] did not materially alter this. A witness speaking for the Hearts of Oak Benefit Society declared that the difference in benefits was 'to the advantage' of the society: 'Formerly people on the border-line of incapacity would tend to go on the sick fund. They will not do so now, because it pays them to receive unemployment benefit.'[3] Sir Andrew Duncan intimated to another witness 'that many of the unemployed persons who fall sick now will not report as sick but carry on as unemployed',[4] while a doctor giving evidence on account of his experience as a practitioner in the East End referred to the loss of medical benefit consequent on persistent unemployment.[5] 'We think it not unreasonable to suppose that unemployed persons will delay in obtaining medical advice and treatment under the National Health Insurance Act, lest they should be disentitled to the higher rates of the Unemployment Act and so a force is created directly opposed to the public interest and the public health', observed the Minority Report, though the Majority Report remained silent on this matter.[6] The clerks in charge of the Labour Exchanges always ask for certificates that applicants are fit for work before unemployment pay is given—a fact which shows that the possibility of persons claiming unemployment benefit when sickness benefit would be due is in the mind of these officials.[7] The Minority Report recommended that the normal rates of sickness benefit should be raised to the level of unemployment benefit rates.

Under Unemployment Insurance there is cash benefit for dependants on a considerable scale. This makes a comparison with National Health Insurance still more unfavourable to the latter. In a family consisting of man, wife and three children, the father, if he has a brief lapse from regular employment, will draw unemployment benefit to the amount of 41*s.* a week. If he remains unemployed long, the time will come when his insurance benefits are exhausted. He can then apply for unemployment assistance

1 Cf. Minutes of Evidence, QQ. 473–6.
2 See above, pp. 34–6.
3 Minutes of Evidence, Q. 3368.
4 *Ib.* Q. 8236.
5 Cf. *ib.* Q. 16,109.
6 Cf. *Royal Commission Report*, pp. 318–19.
7 Cf. *ib.* QQ. 14,791–2.

from the Assistance Board; and if he is without other resources, the normal grant will be 39*s.* 9*d.* If he is not an insured worker or if, for some other reason, he fails to qualify either for unemployment benefit or unemployment assistance, he will be driven to seek help from the Public Assistance Committee; the present scale in Liverpool, for instance, gives a family with three young children 38*s.* 6*d.* Commenting on these figures Prof. D. C. Jones has observed that 'in one way or another these three services succeed in finding a close approximation to the estimated cost of bare subsistence'.[1] The contrast with the cash benefit of 18*s.* a week under National Health Insurance is appallingly evident. In 1942 an unemployed worker with a wife and two children received 38*s.* under unemployment insurance, but 18*s.* when sick![2]

There are also inequalities of cash benefits within the National Health Insurance scheme itself as a result of the smaller amount of the sickness benefits paid to women compared with those paid to men. This is a unique feature of the British system; it reappeared in this war in the scheme for the compensation of civilian war victims, which followed National Health Insurance principles and not those of Workmen's Compensation. While similar schemes in France, Germany or Italy contained no differential treatment between women and men,[3] the British system, based upon flat rates varying with the degree of disablement, showed considerable variations of benefits between women and men. The development of National Health Insurance legislation has seen a deterioration of the position of females. From July 1920 to the end of 1932 the rates of sickness benefit were normally 15*s.* for men and 12*s.* for women (in the case of those who had been 104 weeks in insurance and had paid 104 contributions); and women's benefits were payable irrespective of marital status. From the beginning of January 1933, however, the rate for married women was reduced to 10*s.* and there was a similar reduction in their disablement benefit. These reductions were made because of the heavy expenditure in the preceding years on the benefits to insured women and particularly to married women.[4]

Figures were issued by the Government Actuary in 1932 showing that, for 1928–30, the cost of sickness and disablement benefit in

1 Cf. D. Caradog Jones, 'Three Working-Class Budgets', *The Times*, 1 Feb. 1941.

2 Cf. *Beveridge Report*, p. 230.

3 Cf. I.L.O., *The Compensation of War Victims*, Geneva, 1940, *passim.*

4 Cf. *Memorandum of the Ministry of Health to the Royal Commission on Workmen's Compensation*, 1939, Evidence, p. 154.

respect of women had been much higher than expected; the excess expenditure for married women had been £420,000. This led to the statutory reduction of benefits, which, as a member of the Royal Commission on Workmen's Compensation in 1939 observed, had the effect that 'those who require the most receive the least'.[1] The alteration may have been justified actuarially. But actuarial justifications are not identical with social need. Under a system where contributions and benefits were regulated according to earnings, such inequalities would hardly be possible; women earning the same wages as men in a certain category of work could not be placed in a less favourable position as regards cash benefits. It is only in a system of flat rates that discrimination between males and females is possible.

The question of 'flat rates' is of fundamental importance for all categories of the insured. If an insured person falls sick, a flat rate may be justified by the argument that such sickness is expected to be transitory, and sickness benefit is merely the means of tiding over a difficult time for the bread-winner or the wage-earner. The matter becomes entirely different when invalidity or incapacity for work, full or partial, develops as a sequel to illness. A new set of problems arises. It is no longer a question of assisting the sick man financially during his illness; the aim now is to secure the minimum means of existence for him for as long as his incapacity lasts—which, unfortunately, may be for his whole life. Most countries have made special legislative provision for this purpose by a separate social service, that is, invalidity insurance. In Britain, however, such provision as there is has been made part of National Health Insurance under the name of disablement benefit. When the National Health Insurance scheme was still in its infancy, foreign observers noted this as a particularly valuable feature of the British system. That classic writer on social insurance, Mr Rubinow, observed that 'in marked contrast to all these laws stands the National Insurance Act of Great Britain, which provides benefits unlimited in time. But in drawing comparisons with the German or any other Continental system, it is but fair to state that the British system is a combination of sickness and invalidity insurance.'[2]

We are not, at this stage, concerned with the very complicated problem whether and under what conditions the incapacitated

1 Cf. QQ. 1428–9; the answer of the witness to this remark was: 'In Insurance schemes, in the long run, you can only pay back in benefits what you receive in income.'

2 Cf. Rubinow, *loc. cit.* pp. 265–6.

person should be regarded as incapable of earning and entitled to a pension or disablement benefit, a question which concerns partly the administrative aspect of the problem, and partly the medico-legal aspect. In an analysis of the structure of cash benefits, the issue is the method by which the incapacitated person is provided with disablement benefit. The difficulty with which social legislation everywhere has been confronted is to decide the principle on which such incapacity should be compensated. The International Labour Office in a recent publication has observed that 'logically' compensation paid for incapacity 'should be assessed on the basis of the actual loss of earnings'.[1] In practice, however, the International Labour Office continues, compensation is usually assessed on quite a different basis, and the pension is calculated in terms of the cost of living. 'Cost of living' need not necessarily mean a flat rate for all incapacitated workers. The German invalidity insurance law laid down from the outset certain wage classes which, apart from the amounts fixed by the Reich's grant and a sum provided by the Reich's Insurance Office, still form the basis of a graduated system of invalidity pensions.[2] This system tries to adapt the disablement benefits to the income status of the worker, as well as to cost-of-living considerations. But it is not only a question of the pre-injury earning power of the disabled. The degree of physical disability, or post-injury earning capacity, must also be taken into consideration whenever a case of partial disablement has to be considered.

In the matter of total, as distinct from partial, incapacity, an examination of the different experience of different countries reveals three distinct answers to the question when total invalidity can actually be regarded as starting.

1. Permanent incapacity benefit starts when incapacity has become permanent or persistent (Chile, Italy, Sweden).

2. Permanent incapacity benefit starts on the expiry of a fixed period (Great Britain, France, Germany-Austria, Irish Free State).

3. Permanent incapacity benefit starts when incapacity has become permanent or persistent, but at the latest on the expiry of a fixed period[3]—a combination of 1 and 2.

The idea of the second method is to replace sickness benefit by

1 *The Compensation of War Victims*, 1940, pp. 30–3; this reaffirms the position taken up by the I.L.O. in *The Evaluation of Permanent Incapacity for Work in Social Insurance*, Geneva, 1937, p. xii: 'In reality the damage which Workmen's Compensation and invalidity insurance seek to make up for is the loss or reduction of earning capacity'; also *ib. passim.*

2 Cf. I.L.O., *International Survey*, vol. 1, p. 321 and *Evaluation Report*, pp. 148–9.

a benefit possessing greater stability, on the expiry of a fixed period of incapacity. Actually, however, in Great Britain the difference between sickness benefit and disablement benefit lies mainly in the rate of benefit. The increase in stability is slight; for disablement benefit is only continued—as sickness benefit is—for so long as medical certificates of incapacity are furnished periodically, the maximum interval between certificates being four weeks.

There is no graduation of disablement benefit in relation to the degree of partial disability; and both sickness and disablement benefit end when a member has reached the age of 65. Once a member has been found entitled to disablement benefit it is paid without any graduation in amount. In contrast to this arrangement, the basic pension under the new war scheme combines payments according to the percentage degree of disablement with maximum weekly rates of disablement pension. The rates, at 34*s.* 2*d.* for men of 100 % invalidity and 24*s.* 2*d.* for women, are very much higher than under National Health Insurance.[1] Probably this arrangement was chosen in the case of war injuries in the light of all the notable experience of disability schedules which the Ministry of Pensions, the administrator of this scheme, had collected.[2] The important point is that, in this scheme, a Government department was able to carry out a refinement in the graduation of cash benefits which, under the administration of National Health Insurance by approved societies, has apparently not proved feasible.

The flat rate has remained a more or less unique feature of the English sickness insurance system. Sickness and disablement benefit alike do not profess to compensate the wage-earner for loss of earnings; they merely represent, as Sir Hector Hetherington put it to a witness before a Royal Commission, 'a tide-over scheme', 'a supplement of maintenance derived in part from elsewhere' and 'not full maintenance'.[3] It is impossible to be satisfied against the background of international experiences, or having regard to the different categories of the insured, that the system on which the payment of sickness and disablement benefit is based in Britain offers the best solution. Even more important, it is extremely doubtful whether the actual amounts paid in benefits are adequate.

1 Cf. Personal Injuries (Civilians) Scheme, Statutory Rules and Order, 1940, No. 1307, Second Schedule.

2 Cf. Royal Commission on Workmen's Compensation, *Memorandum of the Ministry of Pensions*, 1939, p. 393; *ib.* Q. 3556: 'our pensions are based... entirely on a physiological basis'.

3 Cf. *ib.* QQ. 1121 sqq.

CHAPTER IX. INSUFFICIENCY OF ADDITIONAL BENEFITS AND OTHER RESOURCES

"'Poor mite,' said Mrs Baxter, turning to me. 'She never had a chance. The mother hadn't any milk. She wanted real nourishing food, but there wasn't the money to get it. Her man's in hospital and there's only a few shillings coming in. . . .'"

MRS CECIL CHESTERTON, *I lived in a Slum*, 1936, p. 119.

'In regard to the amount of benefit', observed a Report of the International Labour Office in 1936, 'the Conference was faced with two different conceptions of the function of benefit. According to the first, the benefit is intended to enable a sick person to maintain his usual standard of living, and it must therefore be fixed in relation to wages. According to the second, the benefit is intended only to secure a strict minimum of subsistence during the period of incapacity, and it should therefore be fixed at a flat rate for all insured persons, irrespective of their earnings.'[1] The reliance of the British system upon flat rates was from the outset an indication that it was not designed to relieve the insured fully from the economic effects of sickness. Flat rates can never aim at full compensation for loss of earnings, for they would have to be so arranged as to cover the needs of the best paid insured; this is, of course, not possible, for the worst paid would then get more in sickness benefit than their earnings. On the other hand, in the case of systems which take earnings as a basis for sickness benefit, it is possible, to some extent at any rate, to adjust benefits to the actual income lost.

No country has yet ventured to guarantee to the sick worker full compensation for loss of earnings. From the insurance point of view, this ought to be regarded as an anomaly. It would be poor consolation for a man who insures his house against fire, even if his premiums were relatively low, to be told afterwards that, though his house has been burnt down, he will only get enough out of his insurance to build a hut. The idea of all insurance is either to give to the insured individual the possibility of ensuring against full damage, or else by some co-operative scheme to make the many who will not incur any loss pay for the damage sustained by the much fewer who do. 'The entire group bears the loss which reduces the suffering of each individual to a minimum'; so states an American insurance authority most concisely.[2] If this principle is applied to existing sickness insurance

1 Cf. *International Labour Organization*, etc., p. 49.

2 Cf. Edward A. Woods, *The Sociology of Life Insurance*, New York, 1936, p. 2.

schemes the name 'insurance' hardly applies. It has apparently proved impossible, in any country, to get the necessary funds from employers and employees or even, through the assistance of taxpayers, from the State. Moreover, national sickness insurance has everywhere had to meet strong resistance against 'high' insurance premiums, which means that the insufficiency of compensation has been still more marked. We shall have to ask later, when dealing with possible economies in the National Health Insurance system, whether the fear of large contributions may not be regarded, in the light of the advantages to be obtained, individually and socially, as ungrounded. At any rate, it is certain that any attempt to introduce a system giving almost full indemnities by relying upon comparatively high contributions would have been the death knell of the scheme.

But the fact that it was never intended to give full compensation should not be used as an argument for regarding the present cash benefits under National Health Insurance as sacrosanct. 'The Health Insurance scheme was based upon a pre-existing voluntary system and it was not the intention of Parliament that the rate of benefit should be related either to wages the man had received or to his necessities. It was to provide a minimum benefit—something sufficiently substantial which would be used as a basis of thrift.'[1] The question is what this minimum actually represents in the light of the existing social conditions of the working class. Even if the scheme is only meant to be a 'tide-over scheme' it must be asked whether and how far it is even this. It is regrettable that the Report of the Royal Commission in 1928 did not find it necessary to enquire what the 'assured minimum', which it believed to be 'not really adequate', really meant in relation to the sick worker's economic status; it merely relied on the assumption that his resources would be supplemented in case of illness by 'additional benefits', 'voluntary insurance', 'savings' and 'etc.'—which sufficiently indicates the inadequacy of the scheme itself. National Health Insurance owed its inception to disappointment with the system of private, voluntary saving and 'thrift'. The Report of the Royal Commission did not make the slightest attempt to find out what weekly sum the average working-class family would have to save in order to ensure the receipt of full earnings in the case of the bread-winner's illness. The figures published by the Ministry of Labour at the end of 1940 in respect of a very elaborate and fair sample of working-class budgets

1 Cf. Royal Commission on Workmen's Compensation, Qu. 1598.

relating to the years 1937 and 1938 revealed the surprising fact that a representative family of three to four persons, with three over eighteen years of age, and a total income of about 85*s.* a week, spent on the average not less than 10*d.* a week on 'doctor, dentist, optician, midwife, nursing fees, etc.' and 6*d.* on 'medicine, drugs, medical and surgical appliances, etc.'; 1*s.* 4*d.* a week went to hospital funds; and an additional 2*s.* and 3*s.* 4*d.* went to insurance premiums and payments to pension funds, respectively, quite apart from National Health Insurance contributions, Pensions and Unemployment Insurance contributions.[1] National Health Insurance does not relieve the working-class family from further money contributions for sickness contingencies; and savings for this purpose cannot be devoted to supplementing the meagre benefits intended to supply the cash needs of the family. If there are savings in the Post Office Savings Bank or elsewhere it is a cruel thought that the only purpose they will serve will be to supplement sickness benefits; and they will hardly suffice to do this for long. It has also to be remembered that there are a number of other purposes for which saving is done apart from a tiding-over in times of sickness. 'The tradition of saving', so remarks Madge,[2] 'is short-term saving—for clothes, for rates, for doctor's bills and for holidays.' Then there is 'saving' for housing purposes. Building societies constantly claim that the system of inducing a workman to buy a house on the instalment plan is a boon because it promotes 'thrift'. Madge states: 'Coventry's rents are high. The average is around 18*s.* 6*d.* a week. The secretary of the Coventry Economic Building Society estimated that 50 % of Coventry householders are tenant purchasers. He said that the average mortgage payment in Coventry is 17*s.* 6*d.* a week.'[3] This average mortgage payment (rent plus amortization) is as much as 2*s.* 6*d.* more than the normal sickness benefit for a male worker. Then there is saving for hire-purchase of such modern commodities of usefulness or pleasure as the washing machine, vacuum cleaner or radio. The Schedule of the worker's saving shows a constant competition between many useful objects, which can hardly be attained if he is expected to provide something

1 Cf. *Ministry of Labour Gazette*, Dec. 1940, p. 305.

2 Cf. in particular Charles Madge, 'The Propensity to Save in Blackburn and Bristol', the National Institute of Economic and Social Research, reprint from *The Economic Journal*, Dec. 1940, pp. 423 and 429.

3 Charles Madge, 'War Time Saving and Spending, a district survey', the National Institute of Economic and Social Research, reprint from *The Economic Journal*, June–Sept. 1940, p. 338.

like the full difference between his ordinary earnings and his sickness and disablement benefits by long-term saving.

This is even less feasible because the British system of National Health Insurance does not provide working-class families, insured for sickness and medical benefit, with payments for burials. For this purpose, perhaps the biggest sums of all out of the worker's savings are diverted from the necessity of 'tiding-over' in times of illness. The premiums paid in 1939 for industrial assurance amounted to as much as £88,000,000 (including free policies). Against this the entire sum of the National Health Insurance contributions of employers and insured, some £27,000,000 for Great Britain, appears small. This £88,000,000 does not represent only premiums paid for a decent burial; it contains premiums for endowment policies and for life-of-another assurance which in many cases may contain an element of gambling.[1] But the main part of the sum remains for the purpose of insuring a decent burial for the insured or members of his family. This is a unique feature of British social insurance. The International Labour Office recommended that 'sickness insurance institutions should, on the death of an insured person, pay a benefit in respect of a decent burial; they should also be empowered to pay such a benefit in respect of burial expenses of the insured person's dependants'.[2] The Royal Commission on National Health Insurance did not seriously consider whether burial benefit could be included in compulsory health insurance; it simply took for granted that there was an apparently inexhaustible reservoir from which the worker could in times of emergency, mainly by saving beforehand, make good the insufficient cash benefits under the National Health Insurance scheme. It is startling, but also tragic, to see how much private interests as well as public administrators rely on the saving capacity of the working classes. The worker is expected to buy his house, his clothes, his furniture and modern utensils of all kinds by saving; to provide for life insurance and burial by saving; and to have saving certificates at the Post Office. Whoever wants to sell something not included in the daily necessities of working-class families appeals to and relies upon their savings; and a Royal Commission thought fit to condone the admitted deficiencies of cash benefits under National Health Insurance by hinting at the possibilities of additional 'voluntary

1 Cf. Wilson and Levy, *Industrial Assurance*, 1937, pp. 149–65 and *passim*.
2 Cf. Recommendations No. 29 concerning the General Principles of Sickness Insurance, 1927, sub A, Cash Benefits, 6.

insurance' and 'savings'—adding that it considered 'such a mixed system' as having 'moral' and 'other advantages'.[1]

In fact, there is not much hope of supplementing inadequate National Health Insurance cash benefits at all effectively by further savings on the part of workers. The question arises how far the normal scale of benefits may be increased by the 'additional' benefits provided by the Statute. These benefits may be distributed under certain conditions: if an approved society discloses at a valuation a disposable surplus, a scheme may be submitted to the Minister for its disposal in the form of additional benefits. Insured persons, however, do not become entitled to any particular additional benefit unless the society or branch to which they belong has adopted that benefit and the member has duly qualified for it.[2] The following table gives the figures (which relate to English societies and branches and international societies with head offices in England) for schemes existing under the Fourth Valuation surpluses and to some part of such schemes already under the Fifth Valuation (which began in January 1938).

	1939	
Kind of Scheme	Number of Schemes	Membership
Cash additional benefits only	51	34,148
Treatment additional benefits only	383	2,886,600
Cash and treatment additional benefits	4,700	10,521,571
	5,134	13,442,319

In 1939, therefore, some 10,556,000 insured persons, 72 % of members of all approved societies and branches, were entitled to additional cash benefits, and a considerable number more, representing 91 % of the total membership, to additional treatment benefits. The position as to additional cash benefits is slightly improved in comparison with 1936 (when both the Fourth and Third Valuation schemes were in force); it was then 70 %. But it has to be noted that 28 % of the insured population are entirely debarred from any additional cash benefits by the financial status of their approved societies. It must also be remembered that not all the 13,442,000 members covered are entitled to additional benefits at once; since the right to these benefits does not mature, for cash benefits, until the beginning of the fifth year, and, for

1 Cf. *loc. cit.* p. 137; for figures of industrial assurance premiums cf. *Industrial Assurance, Report of the Industrial Assurance Commissioner*, 1940, p. 2.

2 For details of qualification, cf. Foster and Taylor, *loc. cit.* pp. 73 sqq.

treatment benefits, until the beginning of the third year, after admission to membership of the society or branch. The additions made to the normal cash benefits are calculated according to a scale of 'units'. One unit of additional cash benefit normally represents an increase of 1*s.* per week in sickness benefit, 6*d.* per week in disablement benefit and 2*s.* in maternity benefit. In certain cases, however, the approved increase for maternity benefit is larger than 2*s.* per unit and differentiated rates are applicable to the additional sickness and disablement benefits of women. Theoretically the position in respect of a society providing five units of additional cash benefit would be as follows:

Class	Sickness Benefit		Disablement Benefit	
	Normal	Additional	Normal	Additional
	s. d.	*s. d.*	*s. d.*	*s. d.*
Men	15 0	5 0	7 6	2 6
Spinsters	12 0	4 0	6 0	2 0
Married women	10 0	3 6	5 0	1 9
Class K[1]	10 0	3 6	—	—

This, however, would represent an exceptionally favourable case. Statistics published for 1936 showed that, out of a membership (in England) of some 13,000,000, just over 7,000,000 members only were covered by schemes providing from one to five units of additional benefit; about 3,500,000 were members of societies and branches which provided three units; and 1,360,000 insured persons were covered by schemes providing five units of increase in cash benefits. This is not a very reassuring picture. Even the five-unit increase does not lead to a definitely satisfactory assistance, for 20*s.* a week in sickness benefits is no real compensation to a household the bread-winner of which may have been accustomed to earn £3 a week or more. It does not amount to more than two-thirds of the 30*s.* maximum under Workmen's Compensation. And the five-unit increase appears to be exceptional. The average increases payable in the form of cash benefits to members of societies or branches which provided such increases in 1936 were just under 3½ units, that is, an addition of 3*s.* 6*d.* a week to sickness benefit, 1*s.* 9*d.* to disablement benefit, and 7*s.* to maternity benefit.[2] In December 1937 Political and Economic Planning

1 For Class K see above, p. 45.

2 Cf. for details, *Annual Report of the Ministry of Health*, 1936, pp. 182–3; *Annual Report of the Ministry of Health*, 1939, pp. 148–9 and 211 (for Wales); it is to be regretted that the latter Report has not published the detailed figures as given in the former.

published some figures giving the benefits of two of the bigger societies, the Hearts of Oak (some 520,000 members) and the Royal Liver (about 400,000 members). Sickness benefit for men was 18*s.* 6*d.*; disablement benefit 9*s.* and 8*s.*[1]

If members of friendly societies insure voluntarily for sick pay, they may expect to get rates of benefit of 10*s.* to £1 for 26 weeks and 5*s.* per week beyond that period; but contributions may be as high as 50*s.* a year if a member is over a certain age, usually 44. It is not known how far the population insured under National Health Insurance may have recourse to these extra voluntary benefits. What, however, is known, is that, in Great Britain, the membership of friendly societies, some 8,000,000 to 9,000,000, is not even half the number of persons insured under National Health Insurance. Of the 8,000,000 or 9,000,000 a certain percentage (perhaps 80 %, if we take the Hearts of Oak as typical) may be insured for sickness; from these there would have to be deducted, if their numbers were known, all those—and they may be the majority—who insure against sickness because they do not fall under National Health Insurance. Moreover, it must be assumed that it is precisely the workers with least pay, and most need, who will not have the double aid of both National Health Insurance cash benefits and the voluntary benefits of friendly societies. Sickness pay by friendly societies in Great Britain, in the years preceding this war, amounted to some £2,500,000 by societies without branches (excluding collecting societies) and some £2,600,000 by societies with branches. National Health Insurance cash benefits for sickness and disablement in that period were some £17,000,000. It obviously cannot be assumed that voluntary insurance provided anything like an essential addition to the average cash benefits granted under National Health Insurance;[2] Political and Economic Planning has not taken these points into account; the uninstructed reader might conclude from its footnote on p. 204 and remarks on p. 205 that sickness pay by friendly societies was a general feature of cash benefit available to most workers during time of illness, while, as a matter of fact, no such conclusion can be drawn from the available statistics.[3]

All the points discussed as to the chance of raising statutory cash benefits to a higher and more satisfactory level by supplementary

1 Cf. *P.E.P. Report on the British Health Services*, 1937, p. 204.
2 Figures taken from *Statistical Abstract for the U.K.*, 1938, pp. 85 and 269.
3 Cf. in this connection also Prof. Gray's calculation, Royal Commission, Evidence, A. 4324.

means lead to the same conclusion. Such opportunities are slight. The working-class family cannot be expected to have much savings to rely upon as an addition to cash payments in time of sickness. The payment of additional cash benefits by approved societies (if at all possible) does not increase the normal payments in any considerable way. To rely upon voluntary recourse to sickness insurance by friendly societies is not only ineffective; it also leads straight back to the very errors to the existence of which the system of National Health Insurance owes its creation. The 'mixed' system, of which the Report of the Royal Commission spoke so approvingly, is comparable to the case of the one-legged man who is consoled for having a weakness in his one remaining leg by the substitution of a wooden leg for the one he has lost.

It now remains to consider what the normal statutory cash benefit, even if augmented by additional cash benefits, means within the framework of the working-class budget during sickness of the bread-winner.

CHAPTER X. NATIONAL HEALTH INSURANCE AND THE WORKERS' BUDGET

'Instability, insecurity of pecuniary position and the constant presence of fear in the lives of the workers and their families constitute the greatest single evil in our society to-day. What, indeed, are the risks of capital compared with the overwhelming feeling of insecurity which haunts the worker's child from birth to grave? What risks of capital can equal in their pernicious effects the extremities of personal want which embitter the life of the labourer?'

JOSEPH L. COHEN, late member, Advisory Committee on Social Insurance of the I.L.O., *Social Insurance Unified*, 1924.

THE normal pre-war average wage of an adult male was about 60*s.* a week, for normal work, assuming Prof. A. L. Bowley's calculations.[1] The gap between this sum and the normal cash benefit of 15*s.* a week had to be filled somehow. Additional benefits might mean only a meagre and insufficient addition; savings and further benefits by voluntary private insurance through friendly societies could not be relied upon to make up. Probably relatives, charitable neighbours, moneylenders and pawnbrokers appeared as the 'deus ex machina'.

1 Cf. D. Caradog Jones, 'Three Working-Class Budgets', *The Times*, 1 Feb. 1941.

Poor Law relief remains a last resort. Although National Health Insurance, among other purposes, was intended to relieve public assistance, the Royal Commission gathered a great deal of evidence that sickness benefits had to be largely supplemented by the Poor Law. Mr Reynard, speaking for the Association of Parish Councils in Scotland, stated that, by a rough estimate, about 75 % of the people in receipt of National Health Insurance 'unless with funds of their own' are being supplemented by the Parish Council.[1] The Association of Poor Law Unions in England and Wales informed the Commission 'that an insured person in receipt of sickness benefit comes to the Guardians for help simply because he has some dependants. He is thrown out of work and there is nothing coming in except his sickness or disablement benefit. In a case like that they are bound to come for Poor Law assistance unless they have some other resources.'[2] The Ministry of Health observed that, although no records were available of the number of applicants or recipients of Poor Law relief, it can only be stated that 'the proportion must be a substantial one'. The Scottish Board of Health submitted a statement to the Commission showing the number of persons in certain industrial parishes who applied for Poor Law relief to supplement National Health Insurance benefit and other resources, and stated that from information based on the Census records 'the indications are that for both sexes 5·9 % and for men 7·3 % of the insured persons drawing benefit applied for poor relief'.[3]

But long before all these possibilities or 'external resorts', such as borrowing, private assistance and Poor Law relief, are tried by the sick worker, the attempt is made to close the gap between the available cash benefit and previous earnings by reducing the household's expenditure to the lower income level. How far this is possible obviously varies from case to case. An almost innumerable variety of single cases may arise. In some cases the 15*s.* or 10*s.* to 12*s.* 6*d.* flat rate for women may represent a far more appreciable benefit than in others. Bachelors, spinsters and widows will be better off than married people. One bread-winner will have to care for a wife and one child; another for a wife and two, three or four children; another may have no children at all to look after. Some households have two wage-earners, and the

1 Royal Commission, Evidence, Q. 20,577.
2 *Ib.* Q. 21,673; also *Report*, p. 25.
3 Cf. Royal Commission, Appendix CV, 51; cf. also B. Seebohm Rowntree, *Poverty and Progress*, 1941.

'overhead charges' are shared. One widow may be the bread-winner for several small children; another widow may live with one or even two grown-up daughters who are also earning money. In those households where two people are earning their wages, there may be wide differences in cases of sickness, since they may earn very different amounts which are pooled for the common family expenditure; if a sum of 85*s.* is earned weekly by a father earning 50*s.* a week and a son earning 35*s.*, the loss of the son's wage less his sickness benefit of 15*s.* will not reduce the total available income as much as the incapacity of the father. All these possibilities must be taken into account when an attempt is made to assess the effect of the low rate of benefit of 15*s.* to 18*s.* a week on households with a case of sickness.

We can, however, arrive at a figure for what may be considered an average 'household', in order to get some indication at least of what the present scale of sickness and disablement benefit means in the context of working-class conditions. In the investigation undertaken by the Ministry of Labour for periods covering several weeks in 1937 and 1938[1] the average household was one of $3\frac{3}{4}$ persons of whom nearly $2\frac{1}{2}$ were 18 years of age or over and one was a child of under 14 years. The average number of wage or salary earners was $1\frac{3}{4}$. Such a family spent approximately 86*s.* 3*d.* a week, and the money went into the following main channels:

	s.	*d.*
Rent or purchase of dwelling, ground rent, rates, etc.	10	10
Food	34	1
Clothing	9	4
Fuel and light	6	5
Other items	25	7

Not much saving is possible in regard to rent, taxes, rates, etc., or fuel and light. Little saving is possible on clothing. There are variations in expenditure on clothing, but it is mainly seasonal, the highest expenditure being between October and January. Perhaps in cases of great necessity there may be some reduction in expenditure on 'women's clothing and material', which was the highest single item with 2*s.* $7\frac{1}{2}$*d.* a week. But the average expenditure on children's clothing, amounting to 1*s.* a week through the year, and on children's boots and shoes, including repairs, which was 2*s.* $2\frac{1}{4}$*d.* a week, cannot be said to be more than adequate, while expenditure on men's clothing, etc., was only 2*s.* $3\frac{3}{4}$*d.* a week. There may be some possibility of cutting expendi-

1 Cf. *Ministry of Labour Gazette*, Dec. 1940.

ture on 'other items' in hard times. Tobacco and cigarettes (2*s.* 6½*d.* a week), the highest of these items, may be cut out altogether; travelling (2*s.* 3*d.*) may, possibly though not probably, not be necessary; newspapers and periodicals (1*s.*), entertainments (1*s.* 4½*d.*), drink (9¼*d.*) and holiday expenditure (7¾*d.*) may be greatly reduced. But it can hardly be expected that all this cutting-down will amount to much more than 5*s.* a week. Some insurance premiums have still to be paid, sickness or not, such as those for burial assurance; and the smaller items, such as payments for education, food for domestic animals, books, etc., do not add up to anything appreciable.

The most important item of all is that of food: and this is where the impact of enforced economy, because of sickness and inadequate sickness benefit, is felt. The material published by the Ministry of Labour on food expenditure does not deviate substantially from the figures published by Prof. Jones relating to the new Merseyside enquiry.[1] The Ministry gives the average quantity of food consumed by a family of 3¾ persons, of whom only one person is under 14; Prof. Jones takes the specimen diet drawn up by the Nutrition Committee of the British Medical Association for a man, a wife and three children. There is a great similarity between the two tables as regards potatoes (13·8 lb. and 10¾ lb.), bacon (1·4 lb. and 1 lb.) and meat (4·6 lb. and 4½ lb.), though there are wider differences in the case of butter and bread. The expenditure on food by the Merseyside family on the British Medical Association specimen diet in October 1940, when food prices had not advanced materially over peace-time levels, was 30*s.* 8*d.* against the Ministry's figure of 34*s.* 1*d.*—it must be taken into account that the Ministry's average family consisted of more persons over 18 than that of the Merseyside enquiry. It may be assumed that a household of 4–5 persons, say, a man, a wife and three children, or three persons over 18 and one child under 14, will normally spend between 30*s.* and 35*s.* on food at 1940 prices. This sum is mainly made up by really necessary foods, such as bread, flour, meat, fish, butter, eggs, margarine, bacon, milk, fruit, potatoes, vegetables and sugar; though a little saving may be possible either by reducing the consumption of food items nearing the luxury line (cakes, buns, pastries, currant bread, 1*s.* 2*d.*, biscuits 4*d.*, tea 1*s.* 7½*d.*), or by a switching over to cheaper foods from more expensive ones, as for instance by increasing the consumption of potatoes, which at not quite 14 lb. appears to

1 Cf. *Ministry of Labour Gazette, loc. cit.* p. 302 and Jones as quoted above.

be very low indeed and capable of expansion. Sir John Orr has expressed the view that it is only in family groups with an income of 20*s.* to 30*s.* per head per week that 'complete adequacy' for health 'is almost reached';[1] and the $1\frac{3}{4}$ wage-earners of the Ministry of Labour's enquiry corresponds to this group, as it consists of $3\frac{3}{4}$ persons with a total expenditure of 85*s.*, which presumably represents the household's income. But Sir John Orr also considers an expenditure of 10*s.* per head per week on food as necessary for adequacy; and in the 85*s.* weekly budget, only 34*s.* 1*d.* was actually spent on food for $3\frac{3}{4}$ persons. One must conclude that any reduction in food expenditure must mean a further reduction of the family's food consumption below the adequacy level. Prof. Jones estimates the cost of living on a 'poverty line' standard (October 1940) at 40*s.* 9*d.* for man, wife and three children, of which food is taken to represent 21*s.* 11*d.* In Sir John Orr's view this would certainly mean under-nourishment. But with the cash benefits provided under National Health Insurance, it is not safe to expect that even this line can be kept. The 85*s.* family with its 34*s.* food expenditure would appear to be in a hopeless position if one of the $1\frac{3}{4}$ wage-earners falls sick and fails to contribute his share of, say, 40–50*s.* a week to the household, with no compensation but 15*s.* National Health Insurance benefit, or perhaps 18*s.* with additional cash benefits. It is not conceivable that the expenditure of the 85*s.* family, with three people over 18 and one child, could be reduced to, say, 50–60*s.* without severe privation.

The conclusion must be that the cash benefits provided under National Health Insurance are insufficient for the bare needs of the average working-class family's budget in times of emergency. And this conclusion does not take into account the further fact that, in cases of sickness, certain important needs will actually be increased. This was not overlooked by witnesses before the Royal Commission, but it was not seriously taken up by either the Majority or Minority Reports. 'As a rule,' observed Mr William Wood, a member of the Executive Committee of the National Federation of Rural Approved Societies, 'he will require more during sickness' (the same, A. 7381), adding, however, 'on the other hand, I do not understand the National Health Insurance Scheme to be a scheme which is intended to provide for all requirements during sickness, but rather to provide a substantial help

1 Cf. Sir John Boyd Orr, *Food, Health and Income*, Report on a Survey of adequacy of diet in relation to income, 1936, pp. 21 and 49.

at these times'. Apparently the latter proviso appealed to the Commission, though Prof. Gray did ask the witness whether he was aware that the low sum of cash benefit was 'in millions of cases' the only source of income, and got the reply that 'it should be kept in mind that in the case of insured women, particularly women who are employed casually or for part time only, sickness benefit represents in many cases more than the actual wage they receive'.[1] Such an answer might have been aptly used as an argument against the anomalies of a flat-rate system of cash benefits. To use it as an argument in support of the sufficiency of cash benefits for the majority of workers was more than cynical. It ought to have revealed to the members of the Commission what the attitude of approved societies and friendly societies towards cash benefits actually was, and what were the motives which caused their witnesses to pretend that the present benefits were sufficient.[2] This attitude emerged with great clearness from the evidence of Mr Thomas James Addly, past president of an important Friendly Society's Council, and of Mr R. Williamson, Secretary to an important Order:

Q. 20,715. 'You press the point as to the maximum that should be received in benefit. I think you have told the Chairman that a man cannot live on £1 a week, a man with a family?' A. 'That is so' (Mr Williamson).

Q. 20,716. 'Why do you say it should not exceed £1 a week?' A. (Mr Addly). 'The reason was that a person who wishes to provide for himself during sickness should be compelled to provide apart from National Health Insurance, and I think the Friendly Societies' view was, and is, that if too high a benefit is given there will be great danger to Friendly Societies.'

Q. 20,717. 'So that you think if this £1 was added the menace to the old Friendly Societies would be still greater?'

A. (Mr Williamson). 'Yes.'

The witnesses, in this case, had declared that 'during the war and up till recently we have been getting very few members',

1 Cf. Evidence, QQ. 11,630–32.

2 Cf. the witnesses speaking for the Ancient Order of Foresters, QQ. 4364–5; further, the witnesses speaking for the Standing Committee of the Scottish Insured Women, representing about nine societies operating in Scotland, Q. 14,510: 'we feel for the individual the sickness benefit is fairly satisfactory'.

and they considered the Insurance Act 'a harsh blow to the old Friendly Societies'.[1] Another important witness, Mr Edwin Heather, speaking for the Order of Oddfellows Manchester Unity Friendly Society, suggested that 'additional benefits should be used as far as possible in treatment benefits instead of cash benefits', as 'National Health Insurance was instituted primarily to provide for the health of the population'[2]—as if it was not one of the blatant dangers to the health of the working-class family that cash benefits were entirely insufficient to provide when the bread-winner was sick, either for him or for his family, the necessary food and other requisites of a healthy existence.[3]

The Report of the Royal Commission could not refrain from observing that 'in reply to questions which we put to them [they] admitted quite frankly' (sic!) that their recommendation was based upon the apprehension that any increase in normal rates of benefit under the Act would be likely to 'have a very detrimental effect upon the voluntary thrift movement'.[4] The views of the societies on cash benefits and their sufficiency should have been regarded with grave suspicion. But while the Report remarked that 'the impression left on us . . . is that the present rates are not considered really adequate for maintenance in time of sickness even by their defenders', it did not attempt to give any detailed analysis of their insufficiency.

The only increase in sickness and disablement benefit which the Commission suggested was an additional benefit to dependants: 2*s*. a week to be added to sickness benefit in respect of a man's wife, and 2*s*. in respect of each child under 14, with special provision for widowers, and an addition of 1*s*. to disablement benefit in the same cases.[5] This was not a really effective supplement to the general scale of cash benefits, but even this was not embodied in legislation.

The Minority Report, for its part, while strongly pressing for an increase of cash benefits, appeared to be more interested in bringing them to the relative level of unemployment benefit than to discover and analyse their absolute inadequacy.[6] It contented itself with recommending an increase to 18*s*. a week for men and 15*s*. for women, though many witnesses had urged something

1 Cf. *ib.* Q. 20,713. 2 Cf. *ib.* Q. 5923.

3 This should not exclude the aim to make medical and treatment benefits the principal aim of National Health Insurance.

4 Cf. *Royal Commission Report*, pp. 136–7.

5 Cf. *Report*, pp. 144 and 280. 6 Cf. *Report, loc. cit.* pp. 318–19.

like £1 as minimum.[1] Fifteen years have passed since the drafting of these Reports; no change has been made in the flat rate of sickness benefits except the war-time addition of 3*s*.

The view of the Majority Report seems to have been that increased cash benefits were only advisable in so far as they would involve no extra expenditure or could be met from the existing financial resources of the scheme.[2] They presented a table showing the cost to Britain of the five great social services (Poor Law, Workmen's Compensation, Old Age Pensions, Health Insurance and Unemployment Insurance) compared with other countries. This is what emerged:[3]

Cost of Social Services per head of total population (Great Britain 100)

Great Britain	100	Czechoslovakia	14
Germany	48	Belgium	7
France	17	Italy	4

The table was submitted by the National Confederation of Employers' Organization.[4] The figures were correct and impressive, but on the point in question they were misleading. The test is not what is spent, but how much of what is spent is received, in cash or kind, by the supposed beneficiaries. If the cost of these services was 78*s*. 6*d*. in Great Britain and 37*s*. 6*d*. in Germany, this comparison does not indicate how much of the so-called 'burden' actually benefited the insured population and how much went, on account of high administrative and other expenditure, elsewhere. It should, for instance, be remembered that the agreement between the Home Office and the Accident Offices Association provides that the so-called 'loss ratio', that is, the proportion which the total amount paid or set aside in respect of claims bears to the premiums, should not be less than 60 % of the premiums; this percentage must appear extravagant, to say the least, from the point of view of benefits. As a matter of fact, in 1938, not less than £2,065,822 of insurance premiums in connection with employers' liability insurance in Great Britain and Northern Ireland was spent in payments for commission, expenses of management and profits, out of a total premium of £6,384,706.[5] It is evident that such a high expense ratio (not identical with the

1 Cf. Statement presented by the National Conference of Friendly Societies, para. 14. Questioned on the point, the Secretary of this body declared that he did not consider £1 sufficient if a man had no other resources, Q. 10,649.
2 Cf. *Report*, para. 153. 3 See para. 146. 4 Cf. *Report*, para. 145.
5 Cf. *Workmen's Compensation Statistics*, 1940, pp. 7–8. Figures relate to insurance companies only.

'loss ratio', as defined above), much higher than the ratio in other countries where it is as low as 10–18 %,[1] must be considered very carefully before the 'heavy' burden in Britain is compared with that of other nations. 'Expenditure' may mean either a sum paid out in benefits or a sum spent in costs. If the former is proportionally high, the total burden of social services cannot legitimately be presented to the public as being very 'high' in comparison with other countries where the expenditure on social services, though involving a lighter total burden, may actually bestow a larger amount of benefits. If the Royal Commission thought fit to hint at the high cost of the social services in Britain, it was surely incumbent upon its members to examine how far administrative costs could be brought down, either by a complete change in method or by some other means. All the Commission did was to observe that it had 'received the strongest representations that industry cannot bear any further burden, and, indeed the need for alleviation of the load is most urgent and could be readily realized by a substantial reduction of the contributions of employers and employed persons under the Health Insurance Scheme'. The Commission might well have taken notice of the fully substantiated estimates made by the late Joseph L. Cohen of the reduction of administrative costs that might be effected by the State administration of social services. The truth is that Mr Cohen's recommendations would have involved a transfer of industrial assurance to National Health Insurance and would probably have evoked the same kind of frenzied opposition as in 1911. Such drastic measures could not be contemplated by the Commission.

A particular problem which confronted the Royal Commission was that of maternity benefit. The Royal Commission rightly observed that it is not so much the money payment that is of importance in this matter as the question of taking steps to secure that every mother received the proper attention. In other words the character of the benefit should change from 'cash' to 'health'.[2] Here, indeed, cash benefit, in the form of maternity benefit, differs from general sickness benefits, as these are directed primarily to the subsistence of the sick worker, while maternity benefit is primarily considered as a necessity in connection with the providing of medical or quasi-medical services. This observa-

1 Cf. Wilson and Levy, *Workmen's Compensation*, vol. II, 1941, chapter on 'Costs'.

2 Cf. *Report*, para. 334.

tion does not dispose of the necessity of paying such cash benefit. Nor does it mean that the present rate of 40*s.* should be regarded with complacency.

The Royal Commission left the problem of cash benefits almost where it was. It took evidence from a long chain of 'bodies', mainly from approved societies, whose bias in this matter we have analysed; from insurance committees, which gave evidence as regards the medical side; from all sorts of associations, semi-official and private; from institutes and actuarial departments. But the man on whose behalf the Commission was sitting, the sick worker, was not interrogated. Here, as in so many other cases, he remained an 'unknown' and unheard witness. Nobody will underrate the importance of mass-observation. Nobody will deny the danger of placing too much reliance on 'case'-experience. The single case may, indeed, be gravely misleading. But, as an illumination of certain vital aspects of social life, and of the life of the worker in particular, the analysis of cases remains of outstanding importance. The 'case work' study practised by the London Charity Organization Society should set a high-class example to Commissions and Committees investigating matters concerning the worker.[1] No Committee investigating the conditions of the unemployed, the sick or the injured worker ought to ignore the necessity to call as witnesses some of the workers themselves and members of their families. The Royal Commission was far more interested to discover how far sickness and disablement benefit fitted into the actuarial side of the picture of National Health Insurance than to find out how the rate of cash benefits fitted into the life of an average working-class family. The whole of its discussion of sickness and disablement benefits, therefore, remained lifeless and unimpressive.

How very different was the picture drawn from a life-long experience of working-class conditions by Lady Bell, the wife of one of the great ironmasters of the North, of the effects of illness and ill-health on a working-class family. Her detailed account was given before the introduction of National Health Insurance; but it still should be a classic piece of guidance to all bodies investigating sickness from a social point of view. Contrasting the

1 In England the practical portion of the training for family case-work study is supplied by the Institute of Hospital Almoners, the Charity Organization Society and other personal service societies. A very interesting description of the whole matter has been given by the London Charity Organization Society in their *Memorandum to the Interdepartmental Committee on Rehabilitation of Persons Injured by Accidents*; see separate print of it, N.D. pp. 3–9.

position of the worker, when stricken by illness, with that of the rich, Lady Bell begins her story with the observation that the worker 'goes out, therefore, as usual, no matter what the weather or how he is feeling, in order not to lose a day's work and a day's pay, and when he comes home it is not surprising if he is worse'.[1] The Royal Commission did not ask how far the worker, fearing to be left with 15*s.* or 18*s.* a week for himself and his family, drags on at work till his condition is worsened, though one Commissioner, Miss Tuckwell, did rebuke the witness representing one of the great Orders, who, while not denying that a person should not carry on on £1 a week, argued that higher cash benefits 'might lessen the incentive to work'.[2] It is not infrequently that higher cash benefits are opposed on account of the danger that they may make it 'a paying proposition for the worker to go on to the sick fund'. Again, it is salutary to recall Lady Bell's description. 'And then follows an illness in which mental suffering is bound to be added to all the rest; a time in which physical discomfort and wretchedness, the inconvenience of having daily life interrupted, so keenly felt and complained of by the man who can afford to be idle, are intensified tenfold in the case of the workman by anxiety at his pay being stopped at a moment when he needs it most. . .for even if he is in a sick club his income is lessened at a moment when it should be increased, and the food and remedies that are desirable are in many cases unattainable without sacrificing something essential to the welfare of the rest of the household. There are of course found among the workers' wives, as in other classes, women who are born skilful nurses; but many a time they are helpless and incompetent; the house in which the patient is lying is often crowded, noisy, stuffy and dirty, and more still in times of illness than at others. For illness brings more for the housewife to do, unaccustomed duties, more trouble; the routine of the house, such as it is, is broken into, everything is bound to be even more uncomfortable than it was before.'

This was in 1911. But in 1941 the position is the same. And the laments of those persons whose duty it is to become acquainted with the sufferings of such people are not less eloquent. Every priest, so we read,[3] meets this situation in practice in his care for the sick. 'The doctor comes along and orders the usual foods and drinks; whiskey and soda water; eggs and milk; oranges and

1 Cf. Lady Bell, *At the Works*, popular edition, 1911, pp. 130 sqq.
2 Cf. Royal Commission, Evidence, QQ. 4292–300.
3 Cf. *Catholic Herald*, 13 June 1941.

orange juice. . . such things are quite impossible even when dad is working. Now that the needs are greater, provision is less. . . . So the mother has to obtain all the extras for the sick man, keep herself and four, five or six little ones and pay the rent—all out of an income of 15*s.* to a pound Health Insurance.' The picture is exactly the same as that drawn by Lady Bell.

Yet there are representatives of friendly societies who are bold enough to argue that sickness pay might, if brought too near to the level of normal earnings, become a 'business proposition'.

The question of the inadequacy of cash benefits has never been considered in the context and against the background of the economic and social existence of the worker as Lady Bell had it before her mind. The main excuse for this has always been, and still is, that National Health Insurance was not intended to grant anything like an existence level. 'The Health Insurance system', explained a representative of the Ministry of Health to a recent Commission, 'was based on a pre-existing voluntary system and it was not the intention of Parliament that the rate of benefit should be related either to the wages the man had received or to his necessities. It was to provide a minimum benefit—something sufficiently substantial which could be used as a basis of thrift.'[1] This explanation is vague in many respects. It was the utter insufficiency of the attempts of the friendly societies to protect the greater part of the working class against destitution through ill-health that led to National Health Insurance. And National Health Insurance was not 'based' upon the previous voluntary system; what happened was that the friendly societies were brought in under peculiar circumstances which had little or nothing to do with their competence in social administration. Moreover, it is very doubtful whether 'the intention of Parliament' was deliberately to give the sick worker and his family too little to carry on decently. Far more probably it was in the minds of the originators of the system to give as much as possible to keep up the previous standard of living of sick people, for it must have been evident that, if the Act was to have its effect 'against Loss of Health and for the Prevention and Care of Sickness', it would do so in proportion as the cash benefits given afforded a decent living to the sick and their families.

The introduction of the 'flat rate' into the scheme, which still represents an anomaly in international sickness insurance, was

[1] Royal Commission on Workmen's Compensation, 31 March 1939, Evidence, 1593.

probably dictated by the desire to make the scheme as simple as possible from an actuarial viewpoint; a flat rate, simply distinguishing between men and women, leaving out of account the age and wage of the insured and the number of his dependants and dispensing with the necessity of classifying wage-earners into groups with basic wages, was considered the only means to avoid further opposition to a measure which already had to encounter bitter attacks on account of 'interference' and 'bureaucracy'.[1] As a matter of fact, the 'flat' rate was considered by the pioneer supporters of National Health Insurance as an outstanding advantage. 'The lowest paid workmen gain most under the Act', wrote Chiozza Money.[2] An American observer remarked in 1913 that 'the British limit establishes an "existing minimum" standard, while in the lower age-groups the sick benefit of the German system must be decidedly inadequate'.[3] The position in this respect is unchanged to-day; the lowest paid worker may get what appears a reasonable benefit in relation to his habitual income. But there is a fallacy here. The lowest paid worker, being already on the margin of existence, should be provided with a sum which matches his regular earnings. The higher paid worker may be expected to get along for a time with a percentage of his income. But this should not be used for an argument for the adequacy of sickness benefit. In one aspect, it is a gross social injustice to penalize the better paid workman. His higher wage may be, and mostly will be, the consequence of his higher efficiency; and this higher efficiency, quite apart from its national importance, may involve particular physical susceptibilities which require special attention in case of illness. A well-paid worker with a family will resent scanty payments and privations during illness far more, and suffer more psychologically because of this, than an unskilled young bachelor does. It is for these reasons that the International Labour Office has come to the conclusion that, if sickness benefits are to be regarded as 'adequate', they should be fixed in relation to the normal wage and should 'be a substantial proportion of such wage, regard being had to family responsibilities'.[4] Apart from this, it may be appropriate to fix a minimum of benefits in order to protect the lowest wage-earners. Actually, in Britain, the wage level has wandered so far away from the flat

1 Cf. Chiozza Money, *loc. cit.* p. 66: 'This flat rate of contribution . . . is designed to place all existing workers on equal insurance footing.'

2 Cf. *loc. cit.* p. 93.

3 Cf. Rubinow, *loc. cit.* p. 273.

4 Cf. *International Labour Organization etc.*, 1936, p. 141.

rate standard, being now something like £3–£4 for a man, a family and two or three children, that the contention that a flat rate of 15*s.* or even 20*s.* is sufficient can satisfy no impartial critic.

A review of the features which characterize cash benefits in National Health Insurance must lead to the conclusion that the system, as well as the actual benefits provided, is far from satisfactory. In the rush and turmoil of 1911, a rudimentary system was adopted which suited legislators partly because of its simplicity, partly because it made it possible to retain as insurance carriers certain interests which were eager, indeed determined, not to be excluded from the scheme. Simplicity in social insurance may be an advantage; but crudity is not. The British system lacks refinement and elasticity; it lacks completeness and adaptability to changing social conditions. Nor can adaptability be secured simply by relating, from time to time, the scale of flat rates to changes in the cost of living index, as it has been done since the last war. It should be out of the question to refer workers to voluntary savings in order to fill the gap left in times of sickness between their needs and their meagre cash benefits. It should be regarded as a grave shortcoming if the task of filling this has to be handed back to the 'thrift agencies' whose inadequacy was the prime cause of National Health Insurance being introduced.

It is obvious that the possibility of an increase in cash benefits or of an extension of their scope ultimately depends upon the financial resources available. This opens a wide range of problems. The question arises how far it may be possible to ask the employers for greater contributions; how far the workers themselves can contribute more; how far the State should be called to give greater assistance. But it depends at least as much on whether economies can be made in the method. The problems of finding the resources to supplement cash benefits will very largely depend upon the reorganization of a system which is costly, wasteful and overlapping. Improvements in administration would at once release sums to be devoted to better benefits. Moreover, any general improvement in the health of workers, with its effect upon the 'expectation' of illness and the shortening of its duration, would also relieve the cash benefit fund. In 1938, out of total benefits of £28,784,000 paid in England, more than £15,500,000 was represented by cash benefits proper,[1] i.e. sickness, disablement

1 Cf. *Annual Report of the Ministry of Health*, 1939, p. 274; the contention of P.E.P., cf. *loc. cit.* p. 203, that cash benefits 'cost nearly twice as much as medical benefit' is erroneous.

and maternity benefits. An improvement in medical benefits might very much lessen the amounts spent on cash benefits.

If, then, we limit the problem of cash benefits to their present deficiencies, the following main points emerge:

1. Cash benefits, for sickness and disablement, must be so reorganized as to bear some relation to the normal earnings of the insured worker. This does not preclude a minimum benefit for low-paid workers. The flat-rate system of payment should be abolished.

2. Cash benefits should enable the worker and his family to keep up, without outside help, a large percentage of their usual expenditure; the percentage envisaged should be between 50–60 % of normal earnings. To this, additional statutory benefits for families with more than three children under 14 years of age should be granted.

3. Distinctions in cash benefits between male and female workers should be abolished.

4. Funeral benefit ought to become a part of National Health Insurance benefits.

Perhaps the first point will raise the greatest difficulties. It presumes a new and quite different National Health Insurance organization. As, if possible, the complications must be avoided which would arise in the computation of individual earnings, a classification of occupational earnings, either on a territorial or local basis or by industrial groups, to arrive at a series of basic wages, on which sickness benefit would be calculated as a percentage, would probably be most appropriate.[1] National Health Insurance in Britain developed as a more or less tentative measure, choosing the most rudimentary methods for the sake of their simplicity. It was first devised to stop a big gap, even by leaving it still fairly wide open. The time has now arrived to transform a defective 'tide-over' scheme into a really effective social weapon against the destitution of working-class families because of ill-health and sickness. If this decisive change in aim and principle is made, the required reforms in benefit and administration should automatically follow.

1 Under the German system Krankenkassen, i.e. the sickness funds, have a rather wide choice in fixing cash benefits in relation to what is called the 'basic wage'; cf. *Krankenversicherung*, para. 180. For other countries using 'basic wages' see I.L.O., *Compulsory Sickness Insurance*, 1927, p. 200.

PART V. *MEDICAL BENEFIT AND MEDICAL TREATMENT*

A. GENERAL MEDICO-SOCIAL ASPECTS

CHAPTER XI. THE SOCIALIZATION OF MEDICINE

'Homines ad deos nulla re propius accedunt quam salutem hominibus dando.'

CICERO, *Pro Ligario*, XII.

('There is no nearer approach to the Gods than the giving of health to fellow-men.')

THERE is one fundamental difference between cash benefit and benefit in kind. It is possible to argue that cash benefits should simply provide sufficient to enable the worker and his family to survive the economic and social emergency caused by the contingency of sickness of some duration. In the case of medical benefit no such limited aim can be accepted. Medical benefit, which is only partly effective, is wholly inadequate. The sole criterion is the full restoration of the sick or injured person's health with the utmost possible completeness. Cash benefit to the extent of 66⅔ % of earnings may be reasonable. But health benefits which give a 66⅔ % cure are quite illogical, medically. Admittedly, it may not be medically possible to restore the working capacity of every sick or injured person 100 %. When a man has suffered a fracture, for instance, restoration to partial capacity may be all that is physically and scientifically possible. But the process of restoration to this 'partial' capacity must be complete. In the case of cash benefits half a loaf is better than none. In the case of medical benefits this is not so. Tuberculosis, for instance, cannot simply be patched up temporarily; only comprehensive and perfect treatment will save the patient's life. The sick worker may sometimes have cash resources to supplement the money deficiency caused by his illness; he has no medical resources of his own to fall back on. Economy in medical treatment contradicts the very foundation of medical science.

The International Labour Office has laid down that the principal object of sickness insurance is to restore health and working capacity, and the first place is given therefore to medical, surgical

and pharmaceutical benefits.[1] There may be a day when an international minimum programme of medical and pharmaceutical aid will exist which every compulsory sickness scheme ought to provide at the outset for insured persons. As conditions are, medical treatment and pharmaceutical and surgical aid vary from country to country, and the term 'medical benefit' covers the general principle only. The actual benefits given depend on a variety of very heterogeneous circumstances and conditions. One of the outstanding factors, of course, is the general standard of medical science, surgery and pharmacology in any particular country. A country may grant very far-reaching medical benefits, in terms of outlay, yet a low standard of medical practice, a lack of progressiveness among the doctors and other circumstances of a medico-technical nature may prevent the benefits laid down by the law from being afforded in practice. British medical science and the capacity of British doctors and surgeons rank high. It is true that the competence of the general practitioner as a panel doctor might be increased, and his medical contribution made more effective by certain changes in the economic conditions of the profession; but it is justifiable to assume that the standard of medical science in Britain is such that National Health Insurance need never suffer for lack of scientific knowledge, medical and surgical experience and enterprise, and pharmaceutical efficiency. Britain's medical achievements and the standard of its doctors' qualifications should provide the ideal background for scientifically effective service of National Health Insurance.

But the actual existing state of affairs is very different. If the question is asked how far these medical achievements and this medical efficiency are in fact of any practical significance to British sickness insurance, the answer is far from reassuring. If the doctor steps out of his purely medical sphere to scrutinize the field of economics and administration he finds that the social application of his medical knowledge is woefully inadequate; that the social use of medicine is far behind the best standard of what is possible.[2]

1 Cf. *International Labour Organization etc.*, Geneva, 1936, p. 51.

2 So Lord Horder, when he speaks of the 'maze, the unwieldiness, the overlap, the uneconomy, the lack of integration of our Health Services, as they at present exist'; cf. S. Mervyn Herbert, *Britain's Health*, 1939, p. xiv, or Sir Morton Smart in 'Physical Medicine and Industry', *Journal of the Royal Institute of Public Health and Hygiene*, July 1939: 'It is for the industrial workers of all classes that I make my plea to-day, that the workers in the sphere of physical medicine should organize themselves and combine their efforts to

The reasons for this gap can be summarized in general terms:

1. In the first place the adequacy of medical treatment in any system of sickness insurance depends upon the limits set by legislation to the obligation of insurance carriers to provide such treatment. How much does the law expect? And what minimum does it insist upon?

2. Secondly, its adequacy depends upon the existence of facilities to carry out the obligations laid down. This problem is entirely economic and organizational. It may happen that in a country, with a very high scientific standard of medicine, facilities for their social exploitation are few; there may be a numerical lack of highly trained doctors or a deficiency in the number and efficiency of institutions, hospitals, clinics, etc. On the other hand, in a country where the standard of medical science may not be particularly high the use made of it and the scope of its exploitation may be exemplary. The question is always how far the economic organization of medical facilities, including the existence of a high-class pharmaceutical service and the efficient manufacture of medical appliances, is actually at the disposal of medical practice. It is a distributive problem.

3. Thirdly, its adequacy depends upon the financial ability of the insurance carriers to make use of the existing facilities. In determining the scope of the medical treatment provided by the insurance carrier, the application of medical facilities to the mass of the insured depends upon financial and actuarial considerations of great practical weight. In British National Health Insurance this point has always been, and still remains, of outstanding importance. It is, perhaps, the most complicated, and at the same time, the most decisive aspect of the whole matter. The main limitation upon medical treatment is not technical or distributive, but financial.

4. Finally, the socialization of medical services depends to some extent on the insured person himself. Reluctance on the part of the insured to make full and early use of facilities, lack of education, carelessness or sheer social necessity may check to a considerable extent the application of the existing medical facilities which the law and the organizational machinery offer. This

evolve a practical scheme which will finally educate the workers themselves to realize that there is more to be expected for the money they pay in insurance than the mere giving of a bottle of medicine—a principle of treatment which is encouraged and perpetuated by the workings of the Insurance Act itself and which is frankly detrimental to the status of medicine.'

may be the fault of the insured. It may also result from lack of the necessary encouragement. But there can hardly be any doubt that the higher the efficiency of medical services under sickness insurance and the greater their completeness, the greater the confidence of the insured and the more determined his efforts to make the best possible use of them. The patient himself must assist the cure; he will do so better when he feels that he is in the best of hands.

CHAPTER XII. TYPES OF MEDICAL BENEFIT

'Gold that buys health can never be ill spent.'

JOHN WEBSTER (1580–1625),
Westward Ho, Act 5, Scene 3.

THE problem of what medical treatment should actually be provided faced National Health Insurance legislation from its inception in 1911. The difficulty of elaborating a definite formula was avoided by the general phrase 'adequate medical treatment and attendance from the medical practitioners with whom arrangements are so made', which is still in the Act.[1] The phrase was heavily criticized by Dr Brend as being extremely 'indefinite'.[2] To-day medical benefit is administered by and through the insurance committees. Its scope, however, has received a wider definition under special regulations, which contain the provision—'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'.[3] This definition of the medical services to be rendered apparently goes farther than the original one; but it is to be understood that normal medical benefit does not include treatment by specialists or treatment in hospitals; nor does it include treatment or attendance in respect of confinement.[4] Maternity benefit must in all cases be dealt with in the interests of the mother and the child, and where an approved society thinks it desirable to do so, it may provide the benefit otherwise than in cash.[5]

These medical benefits may be supplemented by so-called

1 National Health Insurance Act, 1936, section 35 (2).
2 Cf. Dr Brend, 'An Examination of the Medical Provisions of the National Health Insurance Act', reprint from *Lancet*, 1912, p. 15.
3 Cf. *National Health Insurance Approved Societies Handbook*, 1933, from now on quoted as *A.S. Handbook*, 32–142–1–32, section 355, p. 94. 4 Cf. *ib.* section 356.
5 Cf. *National Health Insurance, A Summary of the Acts*, from now quoted as *Summary*, 1939, p. 12.

additional benefits, which as regards cash benefits have already been dealt with. As in the case of additional cash benefits the distribution of additional medical benefits depends on the valuation of the assets and liabilities of approved societies, the result of which is decisive in determining the disposable surplus and, therefore, in determining the scheme that may be submitted to the Minister for its disposal in the form of medical benefits as well.[1] The number of schemes in operation during 1939 for English societies and branches and international societies with head offices in England was 383 with a membership of 2,886,600 for additional treatment benefits only, and 4,700 with a membership of 10,521,571 for cash and treatment benefits.[2] These additional treatment benefits, of which the most important are dental and ophthalmic treatment, treatment in convalescent homes and the supply of medical and surgical appliances, are in general described as the additional benefits Nos. 8–16. They embrace:

1. A benefit which, theoretically called 'specialist service', would provide payment of the whole or part of the cost of surgical advice or treatment, beyond that comprised in any other additional or medical benefit. But this benefit is not actually in operation and cannot therefore be included in any scheme, as it is conditional upon approval by the Central Ministry's Department of a special scheme, which has not yet been formulated.[3]
2. Dental treatment.
3. Payments to hospitals (and certain travelling expenses connected with travelling to and from hospitals).
4. The maintenance and treatment of members in convalescent homes (with travelling expenses).
5. The provision of premises suitable for convalescent homes and the maintenance of such homes.[4]
6. Ophthalmic treatment.
7. Payment of nurses for members.
8. Payments to approved charitable institutions in respect of any treatment of members required for the prevention or cure of disease.
9. Payment of the cost of medical and surgical appliances.

1 See section 103 of the Act.
2 Cf. *Annual Report of the Ministry of Health*, 1938–39, p. 149.
3 Cf. *A.S. Handbook*, para. 883, p. 226.
4 It does not seem logical that this expenditure should be included under 'benefits', which should be regarded as relating to the individual sick person only and not as an outlay made for the entire membership in case a single member should need convalescent treatment as an additional benefit.

An analysis of additional medical benefits in 1939 is as follows:[1]

Name of Benefit and Statutory Number	Number of Schemes	Approximate Membership
Dental (No. 9)	4,834	11,786,000
Ophthalmic (No. 14)	4,821	10,050,000
Convalescent homes (No. 11)	2,603	10,796,000
Medical and surgical appliances (No. 13)	3,968	11,348,000
Hospitals (No. 10)	2,246	1,606,000
Approved charitable institutions (No. 16)	393	7,533,000
Nursing (No. 15)	643	6,396,000
Convalescent home premises (No. 12)	20	614,000

It emerges from this general survey of the situation that the membership covered for hospital treatment is very small. Actually the amount of money allocated to this purpose in 1939 was only £90,000; the entire expenditure on additional treatment benefits for members resident in England amounted to only £2,580,000 during 1938, though this was an increase of about 5 % over 1937. The sum appears almost ridiculously small in view of the £10,535,000 which was spent on ordinary medical benefit and the £28,700,000 spent on total benefits. If the additional treatment benefits were of what one might call a secondary importance —as, to some extent, might be said of dental treatment—the smallness of the sum might perhaps not be too surprising. But actually they relate to such all-important items as hospital treatment, nursing, ophthalmic treatment, etc. The Annual Report of the Ministry of Health seemed painfully aware of this, for it added the following comment to the statistical statement: 'It must not be overlooked that the amounts mentioned represent only contributions made by Approved Societies and branches towards the cost of treatment and appliances received by their members and that, except as regards expenditure on convalescent home premises, sums of possibly equal amount are expended by the insured persons themselves in respect of their share of the cost.'[2] This observation is not to the credit of the social service of National Health Insurance.

In general the benefits to be provided and the services to be rendered by social legislation appear more satisfactory in the printed Statute and the various regulations than they do in actual practice. All the deficiencies, bottlenecks and pitfalls of interpretation do not appear in the 'blue-print'. Even so, simply to enumerate the medical benefits provided for under National Health In-

1 Cf. *Annual Report of the Ministry of Health*, 1938–39, p. 149.
2 Cf. *loc. cit.* p. 150.

surance, as we have just done, reveals their incompleteness. The objective of 'adequate treatment' is sharply restricted by the limitations relating to additional medical benefits. Additional treatment, which in all the more serious cases of illness is so necessary a requirement of treatment and recovery,

(1) is made dependent upon the financial status of the insurance carrier, and is thereby limited and uncertain;

(2) does not include any specialist treatment, without which recovery and the prevention of more serious sickness is unthinkable;

(3) embraces neither in full, nor partially, hospital treatment, nursing or the provision of appliances, etc., which actually should be included in the normal treatment and normal benefits.

This is in sharp contrast to the aim of the International Labour Office that 'in addition to treatment by a fully qualified doctor, there should be available for the insured person specialist services, as well as dental treatment, and for treatment in hospital, where his family circumstances might necessitate it or his illness requires a mode of treatment which can only be given in hospital'.[1] *The International Survey of the Social Services*, published by the International Labour Office in 1936, enables us to draw some comparisons:

Great Britain and Northern Ireland. Medical benefit consists of medical treatment by general practitioner and supply of drugs, as long and as often as necessary.

Germany (before 1933). Benefits in kind. Medical attendance, medicaments, and therapeutic appliances. . . hospital treatment, when the nature or the circumstances of the sickness require. Maternity: obstetrical attendance, and if necessary medical attendance and hospital treatment. Additional benefits: nursing at the insured person's home, aids for reconvalescents, artificial limbs.[2]

Poland. Medical assistance, including medical treatment, medicines and therapeutic requisites, and orthopaedic appliances for a certain period; medical assistance and cash benefit may be replaced by hospital treatment with full maintenance. Maternity: medical treatment and obstetrical assistance before, during and after confinement.

1 Cf. International Labour Office: *The International Labour Organization and Social Insurance*, 1936, p. 51.

2 Cf. also: I.L.O., *Benefits of the German Sickness Insurance System*, Geneva, 1928. (Authors: Dr F. Goldman and Dr A. Grotjahn.)

U.S.S.R. Every form of medical benefit (attendance by physicians and surgeons, special orthopaedic treatment, artificial limbs, etc., hospital treatment, preventive measures, maintenance in sanatoria, etc.) is granted to the insured population free of charge.

Norway. Medical assistance. As a rule dental service. Physical treatment prescribed by a medical practitioner. Free treatment and maintenance in a public hospital or similar establishment (a maternity home in case of confinement).

Austria (former). Medical benefit includes the attendance of a medical practitioner, obstetrical treatment, if necessary, attendance by midwife, treatment, if necessary, for hydrophobia, dental service, medicines and therapeutical requisites, artificial limbs, artificial teeth, spectacles, home nursing, continued hospital treatment.

Luxemburg. Medical aid, inclusive medical and dental treatment, curative appliances and medicines, hospital treatment, nursing, grants to convalescents in convalescent homes; maternity: attendance by midwife and medical practitioner.

There are certainly a great many countries where medical benefit under National Health Insurance is even less ample than in Britain; but it may be doubted whether, in view of the position in the above-mentioned countries, Mr T. Johnston's remark in introducing the National Health Insurance, Contributory and Workmen's Compensation Bill on 15 July 1941 can be justified: 'I do not often attempt to contrast our social insurance system with systems in other lands, but we are at least as comprehensive in this respect as is anybody else.'[1]

To those points should be added the lack of maternity services in kind. This service ought not to be treated as a 'cash' service, but as one calling for treatment of a varied nature. The Majority Report on National Health Insurance, having regard to the Washington Convention of 1919,[2] adopted this point of view and observed that the character of maternity benefit 'should change from "cash" to "health"'; but this, it was urged, should not mean the abandonment of cash maternity benefit. The Minority Report dealt at some length with the matter, suggesting that 'the high maternal death rate and the great amount of sickness

1 Cf. *H.C. Debates*, vol. 373, No. 84, col. 487.

2 Maternity Convention adopted by the International Labour Conference held at Washington, 1919, under the provisions of the Covenant of the League of Nations.

amongst mothers' were a clear proof that the provisions[1] for treatment should be extended. The statement made by Sir George Newman in his preface to *Maternal Mortality* made a deep impression: '3,000 mothers a year die and tens of thousands of young mothers are unnecessarily damaged or invalided each year.'[2] This appalling observation has been amplified by the Departmental Committee on Maternal Mortality and Morbidity.[3] The Committee called for more consultant services and more hospital beds. 'No industry in this country has so high a death rate as motherhood,' writes Sinclair, 'breeding mothers in London die off at nearly three times the rate at which working miners are killed, and in the past dozen years the figure has grown worse.'[4]

There has been an improvement—though not through National Health Insurance. The Midwives' Act, 1936, has opened the way for a complete maternity service under the local authorities; one of the immediate effects of this important piece of legislation was a considerable increase in the number of ante-natal clinics in 1938 and in the number of mothers who attended these clinics, which increased by 45,000. Initiative to improve the medical service in this matter is not lacking. A circular issued to Local Supervising Authorities in Wales in the summer of 1938 urged that steps should be taken to ensure that the best local obstetric skill was called in by the midwife.[5] The Fabian Society Research Bureau suggested in a memorandum that it would be a mistake to include a maternity service in the National Health Insurance scheme in view of the improvement brought about by the new midwives' legislation. It added that it was highly important that the local authorities charged with the duties under this legislation should be compelled, and not merely permitted, to provide the full service envisaged in the Maternity and Child Welfare Acts.[6] This view seems to be reasonable, although it should be noticed that the new midwifery service has already had the effect of causing

1 Then divided between the National Health Insurance as the provider of cash benefit, the arrangements made under the Maternity and Child Welfare Schemes and the provision under the Poor Law.

2 Cf. *Report National Health Insurance*, paras. 332–5, and paras. 103–8.

3 Cf. *Interim Report* (Ministry of Health), Aug. 1930; *Final Report*, Cmd. 5422, Aug. 1932.

4 Cf. Robert Sinclair, *The Metropolitan Man*, 1937, p. 78.

5 Cf. *Annual Report of the Ministry of Health*, 1939, pp. 34 sqq. and 183. The number of cases in which a doctor was called by midwives increased from 20·9 % of the notified births in 1934 to 30·7 % in 1938.

6 Cf. Fabian Society Research, *Health Services Sub-Committee, Social Service Committee*, 13 March 1939.

a sharp fall in the number of midwives in private practice, and an even sharper fall in the number of cases attended by these midwives.[1] In general it may be said that, if a general medical service for the nation could be created, maternity services would be automatically included. But, under such conditions, National Health Insurance medical benefits may disappear altogether. As things are at present, the need for insurance is not lessened, for fees may be charged under the new midwifery legislation according to the patient's means. And it is not certain whether under the new legislation the present lack of co-ordination will be removed; maternity services are now divided into those of the local authorities, those provided by voluntary organizations and those consisting of a combination of the two methods. As long as such lack of co-ordination exists, and as long as uncertainty remains whether, and to what extent, mothers will be able to obtain medical maternity benefits, insurance under National Health Insurance remains desirable, and its absence is a deficiency.

The scope of medical benefit then is in many respects greatly restricted in British National Health Insurance. Since its inception complaints have never ceased, complaints such as those which have been cited from Dr Brend, from the Report of the Royal Commission, from the late Sir Arthur Newsholme, from the Political and Economic Planning Report. The Joint Committee of Approved Societies stated before the Royal Commission that they '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'.[2] The National Conference of Friendly Societies, which then represented over four million insured persons, urged that 'until a public medical service can be instituted medical benefit should be extended to include the provision of specialist treatment and consultant services'.[3] The National Association of Trade Union Approved Societies submitted 'that the term "medical" benefit should mean everything that medical and surgical science can command for the prevention and cure of sickness'.[4] The evidence from insurance committees and their representative bodies was to the same effect. Witnesses

1 Cf. *Annual Report of the Ministry of Health*, 1939, p. 182, where the figures for Wales are quoted.
2 See Royal Commission, Appendix XIV, 24 and Q. 8723.
3 Cf. *ib.* Appendix XXVI, 22 and QQ. 10,913–20.
4 Cf. *ib.* Appendix XCII, 94.

giving evidence on behalf of the Central Departments also agreed on the desirability of extending the medical provisions, and in particular of including specialist treatment—so Sir W. Kinnear.[1] The Report itself stressed the fact that the Commissioners were 'much impressed' by the statutory limitation of medical benefits and the unanimous desire to see them extended. It is now necessary to investigate how far these limitations are increased by deficiencies in the extent and the quality of the existing medical services so far as they are legally available to the insured person in the form of ordinary or additional medical benefits.

B. THE DOCTOR

CHAPTER XIII. THE DOCTOR'S SERVICE

'When the insurance medical service shall have been completed by being brought into organic relation with other branches of medical work as part of a comprehensive scheme of medical services, and not until then, will its full capacity for public usefulness be made manifest.'

Annual Report of the Chief Medical Officer of the Ministry of Health, 1924, p. 163.

ECONOMIC and social science has not yet developed anything like a science of medical economics, nor has there been any systematic attempt to describe and analyse what might be called the socialization of medical treatment. This lack does not apply to England alone. But in other countries, such as Germany, a great amount of literature exists which tries to show the incidence of ill-health in its wide social aspects, mostly in connection with problems of social insurance.[2] In England the Medical Research Council, together with the Industrial Health Research Board, has done a great deal of what may be called border-line work, beginning with studies on industrial fatigue and extending to almost every branch of work in its medical aspects. So far as industrial sickness

1 Cf. *ib.* QQ. 23,682–6.

2 Cf. for instance the very suggestive work of Dr Victor v. Weizsaecker, *Sociale Krankheit und Sociale Gesundung*, Berlin, 1930, which deals among others with such topics as 'The sociological position of the hospital'. There exists in Germany a *Zeitschrift für Gesundheitsverwaltung und Gesundheitsfürsorge*, which is partly a journal of the communal medical profession, and contains a constant review of medico-social problems of all kinds. There exists, furthermore, a great number of essays on social medicine, such as H. v. Hayek, *Sociale und Socialisierte Medizin*, 1925, and A. Grotjahn, *Sociale Pathologie*, 1923.

is concerned[1] a great amount of valuable material has been produced, including special statistical investigations, which may be well utilized one day for the wider field of medical economics. But the tasks of such and similar official or semi-official bodies[2] are generally limited to problems of a purely descriptive and analytical character. Such bodies are not expected to evolve anything like an economic or administrative system out of their medico-social enquiries; they are not expected to approach existing administrative conditions with any kind of criticism or with any suggestions of fundamental socio-political nature. Their labours have certainly advanced our knowledge of the psychophysical aspects of work; and on this basis an attempt has recently been made by one of the earliest investigators in this field to draft a 'Scientific Labour Policy for Industrial Plants', which brings in such problems as diet and health.[3] But there is not yet any systematic approach to a science of medical and socio-medical economics.

The result in regard to the problem of medical benefit under National Health Insurance has been that the socialization or the social diffusion of medical treatment has never been treated systematically. Shortcomings have been revealed here and there. Gaps have been discussed under special headings, in relation to additional benefits, to ophthalmic or dental benefit, to the efficiency of doctors or to the question of hospital treatment. But nobody has worked out, as background, what the socialization of medical benefit and medical treatment should be in a modern state, or how far the present situation in Britain is or is not satisfactory by comparison. This lack is somewhat surprising. Health, its protection and preservation, and the cure of illness and disease might be expected to be regarded as of no less importance to the entire national, economic and social structure than production or commerce.

It appears to us that, in regard to its economic and social aspects, medical treatment should be divided into the following sections:

1. The position and services of doctors and the medical profession.

1 Cf. 18*th Annual Report of the Industrial Health Research Board*, 1938, pp. 30–37.
2 Such as the Industrial Welfare Society, which also produces valuable investigations into certain medico-social questions; cf. for instance *Medical Services in Industry* (issued to Members' firms only), 1936.
3 Cf. P. Sargant Florence and Lella Florence in the *International Labour Review*, March 1941, vol. XLIII, No. 3, pp. 260 sqq.

2. The existence and efficiency of hospitals and similar institutions.

3. The state of the pharmaceutical services and the standard of the manufacture of medical and surgical aids.

Whatever the formal medical benefits provided by legislation, their efficiency in application under sickness insurance schemes depends in extent and quality upon the existence of these services. They are the key to the socialization of medical treatment; and nowhere perhaps is this more apparent than under the British system of National Health Insurance.

The purchasing power of cash benefit, however deficient it may be, is measurable; it does not differ from the general purchasing power of money. With medical benefit there is not the same certainty or uniformity. The doctor gives the 'adequate' treatment which the law envisages in the way he himself thinks sufficient and fair; the definition is personal and subjective. It is true that the insured have a right to a 'free choice' of doctors, that is, among the panel doctors or, as the official expression is, the insurance practitioners. Medical attendance and treatment are ordinarily obtained by insured persons from a doctor who is on the medical list for the area in which the insured person resides. That is, from a doctor who is under agreement with the local insurance committee to undertake medical attendance and the treatment of insured persons. Furthermore, insured persons (except those resident in Northern Ireland) may obtain their medical benefit through certain approved institutions, or they may, in special circumstances, at the discretion of the insurance committee, be required or allowed to make their own arrangements for medical benefit.[1] An insured person, while still resident in his doctor's district, may change his doctor at any time on obtaining the doctor's consent (a consent to be duly signified in Part C of his medical card). He may also transfer, without obtaining his doctor's consent, as from the end of each quarter on giving one month's notice in writing to the insurance committee. These regulations tend to prevent anything like a monopolist hold by the panel doctor over the insured person; they are instrumental in preserving that competition among doctors which is desirable for many reasons and serves to keep alive the patient's confidence. Free choice of doctors was described to the Royal Commission by an official of the Ministry of Health as 'a cardinal feature' of

1 Cf. *Approved Societies' Handbook*, pp. 95–6.

the whole scheme of National Health Insurance.[1] The system of 'free choice' is a safeguard to the insured person, and is regarded as an important right by sick people.[2] On the other hand, it is sometimes regarded by the medical profession itself as leading to unrestricted and harmful competition.[3] 'Patients like or dislike particular doctors for a great variety of reasons, most of which have very little to do with the skill which the doctor places at their service', writes the Medical Practitioners' Union in a memorandum[4] under 'Free Choice of Doctor'. The most 'popular' panel doctor, according to the view of patients, may not always be the most efficient one; the patients are not always in a position to judge. On the other hand, free choice of doctor gives the patient the chance to choose the best medical attendance according to the local 'reputation' of the doctor, which may coincide with his actual efficiency and competence.

It should not, however, be overlooked that, in practice, 'free choice' sometimes does not exist. This is true of many country districts. It was stated before the Royal Commission 'that the value of free choice of doctor is surely something that is going to be felt by people who have been accustomed to free choice of doctor. If in fact you have lived all your life under geographical conditions under which you were lucky if you got any doctor, you have never been accustomed to free choice. The appetite grows with eating.'[5] 'Free choice is almost impossible to-day in many country districts', wrote the Medical Practitioners' Union in 1940,[6] while anxiously stressing the point 'that in populous districts it may be possible to allow free choice [i.e. under the State scheme favoured by the Union], so long as this does not mean

1 Cf. Evidence, Q. 1384; cf. also *ib.* Q. 7858: 'I would put it to you both from the point of view of the patient and from the point of view of the doctor that it is highly desirable that the patient should have free choice.' Further, Q. 15,379: 'You would resent any arrangement under which a doctor was assigned to half a dozen streets to look after all the people in them?' A. 'Yes.' Actually this freedom is only restricted where the insurance committee finds it necessary to allocate the patient to a doctor if the doctor cannot get himself voluntarily accepted by someone.

2 Cf. Royal Commission, Evidence: 'People would resent being told they would have to go to a certain doctor', Dr Alexander Asher, Q. 19,041.

3 Cf. for instance evidence of Dr Comber before the Royal Commission, Q. 15,791: 'You say that the competition among panel doctors to secure patients is degrading and offensive.'

4 Cf. Medical Practitioners' Union, *Memorandum on Home Treatment Service*, 1940, p. 2.

5 Cf. Q. 23,849, evidence by Mr L. G. Brock (Assistant Secretary to the Ministry of Health).

6 See *loc. cit.*

that one doctor is overworked while another has insufficient occupation'. This argument again does not take into consideration that medical attendance by the very best doctor is a social necessity, however that necessity may clash with the economic and professional interests of doctors. Competition among doctors may, like all competition between individuals, raise the average standard of efficiency; and it gives the individual insured person his 'free choice', a chance to take advantage of the selection resulting from such competition. As long as there is no comprehensive, efficient and competent higher authority to decide upon the merits of the individual doctor, this system would appear to be the best possible. On the other hand, it is by no means a guarantee or a measure of the actual efficiency or adequacy of the medical service under National Health Insurance. This can only be judged by the facts, that is, by the actual medical efficiency of the panel, and by the willingness of the insurance practitioners to place their knowledge and assistance as fully as possible at the disposal of the insured sick.

The Majority Report of the Royal Commission apparently saw no fault in the existing opportunities for insured persons to get the treatment required or authorized from the insurance practitioners. It dealt with the matter at some length, and then asserted that there had been 'a great body of evidence not only from the interested parties—the doctors and the chemists—but from societies and representative bodies showing that there was no justification for the suggestion frequently made in the early days of the scheme and still heard occasionally, that doctors and chemists deliberately give to insured persons a service inferior to their private patients'. The Report added: 'There is, we need hardly say, no justification for such a distinction in the Act or in the Regulations, and any practitioner or chemist deliberately differentiating between insurance and private patients in this way would be subject to disciplinary action.' The Report contended that the allegations of insufficient, or rather, discriminatory treatment mostly rested on 'vague impressions or sporadic and unrepresentative incidents'. It recognized that among the 15,000 panel doctors[1] 'there would inevitably be higher and lower standards and that the "honourable profession" of doctors can, of course, claim no immunity from the intrusion of unworthy and undesirable elements'. But, it went on, 'as against the rather vague suggestions that have been made, it is only right to refer to one other considera-

1 The figure is now about 19,000. See S. Mervyn Herbert, *loc. cit.* p. 70.

tion put in evidence before us, namely, that there is a growing tendency among practitioners to be more scrupulous to avoid giving offence in case of insurance patients than in case of private patients, since the former are, in a sense, protected by the machinery under the Act for the investigation of complaints'.[1] It was surely contradictory for the Report to rely upon the observation of a single witness, however authoritative, as indicative of existing conditions, while much more general and widespread views were rejected as being vague and insignificant. This particular witness was Mr L. G. Brock, from the Ministry of Health. His evidence was most careful and considered; and he actually made the proviso that his remarks applied only 'so far as he had opportunities of judging'. 'There are, of course, areas', he added, 'where conditions are difficult because the men on the panel are men who have come reluctantly, who are not dependent to any appreciable extent on the insurance income, and who have, in fact, only come on. . . because they felt that if they were not on the list and were not prepared to take domestic servants some other man might get a footing in the house.'[2] He stated further that 'those men to whom the financial value of insurance practice is small do not find it worth while to familiarize themselves with the regulations; then render their service reluctantly'; and lastly he referred to doctors in districts where there 'is no kind of competition'. It seems hardly conceivable that this witness could be quoted to prove that doctors might in practice be even more careful in the treatment of insured persons than private patients. His evidence rather suggested the contrary; that there were groups of cases and conditions where the complaint of differential treatment to the disadvantage of panel patients might well be justified. The Commission retired behind the meaningless argument that in every profession offences and cases of sub-standard efficiency were liable to occur.

The evidence utilized in the Report came mainly from friendly societies, approved societies, insurance committees and the British Medical Association. Declarations that, as it was expressed in one instance, 'the medical profession as a whole has rendered competent and conscientious service to insured persons', or, in another instance, 'the present panel service deserves more commendation than it sometimes gets', coming from bodies which would hardly be expected to give evidence against their own efficiency, could have little value. We have already seen how it is

1 Cf. *Report*, paras. 67–75.

2 Cf. Q. and A. 1051.

in the interest of friendly societies to see that the benefits under National Health Insurance are not extended to the advantage of members who otherwise might be expected to take out additional voluntary insurances apart from the compulsory one. The Report suggested 'that the only satisfactory evidence available is that which expresses the views of those who have seen the operation of medical benefit at close quarters and who, having seen it in bulk, are unlikely to be unduly influenced by any random deviation from the general standard'. But it completely ignored the view of those who are at the closest quarters of all—the insured sick themselves. Their evidence was not called for. It is very dangerous when investigating bodies take the line that only those deficiencies are significant which are statistically important because of their large numbers or high proportion. On this basis it is easy to minimize almost any evil, for as Masterman has so rightly observed: 'The surface view of society is always satisfactory.'[1] But opinion was not even unanimous among the certainly not entirely unbiased bodies on whose evidence the Report relied. Speaking for the National Conference of Friendly Societies, which then was concerned with 624,000 insured persons and 634 doctors, Mr Alfred J. E. Saunders, the Vice-President, declared: 'In my opinion the service leaves much to be desired, and there cannot be any question in my mind but that there is still to-day a distinction made between the panel patient and the private patient and the respect shown by the medical men to the respective classes of patients. I am not satisfied that that distinction has gone yet, by a very long way.'

The Report did not quote this statement, but only referred to it as being in contrast to the other evidence of similar bodies; and as another member of the same body was eager to assert in general terms that the medical service sub-committees were functioning 'very well' in certain districts the Report thought it[2] fit to represent the evidence of this particular body as 'contradictory'.

The Report made no use of any of the evidence given which was not reassuring about the actual efficiency of the service of panel doctors. Mr E. E. England, Secretary of the Stock Exchange Clerks Health Insurance Society and of the Baltic and Corn Exchange Health Society, declared:[3] 'I have met quite a number of members who complain of the differential treatment that panel

1 Cf. C. F. G. Masterman, *The Condition of England*, 1911, p. 133.
2 Cf. *Report*, para. 72, Evidence, A. 11,016. 3 Cf. Q.8449.

doctors are giving as against private patients, and know from coming in contact with members that many of these cases are genuinely founded.'

Mr E. G. Holdway, Secretary and Treasurer of Lloyd's Health Insurance Society and Lloyd's Convalescent Home Fund, observed:[1] '. . . members dislike the system and then usually do not belong to the class which is compelled to apply to the panel doctor'. This showed that, if they had the opportunity, members of these societies were eager not to be treated by insurance practitioners. Mr England pointed out that the present powers to make their own arrangements should be extended to every insured person. Certain classes of exempt persons were expected to make their own arrangements for medical benefit; and there were two other classes similarly placed. One class was made up of those above a certain income limit (cf. Medical Benefit Regulations, 1936, 4th Schedule); the other case was where an insurance committee 'allowed an insured person to make his own arrangements for obtaining treatment from a doctor not on the panel.[2] If this was the wish of many patients who could afford it, should the Royal Commission not have this as an indication that there was differential treatment? Dr Comber, a member of the Council of the National Medical Union, pointed out that 'patients particularly complain about lack of examination'. This, he said, '. . . is one of the main objections they have. You must remember that a large number of patients have nothing the matter with them, but they wish to be examined. It is no good saying: "you are all right, get out". If you go carefully into their cases, however, and assure them that there is nothing the matter with them, they go away perfectly happy and well.'

Certainly a private patient, paying good fees, would not hear the curt 'Get out, you are all right'. The doctor gave some very appalling cases of negligent and insufficient treatment by panel doctors.[3] Apparently the Royal Commission did not take much stock of what are called 'single cases'; a general statement by this or that body that everything was in perfect order impressed the Commissioners much more. Mr Henry Lesser, the Vice-Chairman of the Insurance Committee for the County of London and President of the National Federation of Employees' Approved Societies, an authoritative writer on National Health Insurance

1 Q. 8449.
2 Cf. for further details, Foster and Taylor, *loc. cit.* p. 160.
3 Cf. A. 15,795.

law,[1] stated that although he considered the service given by medical practitioners in general satisfactory, 'there can be no doubt that there is a feeling amongst many insured persons that they are treated by some practitioners with less consideration than if they were private patients'. This is the line the Report might well have followed up; and the Commission might have arrived at very different conclusions about the satisfactory state of the panel service.[2]

The evidence given before the Royal Commission has not been refuted since. The Political and Economic Planning Report of 1937 was in no way enthusiastic about the efficiency and services of the insurance doctor. It asserted that the panel service and the general practitioner service provided in working-class areas had much improved in quality, but that 'nevertheless it is not as efficient as it might be under different circumstances'.[3] Unfortunately the Report did not think it necessary to enter into a critical and detailed analysis of the position. A close study of what Dr Brend wrote about the insufficiency of the panel system might have been helpful.[4] The popular notion that the panel doctor in many cases sends the patient away with 'a bottle of medicine' after a very cursory examination is not a figment of the imagination. Dr Brend once explained how the insurance practitioner could in many cases do nothing else, because he was not in a position to prescribe the kind of life that would be necessary to restore the worker's health. 'Hence he falls back upon medicine as the only procedure which has a semblance of help, and his patients receive their iron and strychnine "tonic", pill or ointment as a wholly inadequate substitute for the real measures that their condition demands.' And in many cases these humanitarian reasons for prescribing a medicine instead of undertaking a continuous treatment are replaced by the simple wish of the panel doctor to get rid of the case as soon as possible. What Dr Brend wrote in 1917 appears no less true to-day. Sir Morton Smart, Manipulative Surgeon to H.M. the King, wrote in 1939: 'Under present conditions a panel patient suffering from early joint disability or muscle stiffness usually neglects the condition until pain forces him to consult his doctor, and the most the latter can do is to prescribe a bottle of medicine or give an ointment to

1 Henry Lesser, O.B.E., LL.B. (Lond.), *The Law of National Health Insurance.*
2 Cf. Evidence, QQ. 13,489 and 22,900.
3 Cf. *P.E.P. Report on the British Health Services*, p. 162.
4 Cf. Brend, *loc. cit.* pp. 191 sqq. and *passim.*

be rubbed in, in spite of knowledge which may lead him to realize that such treatment is wholly inadequate.'[1]

It is gratifying to note that as regards eye troubles the position is more satisfactory. The dangers and risks related to ocular disturbances (which may be a symptom of any disease) are so well known to ordinary general practitioners that they refuse to treat ocular defects unless they have had a special training. Every insured person has to be seen by his own doctor before he can receive ophthalmic benefit, and many of the patients referred to the National Ophthalmic Treatment Board were sent at the instance of their doctors because there appeared to be something unusual requiring the attention of a medical eye specialist.[2] The arrangements made here to protect the insured person against insufficient and unspecialized treatment are certainly more satisfactory than elsewhere, but they refer to a special and unique group of disease. Moreover, ophthalmic benefit belongs to the 'additional benefits'.[3] The dangers of neglect are by no means absent; but it appears that neglect is due less to the absence of specialist and reliable services than to the attitude of those afflicted by ocular trouble. 'I have known cases', writes a famous oculist, 'of intro-ocular foreign bodies when the men have not even consulted a doctor after, what they thought, a minor injury.'[4]

The position is not dissimilar to, though different from, that of dental benefit, which as the Royal Commission explained is 'one of the most popular, if not the most popular, of the additional benefits'. The treatment and restoration of the teeth is not altogether a matter of health, most important to health though it certainly is. It is, to some extent, a question of appearance. There is no panel of insurance dentists.

1 'Physical Medicine and Industry', *The Journal of the Royal Institute of Public Health and Hygiene*, July 1939. 2 *P.E.P. Report*, pp. 186–7.

3 Examination means an examination of the eyes by a medical practitioner having special experience of ophthalmic work, and includes any advice or service in connection with such examination and the issue of any necessary prescription. Ophthalmic treatment is, according to the regulations, treatment of the eyes by a medical practitioner having special experience of ophthalmic work other than an ophthalmic examination or treatment incidental thereto or treatment provided as a part of medical benefit (cf. Foster and Taylor, *loc. cit.* p. 78). A list of medical practitioners who are prepared to examine insured members and advise in regard to ophthalmic benefit at a fee of one guinea has been prepared by the British Medical Association; cf. for details, *Approved Societies' Handbook*, p. 234.

4 Cf. Joseph Minton, ophthalmic surgeon to Out-Patients, Hampstead General Hospital, 'Eye Injuries in Industry', reprint from *Industrial Welfare and Personnel Management*, Aug. 1939, p. 5.

The Dental Benefit Regulations have laid down certain fundamental conditions, but patients are free to go to any dentist who agrees to provide treatment under such conditions. One of the conditions is that the dentist shall employ a proper degree of skill and attention, not less than he would apply in the case of a private patient.[1] It is clear that dental treatment is a different matter from general medical treatment, and also from such special treatment as that by oculists. A person with means might be inclined to accept the dentist's suggestion to save a decaying tooth by detailed and special treatment which may be lengthy and costly; in the case of an insured person the dentist may think it more agreeable, if not profitable to himself, to make an extraction. The 'medical' effect will be the same; at least, the patient will not suffer any harm. He may even prefer the quick removal of pain and the avoidance of a long treatment. Such alternatives do not offer themselves in other illnesses. Complaints about dental treatment, according to the Royal Commission, related to the quality and standard of workmanship used in dentures.[2] But nothing was heard about the inefficiency of the dentist's service.

This does not mean that the general medical dental service could not be widely improved as to its social diffusion. The Royal Commission stressed the opinion that 'a complete dental service' for the insured would be 'eminently desirable'.[3] So long as the present system of National Health Insurance prevails, there can be no doubt that the question of cost is the outstanding difficulty. So long as approved societies are administering dental benefit as an additional benefit, with only a limited amount of money available, the selection of cases on the basis of urgency, as now practised, seemed justifiable to the Commission; and in their opinion societies could not be blamed for adopting the method of selection which promises the most immediate reduction of their sickness and benefit claims.[4] It must be remembered that—rightly or wrongly from the point of view of social service—the insured public has been accustomed to pay additional sums to dentists who do their insurance work, which is not entirely unjustified in view of the fact that the service is not one in which medical considerations are the only deciding factor.[5]

Neither of these additional medical benefits, ophthalmic and

1 Cf. *P.E.P. Report*, pp. 184–5. 2 Cf. *Royal Commission Report*, para. 362.
3 Cf. *ib.* paras. 361 and 353. 4 Cf. *ib.* para. 357.
5 As to the additional payments by the insured for dental benefit cf. Evidence of Royal Commission, QQ. 3581 sqq., 6654 and *passim.*

dental, is administered to people by insurance practitioners or panel doctors. It might have been remarked by the Royal Commission that there were no complaints about the differential treatment of insured people suffering from eye trouble. The panel doctor, in this case, is subject to the necessity of having recourse to the 'specialist'—the oculist and the eye hospital—and a panel doctor seizes every opportunity of passing on to the hospital as much of his work as he possibly can (declared Mr Orde, Hon. Secretary of the British Hospitals Association, before the Royal Commission on Workmen's Compensation on 25 April 1940; cf. A. 11,055). The Report might have drawn its conclusions about the overwhelming number of other kinds of cases where the panel doctor is unable to pass the insurance patient on to better equipped and more capable doctors. But the Commissioners were satisfied that the panel service was on the whole satisfactory. This complacency still prevails. Thus we read in the latest Annual Report of the Ministry of Health that 'the high standard of service' reached by insurance doctors has been maintained, a contention which is merely based upon the statistics of disciplinary proceedings.[1] The Royal Commission ought to have made it clear that evidence as to this point when given by approved societies does not lack bias. Friendly societies are linked up with those who have a definite interest in not seeing the benefits so far extended as to compromise the flow of savings *outside* the National Health Insurance scheme. What the insured people wish over and above the obligations under the Statute they can get by voluntary additional insurance; that is their argument. It is, therefore, incidentally in the interest of such bodies that the services rendered under the Act should be regarded as quite satisfactory and not in need of statutory extension and amplification. It is the policy of the approved societies to seek, rather, a limitation of the services rendered by the doctor; this is what Dr Brend wrote about this regrettable attitude: 'A person comes to the doctor in such a condition that if he or she belonged to the wealthier classes, abstention from work would certainly be advised. But it is not possible for the doctor to do more than certify that the patient is suffering from "debility", or fix upon some prominent symptom such as "anaemia", "nervous exhaustion" or "dyspepsia" and put that in the certificate. Then comes the Approved Society official who complains that these are not serious conditions, that they do not incapacitate for work, and that the doctor

1 Cf. *Annual Report*, 1938–39, p. 144.

is not making a careful diagnosis or giving his certificates with justification.'[1]

Can approved societies with this restrictive attitude towards medical benefit be expected to blame doctors for 'insufficient' service? Can their evidence be taken as a proof that the desired treatment has been provided? Even Departments may have their own ideas about 'sufficiency'. A revealing experience of this kind was quoted by Dr Morgan in a recent House of Commons debate:[2] 'I had a series of patients with artificial openings for the discharge of waste products. I had five of these patients. Some had malignant growths, others gunshot wounds, and so on. I prescribed cotton wool for these people to clear themselves up with. I was visited by a Ministry of Health doctor, who queried whether I had the right to prescribe cotton wool in cases of this kind and I should use tow. This is a thick fibred substance, the sort of material you make mats out of; cotton wool is a thing you put on as wound dressings. I asked him if he would care to use tow for himself under such circumstances, and he replied that that had nothing to do with the question, and that I should have saved the Exchequer money rather than prescribed the use of cotton wool. . . . I was a Member of Parliament. I told him to go to his Minister. . . and that I would do what I could to fight the point.' This episode deserves more than casual attention. It shows that the panel doctor may be between two fires. He may be accused of giving patients less service under National Health Insurance than he would give to private patients, while, officially, he may be reprimanded for giving them more than the barest and crudest necessities. The inspecting doctor in this case would in all probability have been quite prepared to state that the application of tow would, in his view, be an 'entirely satisfactory' solution.

The official proof of the satisfactory working of the medical service is based on the figures of the numbers of disciplinary proceedings found necessary during the year; the test is the number of cases in which remuneration was withheld from insurance practitioners. The number of such cases in 1938 amounted to 84 cases (8 cases less than in the preceding year) and £900 was withheld. Of these cases, moreover, not more than 11 (11 in 1936, 10 in 1937) were cases of negligence as defined by the Regulations, and before coming to a decision the Minister had before him the recommendations of the Advisory Committee con-

1 Cf. Brend, *loc. cit.* pp. 246–7. 2 Cf. *H.C. Debates*, 15 July 1941, col. 520.

stituted under Regulation 42, which includes representatives of insurance doctors.[1] So far this seems quite satisfactory; but a closer scrutiny puts a somewhat different aspect on the matter. It is very doubtful, indeed, not only as regards National Health Insurance, but also as regards other social services, whether proceedings by the insured against insurance carriers, panel doctors, etc., can be used merely numerically as a test of satisfactory working.[2] The procedure of complaints is not a simple one. There is the Medical Service Sub-Committee which[3] has to investigate the question; their report is presented to the insurance committee; appeals may be made to the Minister. It is quite evident that complaints involving proceedings like these will only be contemplated by the patient in serious cases of some importance. The great majority of cases will never come to the surface because they are of a relatively slight nature. But this obviously does not mean that the medical service may not be capable of very considerable improvement. Certainly it is no reason for regarding it as satisfactory.

We may quote some of the more important witnesses on this question. Dr Comber, Member of the Council of the National Medical Union, declared:[4] 'We have particularly shielded ourselves from making accusations against individual practitioners, and we do not wish to do so; but I think all those of us who are attending the panel patients of other men are very well aware of the fact that there are a large number of cases which would legitimately be a cause of complaint, only no complaint has been made. Women especially do not like to face the ordeal of doing so.... It is very difficult to get women especially to make any complaint. They very much prefer to go elsewhere.'

Mr Henry Lesser said[5] that 'the number of people who make complaints to Insurance Committees are an infinitesimal fraction of the number of people who complain without bringing their cases before the Insurance Committee'. The witness quite correctly inferred that 'as a Committee' they had, therefore, not much testimony as regards the inferiority of the service; the Report ought to have noted this 'proviso'. Giving evidence earlier, the same witness had observed[6] that 'complaints were "sufficiently substantial", but people do not like to carry their complaint right

1 Cf. *Annual Report*, 1938–39, p. 144.

2 Cf. Wilson and Levy, *Workmen's Compensation*, 1941, vol. II, pp. 257, 287, 355; also Hermann Levy, *War Effort and Industrial Injuries*, 1940.

3 See Medical Benefit Regulations, 1936, Arts. 32 sqq.

4 Cf. Q. and A. 15,976 sqq. 5 Cf. A. 22,900. 6 Cf. A. 13,491.

into court'. But Sir Humphry Rolleston, interrogating the witness, could not get away from the contention that, in regard to such complaints, there was not 'a very solid basis of statistics behind it'. Dr Harry Roberts, a medical practitioner, did not think much of the 'complaint' as a weapon which the insured sick person can use; 'he does not understand appearing before tribunals with documents and having a dispatch case handy so that he may produce the right document at the right moment'.[1]

Mr E. E. England, secretary to several health insurance societies, stated before the Royal Commission that, although he had known many cases where a complaint would have been well founded, 'there are few cases, comparatively speaking, that come before the Insurance Committees'. 'We might reasonably assume', he continued, 'that where one case of complaint does come before an Insurance Committee, there are probably 99 that never do, merely because the insured person is either afraid of his doctor or is loth to lodge a complaint, or is too lazy to do it.'[2]

In many cases inadequate treatment may be resented by the patient, but the case may appear even to the sick person not important enough to set the complaint machinery in motion, even though he may have suffered from insufficient or negligent attendance and treatment. In view of these conditions, it is pointless for some writers, such as lately Sir George Newman, to enumerate all the theoretical administrative safeguards which, through the machinery of complaints, should protect the patient against insufficient or negligent treatment.[3]

Another check on 'complaints' is to be found in the time limit; generally speaking, a question must be raised six weeks after the occurrence of the event of which complaint is made.[4] It is well known that in all matters of medical procedure time limits have dangers. In Workmen's Compensation it has been stated over and over again that in many cases the ill-effects of an injury or industrial disease make themselves felt much later than was expected, or could have been expected, after a first treatment was

1 Cf. A. 16,127. 2 Cf. A. 8449; also the same witness, A. 8518.

3 Cf. Sir George Newman, *The Building of a Nation's Health*, 1939, pp. 399–404 (on insurance practitioners): 'In fact, his insurance practice is carried on always in the light of authority and must satisfy the criteria of local committees of administration on which he is represented or may be a member. Any complaint against him, however flimsy or unjustified, will be inconvenient and may be formidable.'

4 Cf. Medical Benefit Regulations, 1936, Art. 33.

over.[1] If a fracture has healed in a faulty position or has involved a joint there may be a period during which the patient can resume his ordinary occupation, following which he may become disabled again owing to osteo-arthritis developing in the injured part, perhaps several years later. There are no 'Ready Reckoners' in medicine.[2] A patient may be aggrieved by the medical treatment applied by a panel doctor; he may have the feeling or suspicion that he was treated negligently; but the effects of such negligence may develop so late that the time limit for making the complaint has lapsed. It was suggested to the Royal Commission by the London insurance committee that the time limit relating to complaints about doctors should be extended to three months,[3] but the proposal was not discussed in evidence.

Then there is the other weapon: changing the panel doctor. We have already seen that this can be done. Here again, some time must elapse till this change can be effected as notice can only be given at the end of certain quarters of the year. This is an improvement on previous regulations,[4] but it still means a check on the patient's liberty to change as quickly and as easily as possible. Doctors apparently do not like the 'open door' which is left to the patient. 'We are told', observed Dr Smith Whitaker, Senior Medical Officer to the Ministry of Health, 'that if they are cross with a doctor for not giving them a certificate or medicine, or if they are cross with a doctor for not attending frequently enough, they go off to another doctor. In former times, when they could only change once a year or once in six months, they had often forgotten their vexation when the time for a change came.'[5] The retarding effect of the time limit on complaints cannot be denied. The 'free choice of doctor' may also exist only in theory in a district where very few doctors are actually available. In areas where there is only one practice insured persons may refrain from making complaints at all in order not to risk unpopularity with the insurance practitioner. Certainly there may be patients—and in particular neurotic cases—who have a fancy for consulting many doctors and are apt to complain about anyone. But this possibility ought not to be used to divert attention from

1 Cf. Wilson and Levy, *Workmen's Compensation*, vol. II, pp. 50, 55, 77 and 291.

2 Cf. Donald C. Norris, 'Some Medical Problems in Accident Insurance', reprint from *Transactions of the Hunterian Society*, 1937–38, pp. 16–18.

3 Cf. Appendix XCVIII, para. 41.

4 Cf. Royal Commission, Evidence, A. 1385.

5 Cf. *ibidem*, A. 1483.

the much more frequent cases where patients genuinely resent their treatment by certain panel doctors and rely upon free choice to remedy their grievances. 'In some cases', observed a witness as regards patients who went to a more distant practitioner, 'I have no doubt they have ample reason for preferring the other doctor.'[1]

The conclusion must be that very little can be deduced as to the actual standard of sufficiency of the panel service from the annual number of disciplinary proceedings or from the number of complaints which otherwise may appear on the surface. And it is a fact that such proceedings as are actually reported tell a very distressing story. The gravity of the cases reported and the seriousness of the effects of negligence by panel doctors must be taken into account in assessing the significance of single cases. There are cases which should never occur. If they do occur, even in single instances, they ought not to be regarded as merely 'exceptions that prove the rule', but rather as a warning that they may be representative of others which perhaps never come to the surface. To use a parallel: a mining disaster where two hundred or more may lose their lives will need more enquiry and attention in order to prevent similar disasters in the future, rare though they may be, than a number of so-called smaller accidents; yet a single accident where a few miners are fatally injured may be indicative, if properly investigated, of defects which are equally harmful and deserve to be remedied. The Annual Report of the Ministry of Health reported in 1939 three cases of neglect in attendance and treatment. 'When the practitioner did ultimately visit, the patient was found in a grave condition necessitating immediate removal to hospital for an operation to which he succumbed.' In another case, where the insurance committee regarded 'the practitioner's conduct as little short of scandalous', the doctor admittedly found on examination the patient in such a state as to lead him to suspect the existence of some grave condition, but he 'contented himself with prescribing a sedative'; and when told the next day that the patient was 'in severe pain' he did not make an offer for another immediate visit, and only did so two days later, when urgently summoned. Would the Royal Commission, if they had taken pains to hear evidence in such cases, have come to the conclusion that there was no differential treatment between private and National Health Insurance patients and that the doctors were even 'more

1 A. 13,160.

scrupulous to avoid giving offence in the case of insurance patients'?[1]

In another case the practitioner, receiving a telephone message that a person had been badly burned, simply advised, when asked that the insured person should be brought to him for a dressing to be applied, that the person had better be sent straight to hospital.[2] The point is that, only in cases where negligence can be actually proved, is the case regarded as evidence of the practitioner's insufficient service. A person, for instance, had suffered for a week from diarrhœa. The panel doctor visited the patient, examined him and ordered a medicine. Later—but on the same day—another practitioner was called in, who thought it desirable to make a rectal examination, whereby he found symptoms of cancer, a diagnosis which had not been made by the first practitioner. The patient, therefore, was moved to hospital, and died a month later from carcinoma of the pelvic colon. The approved society complained to the insurance committee; the insurance committee dismissed the complaint after investigation by the medical service sub-committee; the society then appealed to the Minister. The appeal was dismissed. It was explained that 'failure to diagnose correctly was not negligence unless there was a failure to use the means of diagnosis ordinarily available and to apply them with care'.[3] Under such conditions, very many complaints will have only a small chance of success. The line between negligence proper and conduct which simply consists in the unwillingness of the doctor to try all possible, and even somewhat remote chances of diagnosis may run very fine indeed. Dr Norris reports a case where a man injured both ankles; an X-ray examination showed a fracture of the left ankle only; this ankle was at once put into plaster of paris, but no treatment was given to the right ankle. The patient was sent home from the general hospital, where

1 Cf. para. 73. A very similar case was reported to the Royal Commission: it was presented by members of the Medical Practitioners' Union, which would perhaps not have referred to a case like this if they had not wished to prove that there was no 'gross negligence' in the conduct of the insurance practitioner; but the witnesses had to confirm that the respondent's conduct was open to criticism. 'Whatever may have been the impression produced on his mind by the statements of the deceased's wife at their interview... he then had knowledge that a person suffering from intestinal colic had not recovered in 48 hours and was still suffering pain and was still feeling ill. In our opinion it was his duty from a professional point of view to have taken control of the situation and to have insisted on paying a visit to the deceased on that evening': A. 15,701.

2 Cf. *Annual Report*, 1939, 145–6.

3 Cf. *Annual Report*, 1936, p. 200.

the examination had been made, and on arrival found that he could not bear his weight on the right foot. He sent for his panel doctor, who advised him to stay in bed, which he did for two weeks. The panel doctor saw him once a week for the next eight months, but gave him no advice or treatment. Later on, complications and disabilities became apparent. Dr Norris draws the conclusion: 'Of course one cannot see inside another man's mind; but as far as one can judge from the conduct of the two doctors concerned in this case, one took the view that advice and treatment were none of his business, and that all he had to do was to furnish certificates once a week. The hospital doctor seemed to believe that it was a good thing to put fractures in plaster of paris—that is if they were recognized; but he happened to have but little idea of any treatment other than this, or even of the proper way to use plaster of paris.'[1] At any rate the result contrasts badly with the plain statement of the Statute that the patient should receive 'adequate' medical treatment. It is quite obvious, again, that if a patient in a similar case had been attended by a doctor in his private capacity, the latter would probably, in a case of such chronic and stubborn effects, have advised him to have another examination or to consult a specialist.

The question may also be asked whether the insurance committees which have to deal with the complaints made are in all or even most cases efficient guardians of the patient's rights. If they are not, then again the number of complaints which lead to the institution of disciplinary proceedings may be much smaller than the complaints actually are. The Royal Commission dismissed this point lightly, although it emphasized that 'the problem of complaints' was 'important in character'. Again it was the relative number of such complaints that impressed the Commission; they were only three per committee per year. The Report observed that there was no 'evidence of failure on the part of these Committees or their officers to perform adequately the task which they had to undertake'.[2] But Mr Charles Davis, speaking for the Medical Practitioners' Union as one of their solicitors, emphasized the point that he did not consider that the procedure of the insurance committee as a body responsible for securing a satisfactory medical service for the persons in its area was reasonable. He declared: 'The Insurance Committee ought not to be the body that deals with the complaint between a panel doctor and a patient, but there ought to be an *ad hoc* tribunal specially appointed for the purpose of dealing with these

complaints.'[1] Another witness said that, as regards the treatment in approved medical institutions, 'the arrangements for the investigation of complaints had not been generally satisfactory. Some institutions have been very lax in enquiring into complaints' although the patient had a further right to make a complaint to the insurance committee.[2]

It should always be remembered that, in the matter of complaints relating to the social services, the mere existence of the right in blue print is in no way a guarantee that the object of legislation to secure to the complainant a full opportunity for redressing his grievances will be attained. Very much depends upon the kind of administrative machinery which is set up, upon the simplicity of this machinery and upon the confidence of complainants in the efficiency and impartiality of the committee of appeal. From other experience it appears that the central administration of complaints is most desirable. It removes the complainant from what he may think the bias of local administration and from possible personal dislikes and prejudices. Where such central bodies to deal with enquiries and complaints have developed they have proved successful. The position of the Industrial Assurance Commissioner, for instance, has developed into a sort of bureau of enquiry. He received some 36,000 letters in a year relating to more than 9,000 cases of enquiries and complaints from policy-holders. It may be agreed that National Health Insurance covers problems with many special medical intricacies and complications, while complaints about industrial assurance generally relate to legal and judicial questions only. But this does not diminish the task which was laid upon the Industrial Assurance Commissioner who has to sift an enormous amount of complaints of an irrelevant nature (often from illiterate persons, and vaguely and badly expressed) from those which he thinks important enough for further steps and decisions to be taken. Patients complaining about medical treatment have also both real and fancied grievances; but they have no place to go to for quick information and guidance administered by a civil servant who must be regarded as an impartial and well-meaning authority. It is, to a large extent, for this reason that complaints which might be justified never reach the surface at all. The cases actually brought up for decision represent nothing more than the hardest cases and should not be used for any statistical purpose at all. They may simply be indicative of the worst that can happen. The cases quoted above tell their own story in an unmistakable language.

CHAPTER XIV. THE DOCTOR'S REMUNERATION

'I do not think there is anything so satisfactory as the association between doctor and patient who have confidence in each other. It is the basis of medical work.'

DR R. A. BOLAM, Chairman of the Council of the B.M.A. before the Royal Commission in 1925.

THE NATIONAL HEALTH INSURANCE ACT was drafted with the explicit aim of improving the social and professional conditions of the doctor in order to improve the services rendered by him to the patient. 'The effect of the Act from the doctor's point of view is to raise the status and pay of Society doctoring, and to enlarge and make definite the medical income derived from working-class practice', wrote Sir Leo Chiozza Money in 1912.[1] Even as regards religion a great catholic cleric is said to have observed that with empty stomachs people cannot be expected to be devoted church-goers. Whatever may be expected from a doctor over and above a purely commercial view of his occupation, a limit to such expectations is set by his income. Poor doctors, struggling for their very existence, cannot be expected to devote much of their enthusiasm, energy and interest to the social side of their activities. Doctors overwhelmed with work cannot be expected to devote a maximum of care and responsibility, of scrutiny, examination and diagnosis to the single case, whatever their anxiety might otherwise be to give the best and most efficient service they can. If the State or the administrative bodies entrusted with medical benefit under social insurance allow conditions of such a kind to exist they lay the seed of an insufficient service, and they ought to be aware of this, however few the complaints made by the patients.

The mode of remuneration of panel doctors in Britain has undergone many changes since its inception over thirty years ago; and the earlier arrangements have nowadays an historical interest only. In 1920 the so-called 'floating sixpence' was abolished, with the consequence that the arrangement of the capitation fee became simplified, for the drug (see below, ch. XIX) was now eliminated. There followed a period of disputes over the standard of the fees; opinions differed as they were brought forward by the Ministry of Health, the approved societies or the doctors themselves. The approved societies made at times very strong representations for a more substantial reduction of the fee, while the Minister apparently tried to follow a middle line.[2] In assessing the effect of

1 Cf. Chiozza Money, *loc. cit.* p. 97.

2 Cf. *Royal Commission Report*, para. 420 and sqq.

the capitation fee awarded upon the actual remuneration of practitioners with lists of various sizes, the large mileage grants must be kept in mind; these provide substantial additions to the capitation income of many rural practitioners.

In 1938 about 16,840,000 insured persons were entitled to medical benefit. They were attended by about 16,200 doctors; the total expenditure on medical benefit was £2,308,900. About £211,000 was paid to insurance doctors in rural areas on account of mileage, the payment being so calculated as to take account both of distance covered and of the difficulties of locomotion in country districts.[1] These figures cannot be taken as a test of what an average insurance practitioner actually gets from insurance practice, since the number of persons on a panel differs very widely. The capitation fee is at present 9*s.* per patient. The largest number of persons a practitioner may have on his panel is 2,500 which would bring him a gross income of £1,125. If he had 1,000 persons on his panel the income would be no more than £450, which is certainly not much in view of the expenses involved. As the Political and Economic Planning Report pointed out in 1937, it is worth remarking that friendly societies often pay capitation fees of only about 6*s.*; but certain 'public medical services', as promoted by the British Medical Association, pay a general average of 11*s.* 3*d.*, while sometimes the fee goes up to even 15*s.*[2]

The question of the insurance doctors' remuneration is to some extent linked up with that of 'free choice' on the part of the patient. If the insurance institutions were entitled or obliged to employ their own doctors at fixed salaries the consequence would probably be that they would ask for the patient to be compelled to make use of the reduced panel, that is, to be treated by one of the few, but highly paid, doctors whom the insurance institutions would employ as full-time insurance practitioners with a guaranteed income. This would practically do away with 'free choice'; and the medical profession constantly stresses that the 'relations between doctor and patient are so intimate that both doctor and patient rightly resent any outside interference'.[3] It is explained: 'Such interference is bad for the doctor and worse for the patient. It is bad for the doctor because his whole training and the traditions of his profession tend to foster the idea of personal responsibility, and this can be only at the risk of rendering the doctor less efficient. It is worse for the patient, because, *ex hypothesi*, he

1 Cf. *Annual Report of the Ministry of Health*, 1939, p. 141.
2 Cf. *P.E.P. Report*, pp. 216 and 153.
3 Cf. B.M.A., *A General Medical Service for the Nation*, 1938, pp. 18 sqq.

or she is a sick person whose cure depends very largely on complete confidence in the doctor, and this confidence is built up to a great extent on psychological factors which are disturbed by the intrusion of outside agencies.' The British Medical Association stresses the fact that the National Health Insurance system 'has shown that the interests of the public are best served in any organized medical service by putting as much responsibility as possible on the doctors giving the service'. This clearly means that control coming from outside the sphere of doctors and their associations would be resented.

Under these circumstances the system of 'free choice' apparently still offers the best guarantee for that competition among practitioners which in its turn provides a spur to efficiency, as the accumulation of confidence and trust on the part of would-be clients assures a great volume of business. The method of converting such popularity into financial advantage is to allow the fee to mount with the number of patients on a capitation basis. The Royal Commission simply concluded then that this system should be continued. The capitation system, pure and simple, consists in payment by reference to the number of insured persons included in the practitioner's list. The Royal Commission contrasted it with the so-called attendance system, which consists in payment by reference to the attendances made and services rendered.[1] This is only a species of the capitation system, both being the opposite of the system of fixed salaries, which is almost unanimously opposed by the medical profession.[2] At the time of the Commission the attendance system was practised only in Manchester and Salford. It should, however, be noted that in Germany the system of paying insurance practitioners by reference to attendances is the normal one.[3] Another deviation from the pure form of the capitation system would be to remunerate doctors

1 Cf. Foster and Taylor, *loc. cit.* p. 158. 2 Cf. *Royal Commission Report*, para. 431. 3 Under the German system the 'free choice' is even more pronounced than under the British system. The insured person is not obliged to remain with the panel doctor treatment any longer than he wishes or to give notice of a change, provided that the statute of the Krankenkasse sickness fund has made no other regulations, see para. 369 of *Reichsversicherung*, Buch II. On the other hand the number of panel doctors is restricted according to the number of insured in each district; the supply of panel doctors must not be more than one doctor to 600 patients. The sickness fund pays the total amount due for medical services to the German Insurance Practitioners' Association, which shares the sum among the medical practitioners according to a scale approved by the head office, generally in proportion to the number of cases treated. Cf. I.L.O., *Economical Administration of Health Insurance Benefits*, 1938, p. 190.

according to a graduated scale; under such arrangement, for instance, the highest rate would be paid in respect of the first 500 insured persons accepted (or the first 500 cases treated), a lower rate or rates being paid in respect of the remainder. Such a system was advocated to the Royal Commission by the National Federation of Rural Approved Societies on the ground that a list of 1,000 does not involve twice as much time and expense as a list of 500. This system might help the less fortunate panel doctor compared with those of his colleagues who are more in demand, although it can be argued that a doctor with a small insurance practice may still have a large private practice.[1]

In Germany such a 'gradual tariff' is in existence, the rate per case treated being the lower the higher the number of cases; moreover, equalization funds were created in 1934 to provide special allowances to insurance practitioners with more than two children and to practitioners in distressed areas unable to make a living out of insurance practice.[2] In Britain the capitation system prevails, with no modifications to alleviate the economic position of the insurance practitioner; the attendance system is the exception.

The Royal Commission paid little heed to the fact that the remuneration of the panel doctor and his economic and social status must react immediately upon the degree of willingness to exert himself in the service he has to render. Nor did the Commission consider important the belief of the patient, whether justified or not, that a low-paid medical profession and an unsatisfied class of panel doctors cannot render the best service. The system of payment by attendance, as it had been introduced in Manchester and Salford, had been studied by leading members of an Association of Approved Societies. They stated before the Commission that they had approached this enquiry of the attendance system 'with the greatest prejudice';[3] and if they came to the conclusion that it had considerable advantages and thought it fit to call the Commission's attention in much detail to its working and effects, this should have been reason enough for the Commission to discuss it on the widest possible basis. But the system did not win their attention. Sir Arthur Newsholme gave prominence to the experience of Manchester and Salford, much later, in 1931, some time after the system had been abandoned.[4]

1 Cf. *Royal Commission Report*, pp. 432–3.

2 Cf. *Economical Administration*, p. 191.

3 Cf. A. 14,334.

4 Cf. Newsholme, *loc. cit.* vol. III, p. 120; also G. F. McCleary, M.D., *National Health Insurance*, 1932, pp. 114–15, who gives an account of the system without commenting upon it critically.

The Commissioners paid little regard to the point that the system contrasted favourably with the capitation system in so far as the interest of the doctor and the confidence of the patient were increased. Witnesses stressed the fact that the panel doctor does not enjoy the confidence of the patient just by being a panel doctor. 'There are a number of people who in any case will not go to a panel doctor, because he is a panel doctor', observed the chairman of the Association of Approved Societies, adding, 'I think that it is a prejudice which is unreasonable but it exists'. Asked by Sir Arthur Worley: 'He would still be a panel doctor under the Manchester system?' the witness replied: 'He is still a panel doctor, yet at the same time there is a greater individual connection—a better and more individual connection—between the doctor and the patient.'[1] The system of payment by attendance raised the doctor in the people's view from that of a panel doctor to that of a private practitioner, because the patients knew that the doctor was paid by the number of attendances and therefore more interested in the case than if he received a capitation fee whatever the number of attendances. There is a certain resemblance to the piece-work system of wage payment.[2] In general, the attendance system acted as a stimulus to doctors.[3] It enabled the doctor to apply any of his special capacities to a case, while in the prevailing system, under National Health Insurance, he is expected to give not more than ordinary service.[4]

Thus the conclusion at which the Royal Commission arrived in regard to the Manchester system, that 'it differs in essence very little from the capitation system', appears hardly understandable. It seems, on the contrary, that the system stood in the sharpest contrast to the capitation system pure and simple; that it was an attempt to avoid the evils resulting from any system of remuneration which does not make efficiency dependent upon individual exertion; and that by increasing the inclination

1 Cf. QQ. 14,285–86.

2 Cf. A. 14,304: 'In Manchester we feel that there is a greater proportion of insured persons who actually go to the doctor and receive panel service rather than go to a doctor and pay as private patient.'

3 Cf. Q. 14,338, Sir Arthur Worley: 'I think the unit system would enable a man to give more attention to a patient than would be the case when a man did not get any more for going to a lot of trouble, human nature being what it is.'

4 Cf. QQ. 14,338–46. Q. 14,344: 'So that they are in effect getting a service to which under general arrangements they are not entitled?' A. 'That is so,

of the doctor to render more complete and comprehensive service, it created greater confidence and improved his relation to the patient. But the preoccupation of the Commissioners with the possibility that the Manchester system might lead to over-attendance drew their attention away from this essential outlook.

There are significant signs to show that the capitation system works in the direction of inducing the panel doctor not to exert himself by giving the best possible service. The insured person does not in general expect a doctor to render more service in the way of treatment, including diagnosis, than he is necessarily obliged to give. This seems to be natural in view of the fact that the insurance practitioner is expected not to give more service than is within his competence. 'If he attempts to give hospital treatment he is doing what he ought not to do.'[1] The application of special skill and experience is expressly excluded from the assistance at operations, for instance, as an obligation of the insurance doctor. In cases of emergency the practitioner is required to render whatever services are, having regard to the circumstances, in the best interest of the patient. The practitioner, however, may claim that his services may be deemed to represent special skill and experience if he can prove certain facts, for instance, that he has held hospital or other appointments affording special opportunities for acquiring the special skill and experience required for the service rendered, or that he is generally recognized by other practitioners in the area as having special proficiency in a subject which comprises the services he has rendered in a particular case.[2] Under such circumstances the incentive for special exertion in insurance cases must be reduced. Mr Orde, speaking for the British Hospitals Association, told the Royal Commission on Workmen's Compensation:[3] 'The panel doctor passes on to the hospital as much of his work as he can. He is not undertaking work if he can avoid it.'[4] It may be understood that the panel doctor is not inclined to do more than he is entitled, or obliged to do. But actually the line may run very fine. There can be no doubt that the panel patient expects, and should expect, that the insurance doctor should deal with every case, within the

1 Royal Commission on Workmen's Compensation, 25 April 1940, Q. 11,051, observation made by one of the Commissioners, Mr Hackforth.

2 Cf. *Memorandum by the Ministry of Health*, presented to the Royal Commission on Workmen's Compensation, 30 March 1939, Appendix III, Evidence, p. 165.

3 Cf. Evidence, 25 April 1940, A. 11,055.

4 Cf. also D. Stark Murray, *Health for All*, 1942, p. 55 and *passim*.

framework of his competence, as thoroughly as he can; and, actually, the popularity of insurance doctors is in many cases founded on the opinion that some practitioners take their duties more seriously than others—that they really want to give their best. There is a wide margin for attention, scrutiny and personal interest left even within the confines of the prescribed panel duties and obligations. If Mr Orde's statement that the insurance practitioner is not undertaking work if he can avoid it—a statement apparently based upon ample experience—has taken hold of the mind of the average insurance patient, it is no wonder that the doctor's attitude towards insured persons is vividly contrasted with his attitude towards private patients. Mr Orde's statement constituted a flat contradiction of any contention that insurance patients were treated with the same sort of interest as private ones. His observations had been confirmed some time before by a special investigation of the British Medical Association. A special report of this body, made in 1929, brought evidence of the enormous growth in the number of out-patient attendances at London hospitals; in 1927 alone, the number had increased by 349,000.[1] The Report made the following statement:[2] 'The introduction of the National Health Insurance system should have led to a considerable decrease, if not in the number of out-patients, certainly in the number of out-patient attendances. . . . Unfortunately there is a body of testimony from members of the Staffs of large hospitals that considerable [sic!] numbers of insured and other contract patients are sent to out-patient departments for services well within the competence of practitioners sending them; not for the purpose of getting a second opinion so much as in the hope that the patient will be taken off the doctor's hands. The duty of the members of the staff to refer such cases promptly back to their own doctor cannot be emphasized too strongly.'

The statement is revealing. Nothing can be said against the doctor who feels himself constrained for medical reasons to shift his patient to hospital. But this statement leaves the impression that such shifting is in many cases the result of what Mr Orde later mentioned as the 'not-undertaking of work if it can be avoided'. This should be noted in conjunction with the Manchester experiment, which was said to result in an enhanced desire

1 Cf. British Medical Association, 'Report on Encroachment on the sphere of Private Practice'; *British Medical Journal*, 20 April 1929, Appendix XI, pp. 130 sqq.

2 Cf. *loc. cit.* p. 134.

by the insurance practitioner to give whatever treatment he was medically entitled to give. Indeed, the contrast between the pure capitation system and the attendance system, which is characterized by some sort of payment by result, could not be better illustrated than by reference to Mr Orde's experience.

It appears that practitioners, as far as their private practice goes, are rather perturbed by the growing influence of hospitals; on the other hand, they feel relieved by it as regards their panel practice. Dr Harvey, a regional medical officer under the Ministry of Health, speaking before a Court of Enquiry about the matter, asserted in respect of the 'encroachment by hospitals and clinics set up by the local authorities' that it had to be admitted 'that the effect upon the panel practice was to lessen the volume of the work demanded, without any reduction of the remuneration received'.[1] This observation shows how the capitation fee works as a restraint to the panel doctor's exertions.

Here then is one set of conditions which may bring about less efficient service by insurance practitioners. The other set is the social conditions which characterize the life and living of insurance doctors. Doctors who are overwhelmed with insurance work, and find that the income from this source is not sufficient to meet their budget, cannot be expected to put all their energy into each individual case. There are no statistics showing the amount of private practice done by insurance doctors. But it is known that over two-thirds of the doctors in practice in England are engaged in insurance practice; in the industrial areas the proportion may be nearly 100 %.[2] Where a doctor is of the opinion that his private practice constitutes the backbone of his yearly income, he must necessarily stress his efforts to preserve and extend it, which may be to the disadvantage of insured patients. Where a doctor is in a less fortunate position as regards private practice, he may feel constrained to have a very large panel of insurance patients; this again may react adversely on their treatment. Underpaid doctors should be expected, from a social point of view, to be the lowest in the list of efficiency. Under the German law[3] care is taken that the insurance practitioner, so far as this is possible, should not have less than 600 persons on his list. In England there is a maximum limit of 2,500 for each insurance doctor, but no step has been taken to limit the number of doctors so as to prevent a possible local over-competition. Such over-

1 Cf. *Lancet*, 14 Aug. 1937, pp. 932 sqq.
2 Cf. Newsholme, *loc. cit.* vol. III, pp. 120–22.
3 See above, pp. 124–5.

competition may easily lead, here or there, to a reduction of the willingness of service, by deteriorating the standard of life of the doctor and by focusing his interest on another clientèle.

Before the Royal Commission a witness, speaking for the Foresters, was asked whether, in view of the fact that the capitation fee secures a certain income to the doctor, one should not expect a higher standard of treatment than in private cases. He answered:[1] 'A higher standard of service than that provided to the non-insured person? Would not that depend to a very great extent on the medical practitioner and the type of his practice? He may not be finding his insurance practice more remunerative than his private practice.'

Indeed, it will depend on the practitioner—just as the efficiency of the worker depends on certain psychical conditions which may or may not react upon his incentive to work and the degree of his efficiency. Nothing, or very little, has yet been published on the professional outlook as it is influenced or dominated by economic and social conditions, though a good start has been made by A. M. Carr-Saunders and P. A. Wilson.[2] The view of these writers is that, although they agree that very little is known about the average income or the range of income in any profession, 'the medical profession is remarkable for the fact that only a small percentage of practitioners fail to earn a very fair income'. But this general observation does not imply that doctors who are giving their time both to private and insurance practices do not have to struggle hard to do their work conscientiously; and where this is so, insurance practice is certainly the sufferer. At a recent congress of the Royal Institute of Public Health, Dr H. B. Trumper of Imperial Chemical Industries declared that 'at present no man of ability entering panel practice could hope to obtain a good income without exploiting the service'.[3] It is indeed necessary to take into consideration 'the type of practice' in order to judge whether the doctor finds himself so situated as to give his full energy and willingness to the insured patient for whom he gets the capitation fee. A witness before the Royal Commission drew attention to the fact that the urban insurance practitioner with a large panel may get a payment 'unduly high', while it would be 'unjust to those who have too little work'.[4] But it was agreed

1 Cf. Evidence, Q. 4198.
2 Cf. A. M. Carr-Saunders and P. A. Wilson, *The Professions*, 1933, pp. 451 sqq.
3 *Lancet*, 18 June 1938, p. 1417.
4 A. 7834; for the same point cf. also QQ. 11,438 sqq.

by other witnesses that a 'really big panel has a great many objections' and a sliding scale of fees recommended as a means to 'encourage' the doctor 'to accept fewer, who will thereby get better treatment'.[1] Witnesses speaking for the Medical Practitioners' Union were not satisfied with the income of panel doctors from insurance patients, and it was emphasized that a figure of about £1,400 income per annum[2] was certainly quite satisfactory, but that from such average figures no conclusion could be drawn as to the general sufficiency of the capitation fees.[3] It cannot be stressed too strongly that if the capitation fee is to be considered from the viewpoint of its effect upon the doctor's efforts, its relation to his income from private practice must be taken into account.

During the sitting of the Royal Commission the Ministry of Health made certain investigations into the proportion of persons on the lists of panel doctors; the result was that

35 % of the total had lists of 600 or under,
30 % ,, ,, ,, 600–1,200,
21 % ,, ,, ,, 1,200–2,000,
14 % ,, ,, ,, more than 2,000.[1]

1 Cf. Evidence, A. 1222.

In all probability at the present time a relatively small percentage of panel doctors reach the maximum number, and more than 60 % may have a panel which will give them a net income ranging in the average from £500 to £600. The same investigation estimated the work to be done by a panel doctor; on the average it was found that a panel doctor sees 40 % to 50 % of the patients for whom he is responsible in the course of the year. On the average, each person who is seen at all is seen seven times, so that the doctor has to render 3·5 services per person on his list per annum. That would mean, with a list of 2,500, that he would have altogether to render 8,750 services a year. On the average of 300 working days the doctor of such a panel would have 29 services per day on the average; of these 29 services, probably eight in an urban area would be domiciliary visits; the remainder would be surgery attendances. It must, however, be taken into

1 See the evidence of witnesses speaking for rural approved societies, QQ. 11,614 sqq.
2 The same figure is taken by Carr-Saunders and Wilson, *loc. cit.* p. 460, from the Royal Commission on the Civil Service, 1929–30.
3 Cf. QQ. 15,734 sqq.

account that these figures do not include the minor services which even the most conscientious doctor does not always record.[1] In view of these figures it is hardly possible to contend that the panel doctor does not have to work hard, indeed very hard, for his money. It is quite evident that the panel doctor with a big insurance clientèle will try to economize his time on it as much as possible in order to be able to attend the more remunerative private practice; he may engage an assistant (for this he must get the sanction of the insurance committee), but this again will increase his expenses. Moreover, complaints that some of these assistants are on their part underpaid have not been absent.[2] On the other hand, the danger of insufficient service is not less with the doctor who has a small panel. On the contrary, the view was expressed by Mr Brock from the Ministry of Health that, broadly speaking, 'in the main the doctor with a big list gives rise to fewer complaints than the doctor with a small list, because the man with a substantial list is a man whose living depends to a very large extent on the insurance work, and he is not going to jeopardize his position or impair his popularity by not giving the best service he can. The man with a small list may possibly be a man who has come on the panel rather unwillingly and gives a grudging and sometimes unsatisfactory service.'[3] And from the above figures, it emerges that the panel doctors with a small list form by far the majority.

It should, of course, be taken into account that the panel doctor usually has the advantage of attending the dependants of the insured persons on his list. It has been estimated that the 'rest of the household' he will so attend will be about 1·5 per insured person.[4] But, of course, a good deal of sickness may be treated by other services; school-children, for instance, in the case of measles may be dealt with through the school by the infection hospital, and other minor child sickness by clinics provided by the Local Education Authority. It must also be recognized that, as the working-class family has to pay for the panel doctor's services when he attends in his non-insurance capacity the remuneration may not be very generous and in many cases may be even difficult to obtain; the family may become destitute and be obliged to seek medical treatment elsewhere.[5] A Commissioner very definitely

1 Cf. Royal Commission, Evidence, A. 1219.
2 Cf. *P.E.P. Report*, p. 144. 3 Cf. A. 1225.
4 Cf. Royal Commission, Evidence, Q. 1220.
5 Cf. Royal Commission, Evidence, AA. 8017–19.

stated that there was 'evidence adduced before the Commission that has frankly admitted that the wives and families of large sections of the workers are not adequately attended; that it is only when the wife's illness is very serious and critical that the doctor is called in, and that the medical attendance of dependants is far from being satisfactory'. The overwhelming opinion of to-day,[1] that dependants' treatment should be included in National Health Insurance, goes far to show that this verdict has not lessened in conviction. In present conditions panel doctors cannot see a very great addition to their income from this kind of practice, although things might be different if all dependants were included on the panel list and the capitation fee increased accordingly.

In assessing the economic status of panel doctors an important point is sometimes overlooked. The doctor who earns, say, £1,000 per annum should not be considered as a wage-earner who from his wage simply expects a return for the labour done. The doctor's career involves a substantial outlay of capital, which he expects to get back by his professional services. The *British Medical Journal*[2] puts the cost of a five-year course of medical education at £1,500, of which two-thirds to three-quarters are for maintenance. Examination fees, according to Carr-Saunders and Wilson,[3] are 'everywhere moderate', but not according to these writers the charges for practical training. A medical student 'need only find about £85 a year for examination fees, books, equipment, and charges of all kinds'—but the sum may mean more than 10 % of his income in the first years of practice. Moreover, beginning a practice may involve a heavy capital outlay, quite apart from the purchase of medical and surgical requirements. Such is the case if the doctor buys a practice, a possibility which does not exist in all countries and which does not deserve praise, as it makes the profession into what it should not be, a business with capitalizable goodwill. The purchase price is usually based upon the gross average of the preceding three years, and the average price to pay is one and a half year's income. Political and Economic Planning rightly remarks in this connection: '. . . by whatever means he raises money the arrangements will probably lay a heavy and worrying burden upon him, since they may entail the repayment of as much as £2,000–£3,000'.[4] If we compare with

1 See also Chapter v. 2 Cf. *British Medical Journal*, 1930, vol. II, p. 347.
3 Cf. Carr-Saunders and Wilson, *loc. cit.* pp. 383 and 99–100.
4 *Loc. cit.* p. 143.

these figures the sums adduced sometimes as the proof that panel practice is remunerative (a list of 1,000—an income of £450), it is evident that it will be a long time before the doctor gets back what he has spent on training and setting himself up in practice. Indeed, for some years he may regard his work as leaving no net profit at all. The buying of practices, by young doctors in particular, was recognized as an evil by the Orrs when they visited England; they observed: 'The young doctor is forced to sign a contract by which he gradually buys the practice, but on terms that make him a virtual "share cropper".'[1]

High medical authorities who cannot be suspected of bias have again and again expressed dissatisfaction with the present system of capitation fees, although they have not been able to suggest approved remedies. Sir Henry Brackenbury, for instance, declared in 1938: 'There are a large number of doctors who do not feel that that [the capitation system] is the right way to assess their value, who feel that if you could find some means by which you could assess, even if more vaguely, the responsibility which the medical practitioner undertakes, it would be very much more satisfactory than trying to gauge it by a mathematical method dealing with items of service [i.e. pay per number of panel patients].' He emphasizes that 'there is the temptation to assume responsibility for a larger number of patients than those for whom you are really able to discharge that responsibility'. He proposes 'higher remuneration' and 'a lowering of the maximum number of patients'.[2] But this proposal does not take into account that, with a very much smaller number of people on his list, a doctor might not be much better off, even with relatively higher remuneration per member.

An enquiry into the economic and social conditions of panel doctors is an urgent necessity. The problem has until now been considered, if at all, far too much from the angle of what insurance benefits cost and what it would cost to extend the scope of medical benefit, and has therefore been constantly influenced by the views and natural bias of insurance carriers who do not wish to extend their financial liabilities. From the angle of the patient who wishes to be treated by a panel doctor who, because he is satisfied with his remuneration and conditions of life, will try to give the utmost service, the position is far from satisfactory. Unfortunately, the

1 Cf. Orr and Orr, *loc. cit.* 1938, p. 147.

2 Cf. Sir Henry Brackenbury, 'Some Problems of National Health Insurance', in *Journal of the Chartered Insurance Institute*, 1938, vol. XLI, pp. 299 sqq.

truth is not often stated in public as it was by a medical official (holding office under the Ministry of Pensions) before the Royal Commission when he declared: 'I do not condemn panel doctors. Some of the finest doctors I know are panel doctors, but knowing what I do of the life of a panel doctor, having gone through it, one does not care to stick to it for ever.' The evidence continued:

Q. 'Your suggestion was that the panel doctor had no outlook in life, and that most doctors desire to cease to be a panel doctor as soon as possible?'

A. 'I agree. The life is intolerable.'[1]

This was stated in 1925. But on 15 July 1941 Dr Morgan told the House of Commons exactly the same: 'I was one of those who, after the last war, went by choice not from necessity into National Health Insurance against all the advice of my professor. I said I thought I could serve the working class best by going into National Health Insurance. I made a mistake, and I left it disappointed and disillusioned.'[2] Political and Economic Planning observed not long ago:[3] 'Excessive numbers of panel patients and excessive demands for certificates and returns of all kinds quickly reduce the general practitioner to an agent for making out prescriptions (too often for mere palliatives), and for operating something more like a sickness licensing and registration system than a health service.' It should be noted that it is not only the physical burden and the hard economic struggle that account for much dissatisfaction among panel doctors, but also the moral and psychological discontent with work which was once begun with the object of satisfying some scientific and cultural personal ambition, and which ends in the monotony and drudgery of hopeless clerical routine work.[4]

Insurance patients will not get much profit from doctors who think their life intolerable. To raise their standard, mode and outlook of living should be one of the essential tasks of coming National Health Insurance reform.

Yet a mere increase in the capitation fee would not offer a satisfactory solution. Some sort of payment 'by results'—though

1 Cf. Q. and A. 16,322–3.
2 Cf. *H.C. Debates*, 15 July 1941, col. 519. 3 Cf. *P.E.P. Report*, p. 397.
4 Cf. for a recent statement British Association for Labour Legislation, *The National Health Services*, article by Dame Janet Campbell, M.D., 1941, p. 20: 'Panel practice does not justify the keen doctor... Work is hard, hours are long, and general practice is not always remunerative.'

results can never be precisely assessed in medical treatment—seems the only remedy. Any remedy, however, must be dependent on wider changes: on the extension of the financial basis of National Health Insurance; on the creation of a national medical service which would place National Health Insurance on an entirely different footing as regards medical benefit and treatment; or on a unification of social insurance services, as for instance by combining of National Health Insurance and Workmen's Compensation in respect of treatment, cure and rehabilitation. In this chapter we have merely been concerned with the conditions of the doctors now working under National Health Insurance. These conditions are in many respects most unsatisfactory, and this is apt to react immediately upon the efficiency and effectiveness of the medical treatment given. The great majority of minor, though taken together by no means unimportant, cases never reach the surface. The machinery for complaint is too complicated, and its results are not representative of the complaints of carelessness, deficient attention and other grievances which are rife among panel patients. The contention that panel patients receive the same (if not better) treatment than private patients is refuted by much indisputable evidence from many different quarters. The lack of efficiency of the treatment given under medical benefit is explained by a series of facts which arise from the economic and social situation of panel doctors. Their working conditions to-day are not such as to guarantee that their work will always be that of a class of people satisfied with their livelihood and striving to give the utmost in their power. Pressure of work; the temptation of better paid jobs; the constant necessity of balancing private against insurance practice; the difficulty of making a living which is socially justified from the viewpoint of a learned profession and permits the repayment of expenditure and expenses on his career; dissatisfaction with work which, because of the clerical duties involved, after some time, degenerates into a lifeless routine, all these circumstances go far to explain why the complaints about unsatisfactory, careless and even negligent medical service by the panel doctor are only too well founded. The profession of insurance doctors is not well served when claims of their 'high standard of service' are made officially. It would be far more useful to the profession as a whole if the service were frankly criticized wherever necessary and with no complacency—provided that it is fully understood that the panel doctor tends to be the victim of conditions which are outside his responsibility

and control. 'Ultra posse, nemo obligatur.' The inadequate conditions of treatment which have developed represent an uneconomic utilization of the service which doctors as a whole could render, by the failure to socialize that service properly; and it is a national calamity.

CHAPTER XV. SPECIALIST TREATMENT

'. . . nothing is more estimable than a physician who, having studied nature from youth, knows the properties of the human body, the diseases which assail it, the remedies which will benefit it, exercises his art with caution, and pays equal attention to the rich and poor.' VOLTAIRE, *A Philosophical Dictionary*: Physicians.

THE progress of medical science and practice has for many decades been characterized by a steady and rapid increase of specialization. A new class of doctors, in every branch of medicine, pathology or surgery, has emerged, in general called specialists, and this development has not been altogether viewed with favour. It is often argued that the specialist is inclined to look at illness only from his own specialized angle of outlook. 'Modern developments have magnified the importance of the specialist in medicine as in everything else. . . the tendency has been exaggerated by the creation of specialist clinics by local authorities', writes Mervyn Herbert in 1939.[1] The Political and Economic Planning Report on the Health Services roundly stated that 'The public has been hypnotised by the word "specialist", and tremendous stress has been laid on the value of increasing the number of specialists in any service, regardless of whether or not they are the right persons to do the work or whether in that particular field division of labour is desirable.' English people are not very fond of specializing; it is regarded as making men as narrow-minded as their field of research or practice is limited. But specialist medicine is more and more recognized as an indispensable complement of general medicine; and it is realized that specialist treatment, where opportune, must stand in the foreground of the nation's health and, therefore, of the national health services.

Specialist treatment is not provided under National Health Insurance among the normal medical benefits; among additional benefits it is limited to ophthalmic and dental benefit. On the

1 Cf. Herbert, *loc. cit.* p. 78.

other hand, the patient may receive specialist treatment as an insured beneficiary, as soon as he is sent to hospital by the panel doctor if additional treatment benefit[1] is granted; it may be assumed that hospital treatment in many of the more serious cases means specialist or some sort of specialist treatment. But the imperfection remains that specialist treatment is absent from British National Health Insurance as a general feature. The sick worker may belong to a Hospital Contributory Scheme and, if the hospital provides it, he may receive specialist treatment. A Hospital Contributory Scheme is a voluntary scheme administered either by an independent body operating in a definite area or by the individual hospital for whose benefit it has been started. The schemes vary in detail considerably, but their main features are more or less the same; the member makes a regular weekly contribution and in return is entitled to benefits, the chief of which is free treatment in hospital if admitted. The existence and wide extension of these voluntary schemes—there are now more than 100 such schemes affiliated to the British Hospitals Contributory Schemes Association, with approximately 4,000,000 contributors and an annual collection of nearly £3,000,000[2]—may be regarded as the result of the lack of such services among the normal medical and additional medical benefits of National Health Insurance.

In Germany sickness insurance includes specialist services, and, apart from dental treatments, special therapies such as X-ray, radium, light, heat and other physio-therapies, orthopaedic and medico-mechanical treatment, massage, supervision of baths and inhalation, radiological examinations and electro-cardiographs and laboratory tests; all these may be performed at the doctor's surgery or at the home of the patient. Before recommending hospital treatment, the panel doctor carefully weighs up whether consultation with a specialist, reference of the patient to specialist treatment, home attendance by a sick nurse or admission to a nursing home would not be equally effective. These arrangements contrast sharply with the position of the panel doctor in this country, where hardly any link exists between the insurance practitioner and the specialist, either in or outside the hospital. Before the Royal Commission the position was described by the Senior Medical Officer, Ministry of Health, in the following state-

1 For in-hospital treatment only!

2 Cf. *Memorandum of Evidence by the British Hospitals Association,* Royal Commission on Workmen's Compensation, Evidence, 25 April 1940, pp. 1080–81.

ment:[1] 'At present the practitioner says "You had better go to the hospital!" The patient turns up at the hospital and is seen by somebody there. The physician or surgeon at the hospital knows nothing about what has been done by the practitioner, and the practitioner knows nothing of what has been done at the hospital. There is no co-operation between them and no arrangement for co-operation.'[2]

In Germany the practitioner, in the more serious cases, simply gives first-stage treatment—although his special services are in no way so restricted as in Britain. Specialist treatment is always available in the background. This is even more the case in industrial injuries which, if they are injuries of a light character and limited duration, remain under the care of the sickness insurance funds. But before the injured or diseased is dealt with in this way he is seen by the 'Durchgangsarzt' or forwarding-doctor of his professional association who may have to decide, at once or at a later stage, whether the patient should be seen by the Beratungsfacharzt, the advising specialist[3] or any other specialist. Arrangements between the sickness funds on the one hand, and the professional mutual indemnity associations (Berufsgenossenschaften) on the other, provide that panel doctors will facilitate early access to specialists in cases of industrial injury.[4]

In Switzerland hospital and specialist treatment is included as a regular feature of benefits in kind.[5] Under the French health insurance scheme any qualified general practitioner or specialist may undertake to treat insured persons and their dependants;[6] the insured person is also free to select the hospital or other establishment where he wishes to be treated. No distinction is made as regards consultations and visits between the general practitioner

1 Cf. Royal Commission, Evidence, A. 1128.

2 Cf. also *National Health Services, loc. cit.* p. 10: there is 'no definite association of the panel doctor with the consultant of the hospital'.

3 Cf. *Memorandum of Evidence by the International Labour Office*, Royal Commission on Workmen's Compensation, 20 July 1940, pp. 606–7; I prefer the term advising specialist to the translation chosen by the I.L.O., i.e. medical adviser; the expression 'Fach' is not embodied in this translation, while it contains the essential 'specialist' element, in this case that of a specialist who has in particular acquired special knowledge and experience with industrial injuries of various kinds.

4 Cf. *Die Neuregelung der Beziehungen zwischen den Traegern der Krankenversicherung und der Unfallversicherung*, Berlin, 1936, pp. 16 sqq.; also *Memorandum by International Labour Office, loc. cit.* p. 607 and I.L.O., *Economical Administration*, pp. 187 and 197.

5 I.L.O., *International Survey*, vol. II, p. 427.

6 Cf. I.L.O., *Economical Administration*, pp. 171–2.

and the specialist, but if the attending practitioner is of the opinion that the consultation of another doctor, whether general practitioner or specialist, is needed, or that recourse should be had to surgical intervention, special treatment or auxiliary services, such as the services of a nurse or a masseur, the expenses of such treatment are only repaid by the sickness fund if the fund agrees beforehand, at the request of the insured person, to accept this liability. A system of paying doctors on the basis of units (the so-called 'nomenclature', established by the Confederation of Medical Associations, assigns a coefficient to each medical service or group of services) has been established, not wholly unsimilar to that which existed in Manchester and Salford and which the Royal Commission thought so complicated in its features.[1] In Czechoslovakia, sickness funds or federations of such funds may set up dispensaries where members or their dependants are treated by the insurance practitioners, and where specialist treatment can be given by a specialist who undertakes to practise for the sickness fund (cf. *Economical Administration*, p. 148). These examples show the degree to which the provision of specialist diagnosis and treatment has been carried out in other countries.

The International Labour Office has not hesitated to draw particular attention to the desirability of providing for specialist treatment in any sickness insurance scheme. It has expressed the view that 'In the event of any difficulty or doubt, the insurance practitioner should, for reasons of economy, call in the appropriate specialist at an early date'; but it adds significantly: 'provided that the insurance institution permits this to be done'. In many cases the International Labour Office observes that consultation with a medical adviser or a local body of medical advisers or investigators consisting of experienced insurance practitioners with the right to co-opt specialists has been found useful, not only in the patient's interests, but also in that of the economical administration of the insurance institution. And the International Labour Office holds that therapeutic treatment by the insurance practitioner should be a standard medical benefit, and suggests that such work must take account of the special somatic and psychological conditions of the insured persons and their medical, family, occupational, financial and social situation. Here the scope of specialization is so widely enlarged as to touch important fields even of sociology. The International Labour Office does not make these recommendations in any purely theoretical or aca-

1 Cf. I.L.O., *Economical Administration*, p. 174.

demic manner. It can claim that 'in many countries specialists in increasing numbers and sometimes in new branches of medical science, such as psychotherapy, plastic surgery, etc. are admitted to panel practice either to advise the general practitioner or the insured person upon isolated therapeutic measures or to undertake complete treatment'. Many sickness funds have contracts with suitable institutions, apart from their own institutions,[1] for physical therapy and leave it to the discretion of the insurance practitioner to decide when they should be used. This may be contrasted with the constant complaint of the entire lack of co-ordination between the panel doctor and the hospital in this country. In particular the general practitioner in the poorer quarters, working under the most difficult conditions in an environment of disease, bad housing and dietetic ignorance, is given no opportunity to obtain the specialized diagnosis which is so important as a preparation to specialist treatment.[2]

It is not without interest that perhaps the most vigorous and earliest attempts to provide specialist services and specialized treatment for sick workers have come from the side of industrial accident insurance. Workers injured 'in the course and out of their employment' do not represent, numerically, the largest part of sick workers. Comparative figures are not available, and mere numbers would give no useful comparison, unless the totals were split up according to groups of illnesses or diseases. The fact that in 1938 there were, in seven groups of industry comprising only 7,800,000 workers out of some 17–18,000,000 covered by the Workmen's Compensation Acts, some 460,000 non-fatal cases of compensation for injury throws some light on the importance of the problem; some 125,000 of the industrial injury cases terminated in 1938, in which compensation (exclusive of cases terminated by payment of a lump sum) had been paid, had lasted more than four weeks, while there were some 30,000 cases which had lasted more than a year and were not terminated.[3] The Rehabilitation Report of 1939 stated that, according to estimates, 'industrial' accidents do not form more than a third of the total number.[4] If, nevertheless, the impetus to set up rehabilitation schemes has come very largely from this side, another reason than mere numerical preponderance must be sought.

1 Cf. for example McCleary, *loc. cit.* p. 53.
2 Cf. Dr Morgan in the House of Commons, debate of 15 July 1941, col. 519.
3 Cf. Home Office, *Workmen's Compensation Statistics for* 1938, 1940, pp. 5 and 22.
4 Cf. *Final Report on the Rehabilitation of Persons injured by Accidents*, 1939, p. 10.

Workmen's Compensation differs from that of National Health Insurance in that it is an indemnification of the injured worker. In Britain, partly for historical reasons,[1] industrial accident insurance has been built upon the principle that the injured worker is only to be compensated for loss of earnings. Other countries have, in many cases, created a system of medical benefit under industrial accident insurance, accepting the principle that restoration to health is even more important to the worker than cash payments. Actually, measures to secure the recovery of the industrially injured have always been logically in the mind of legislators as incumbent upon those who bear the obligation for restoring corporal damage which someone else has received by being their employees. In the Old Testament we read: 'And if men strive together, and one smite another with a stone, or with his fist, and he die not, but keepeth his bed: If he rise again, and walk abroad upon his staff, then shall he that smote him be quit: only he shall pay for the loss of his time, and shall cause him to be thoroughly healed.'[2]

Workmen's Compensation in Britain did not disregard the point; but it was thought that the existing friendly society machinery would be sufficient, and efficient enough, to tackle the matter of cure although the injured had to pay for it by his previous contributions. When National Health Insurance was introduced, the employers and the State took over some of the cost of the injured workers' recovery, as medical benefit was included in the scheme, and there was now some indemnification of the injured worker in a medical sense, though not under industrial accident insurance. But, as treatment under National Health Insurance was not in any sense a sufficient guarantee of the restoration of health by all possible means, the demand for other, better and more complete means of restoration for industrially injured persons has remained very much alive. Mr Wackrill, from the Ministry of Health, stated the issue very lucidly before the Royal Commission on Workmen's Compensation in 1939, when he said:[3] 'I think there is some difference between the sickness risk, notwithstanding it may be directly related to the occupational risk, and the accident risk which is regarded more as a responsibility of the employer and not to a similar degree of the

1 Cf. Wilson and Levy, *Workmen's Compensation*, vol. I, chapters II and III.
2 Cf. Exodus xxi. 18–19.
3 Cf. Evidence, 31 March 1939, Q. 1593.

employed person.'[1] It is to the credit of those who have been concerned with investigating the deficiencies of industrial accident insurance in this country that they have not lost sight of the fact that National Health Insurance, as the administrator of medical benefit to the injured worker, does not provide the conditions for comprehensive and specialized treatment. The Holman Gregory Report of 1922 envisaged a definite extension of the medical services under the National Health Insurance scheme in the direction of specialist services for both medical and surgical treatment. It listed the services which, in its opinion, ought to be 'superimposed upon those already available under National Health Insurance'. 'We refer particularly', the Report observed,[2] 'to various special services, including those of expert physicians and surgeons, massage, X-rays (for diagnosis as well as treatment), hydro-therapeutic and other kinds of treatment not requiring residence of the patient in a hospital or other residential institution, in-patient hospital treatment, convalescent homes, and such supervisory medical arrangements as would secure proper co-ordination of the different branches of treatment'. The Report added that 'efficient treatment of this kind' was as important to the sick worker as any monetary payment, and that some scheme embodying these aims should be drafted. But the Report, while giving this excellent advice, which still waits for realization, pointed out that the Ministry of Health had at that time under consideration 'a further development of the medical services for the benefit of the population generally' and relied on the expectation that such improvements would be co-ordinated with the needs of Workmen's Compensation. Thus, unfortunately, as in so many other cases, one Department waited for the proposals of another, and in this particular instance this tendency to 'pass the buck' was strengthened by the fact that the Holman Gregory Committee wished to avoid the drastic change in the 'system'

1 Mr Hackforth's reply—A. 1594—that this contention might relate to Employer's Liability but not to Workmen's Compensation, 'which does not presuppose any fault or negligence on the part of the employer', does not seem to meet the point. Workmen's Compensation legislation has always and everywhere resulted from the consideration that industrial injury is a sequel to the employment risk (which, of course, is not identical with the employer's negligence), against which the employee should be protected financially and medically; cf. also some interesting remarks by Henry D. Sayer, Deputy Executive Director, the New York State Insurance Fund, in the *American Journal of Surgery*, Dec. 1938, 'The Fundamental Philosophy of Workmen's Compensation', pp. 483–4.

2 Cf. Dept. Committee on Workmen's Compensation, 1922, Cmd. 816, p. 49.

of Workmen's Compensation that would have been necessary if medical benefit had been taken from National Health Insurance and made a separate branch of industrial accident insurance. Had this been courageously recommended by the Committee, and had the appropriate legislation followed, the entire aspect of the medical treatment of the sick worker in our day would have been changed. If such improvements had been forthcoming for the industrially injured under Workmen's Compensation, it would no longer have been possible to deny them to the normally sick worker. But the Holman Gregory Report contented itself, in view of the expected reforms in National Health Insurance, with recommending the inclusion of these specialized services among the additional benefits.[1] The Royal Commission, six years later, took great pains to explain and underline the necessity of specialist diagnosis and treatment. There can be only praise of the manner in which the problem was tackled. The Report considered specialist treatment as an extended medical benefit; it envisaged the inclusion of all specialist treatment, and also ophthalmic diagnosis and the prescription of glasses, in what were called 'expert out-patient services'. The work of the general practitioner was to be supplemented by:

1. Expert medical advice and treatment for patients who can travel to meet the specialist.
2. Expert advice for persons who are unable to travel.
3. Laboratory services.

'It has always been recognized', declared Mr Brock, from the Ministry of Health, 'that medical benefit could not continue indefinitely to be limited only to general practitioner service.' In 1914, provision had actually been made in the Budget for specialist services, and money was voted by Parliament; but it fell through on account of the war.[2] The Report made it clear that 'medical benefit is at present a general practitioner service; but it cannot seriously be claimed that this is a satisfactory state of affairs'.[3] The Report described in some detail the services by which specialists could greatly supplement or assist the work of the general practitioner; that specialists would advise as to diagnosis and to treatment which the practitioner could himself not properly undertake. But the Report went even further, and scrutinized the reactions on the efficiency of general

1 Cf. *loc. cit.* p. 49. 2 Cf. Q. 23,830 and Q. 23,835.
3 Cf. *Report*, chapter x, pp. 123 sqq. for the following description.

practitioners which a specialist service would immediately bring with it. 'It has been long recognized', observed the Report, 'that the general practitioner suffers great disadvantages in the maintenance of his professional efficiency, through isolation experienced under present conditions of practice. A large proportion of practitioners have few opportunities for coming into contact with those who are devoting themselves to the study and practice of particular branches of medicine and surgery.' Unfortunately the position has remained unaltered until our own time. Dr L. Mackenna, a regional medical officer under the Ministry of Health, giving evidence before the Court of Enquiry held at the end of May 1937 into the capitation fee payable to medical practitioners under the National Health Insurance scheme, observed: 'Of course it has always been the duty of a practitioner to advise in the early stages of diseases in order that a more serious condition might be prevented from arising. . . . The Insurance Acts Committee state that there has been an improvement in and an elaboration of method of diagnosis and treatment. No one is going to deny that at all; we all know it; but I maintain that these methods of diagnosis are mainly confined to the domain of the specialist and do not concern the general practitioner.'[1] It is worth while to record the very apt observations which the Report of the Royal Commission made on this point: 'The mere obligation to furnish the expert with a statement of the case would have a valuable and educational influence in constraining the practitioner to give definiteness to his ideas. When he had to prepare a statement to come under the critical eye of the expert he would, by that mere fact, become alive to the defects in his conduct of the case, which he had not previously realized. The indirect benefit resulting from this requirement has, we are informed, already been seen in the work of the Regional Medical Staff. Again, the specialist's report will often reveal to the practitioner points in diagnosis or treatment which he might have overlooked. It will thus add to his knowledge by enabling him to assimilate the expert view of his cases as they come along. In all these ways the provision of a specialist service would operate as a most valuable form of post-graduate instruction and would probably be gratefully welcomed by the isolated general practitioner. The educational benefits

1 Cf. *Lancet*, 14 Aug. 1937, p. 392; the remark was made in order to prove that an increase of the capitation fee would not be justified on account of an increased service by doctors; otherwise it would hardly have been made with such frankness.

would not be confined to the insured persons, but would be extended to the whole range of general practice.'

No better statement could be made of the effects which might be expected from the extension of specialist services under National Health Insurance upon the insurance practitioner's efficiency and preparedness for service. All the implications of a psychological and socio-medical character involved in this problem were fully understood by the Royal Commission, and nowhere have they been more clearly expressed than in the Report. The Report foresaw immediately the difficulties which lay in the way of administration and were to some extent due to the existence of other agencies without any system of co-operation or co-ordination. The representative of the Ministry of Health had informed the Commission that 'there is the difficulty that a statutory benefit implies some guarantee that the required accommodation will be available when it is needed. So far as regards voluntary hospitals no such guarantees could be possibly given.'[1] On the other hand—and this, perhaps, led the Report to some complacency—the Commissioners had been satisfied that out-patient treatment at hospitals included here and there, particularly in the neighbourhood of the great hospitals attached to medical schools, good opportunities for obtaining specialist treatment. This fact certainly ought not to have been regarded as a justification for not including specialist treatment as a normal medical benefit in National Health Insurance. Indeed, it is difficult to understand why the Report had scruples in recommending this, in view of the fact that it felt seriously concerned 'about the position of non-insured persons of moderate means'.[2] The question of costs which played its part in the decision not to recommend the inclusion of in-patient treatment in hospital treatment we shall have to discuss later.

The position to-day in regard to the introduction of specialist treatment under National Health Insurance is even more difficult than it was in 1928, when the Royal Commission's Report was published. Since then the growth of public hospitals has increased the dualism that might result. But the necessity of including these extended services in the National Health Insurance scheme remains.

While the importance of specialist advice and treatment is now generally recognized as a necessary part of any coming reform of National Health Insurance, there still exists a tendency to consider the services of the common practitioner and insurance doctor

1 Cf. *Royal Commission Report*, p. 125. 2 Cf. *ib.* p. 126.

as competitive to the specialist. We have already referred (see p. 128) to the British Medical Association Report on encroachments on the sphere of private practice and its complaint that insured and others under contract practice are sent to out-patient departments, even if they could and should be treated by regular doctors. But the difficulty arises: what is the test in this matter? If one reads carefully what the British Medical Association had to say about general practitioners and specialists in 1938[1] one can hardly avoid the impression that, though the value of specialists is fully recognized, there is some apprehension that by the extension of specialist services the status of the general practitioner and insurance doctor might experience a set-back. A passage of Political and Economic Planning is quoted in which, quite rightly, the general practitioner is claimed to be indispensable because he is acquainted with 'the medical record and the environment of the person requiring attention'. The importance of the family doctor is emphasized: 'The value of a family doctor to his patient is immeasurably increased where complete confidence exists', adds the publication of the British Medical Association. But does this confidence really exist to the desired extent? It is just the lack of such confidence that drives insurance patients to seek the advice of specialists, if possible. These are the cases where the insurance practitioner is neither able nor willing to give the additional specialized services required. Prof. R. J. Johnstone declared in his Presidential Address before the British Medical Association in 1937: 'The general practitioner must learn to make his diagnosis without the skilled help which the specialist commands, and to carry out his treatment with makeshift appliances and with amateur nursing.'[2] This may be an excuse for the general practitioner; but it is no consolation for the patient; and, in many instances, the general practitioner has the equipment and skill to give more than he actually does give to the insured. The Royal Commission had this clearly in mind when they stressed the importance of a specialist service for stimulating the general practitioners to greater exertions. While the British Medical Association agrees that the family doctor must be supplemented by the provision of specialist aids for diagnosis and treatment, it ignores the fact that, in many serious cases, the specialist must be regarded as the prime personality with the family doctor as the auxiliary.

It is not accidental that the loudest call for specialization comes from those representatives of the medical profession who have

1 Cf. B.M.A. *loc. cit.* pp. 8–13. 2 Cf. *Lancet*, 24 July 1937, p. 175.

come in contact with, or are investigating, industrial diseases. There is a difference between illnesses or diseases which, though of a general character, may require more refined treatment for a quicker and safer recovery, as in the case of fractures, and illnesses or diseases which are the result of some specific work and therefore require from the outset a special treatment based on experience of this particular malady. Wherever members of the medical profession speak without restraint, there is no denial that the general practitioner and panel doctor are not competent to deal with the diagnosis and treatment of the more important industrial injuries and diseases. 'The doctor's view of industrial medical service is usually based on his ignorance of factory life during his student days. He was never taught to think in terms of industry—nor is he to-day. Any disease arising from industrial causes was touched upon most casually, in spite of the fact that we have been a great industrial nation for over a century', writes a medical officer of a big London gas supply undertaking.[1] An authority urges, for instance, that those likely to develop chronic dermatitis should be weeded out as far as possible at a preliminary examination and never allowed to come in contact with irritating substances;[2] but no panel doctor could be expected to insist on this. And the same need for an early specialized diagnosis exists in the case of such a common ailment as rheumatism.[3] Even in the case of 'harmless' catarrh, specialist treatment at an early stage is urged by progressive medical evidence.[4] And in the cases

1 Cf. W. D. Jenkins, M.R.C.S., 'Relations between Doctors and Industry', *Industrial Welfare*, Aug. 1941, p. 166.

2 Cf. A. L. Leigh Silver, 'Treatment of Dermatitis', *Journal of the Royal Army Medical Corps*, July–Dec. 1938, p. 89.

3 Cf. 'Notes on the Treatment of Rheumatic Diseases', *Journal of the Royal Army Medical Corps*, May 1940, p. 277: 'It is suggested that the special treatment of cases of rheumatic disease would prove worth-while in view of the fact that it would serve (*a*) to save considerable invalidity ultimately, by sorting out at an early stage those cases likely to become serious or permanent, (*b*) to get less serious sufferers to take the line more quickly than is usual at present, and without there being developed the "chronic mentality".' Cf. also Dr Matthew B. Ray, *The Treatment of Rheumatism*, Chadwick Lecture, 1930; also Sir Morton Smart, *loc. cit.* p. 5: 'I cannot conceive that anyone will dispute the right of a worker to have the latest scientific methods of treatment provided for him so that he may obtain their benefits not only in cases of advanced and serious disease, but also in many cases of minor injuries and early rheumatic affections of joints and muscles which become so fruitful a source of serious incapacity and loss of working hours if not treated in the early stages.'

4 Cf. Dr Harley, regional medical officer under the Ministry of Health: 'As regards the treatment of catarrhal conditions, I think that to a great extent the treatment is the domain of the hospital specialist', *Lancet*, 14 Aug. 1937, p. 932.

of such diseases as nystagmus, it is hardly conceivable that the general practitioner can give any appropriate advice or treatment, unless he happens to have acquired experience in a practice where this mining disease is frequent.[1]

Of course, in the case of compensatable industrial injuries and diseases, the certifying surgeon and the medical referee may provide the possibility of an early and specialist diagnosis. But the lack of specialist treatment remains, and must have its effects upon the treatment of injured workers under National Health Insurance. The certifying surgeon need by no means be a specialist. It even happens occasionally that a group of mines is remote from the surgery or place of residence of the certifying surgeon; and in such cases the Secretary of State may confer on some local practitioner the powers and duties of a certifying surgeon under the Workmen's Compensation Acts. Every effort is made by the Home Office to secure doctors of the highest qualifications as medical referees. But, as the Stewart Report stated, this is not always easy, because in some areas the appointment, although conferring a certain amount of prestige, does not provide much work. Before the same Committee the view was expressed that it was precisely in specialist knowledge that certifying surgeons and medical referees were lacking. Many witnesses contemplated 'a panel of specialists each one of whom would be entitled to act as Certifying Surgeon in respect of particular diseases'.[2]

Unfortunately the topics which bear on the necessity of specialist diagnosis have not been discussed with the same frankness as regards sickness under National Insurance as they have in relation to compensatable injury.

As matters stand at present the desire to see specialist treatment established has been mostly confined to industrial malady and disability. Sir Morton Smart has recommended that, as long as 'a comprehensive national scheme' for medical treatment cannot be envisaged, it should be possible to work out a less ambitious but none the less important scheme to enlist the sympathy and co-operation of industrial employers in the formation of local clinics for their own workmen. These clinics would in many respects be clinics for specialists. Sir Morton emphasizes that 'such clinics

1 Cf. B.M.A., *Report of Committee on the Diagnosis and Certification of Miners' Nystagmus*, 1936, pp. 6–7 and 11; also 'Discussion on Miners' Nystagmus', before the Oxford Ophthalmological Congress, 1939, reprint *Transactions of the Ophthalmological Society*, vol. LIX, Part II, 1939, p. 756.

2 Home Office, *Report by the Departmental Committee on certain questions arising under the Workmen's Compensation Acts*, 1938, paras. 107, 110, 122 and 135.

would be of great assistance to local medical men', and referring to physiotherapy he significantly adds, 'they would give them a means of dealing with a type of case which is present in all communities in large numbers and which admittedly [sic]! cannot be adequately treated by the means at the command of the panel doctor.'[1] The same tendency has found expression in the introduction of factory doctors, who have greatly increased in numbers during the war. High credit is due to unceasing efforts made by the Industrial Welfare Society for a long period to improve the medical service in industry. Actually the works' doctor, as far as he exists—and this, of course, is mainly in large firms—is what we have described as a 'forwarding doctor'. The Industrial Welfare Society states that 'in the majority of firms with a medical service the works' doctor is concerned with the general supervision of health within the factory and this work in its various aspects is in the main preventive. The cases in which the works' doctor undertakes treatment are clearly defined, and it is usual to refer all other cases to the panel doctor of the employee, or to a specialist in consultation with the panel doctor.'[2] This appears to be a hopeful beginning of the provision of special treatment as a private social service combined with general treatment under National Health Insurance. Another experiment is that of the works' doctor being the panel doctor of the bulk of the employees. Free choice is not limited by this arrangement. But it is questionable whether this arrangement suffices to provide the necessary specialist treatment which may be better secured by an *ad hoc* works' doctor with a special knowledge of the medical requirements of the particular factory or undertaking. That the Industrial Welfare Society is fully aware of the need for such specialist work is shown in the 'duties of the works' doctor'[3] which, among many other valuable points, include the obligation to undertake such appropriate research and investigation in connection with the company's products or processes, or contemplated products or processes, as may be required from time to time. A memorandum published by the Ministry of Labour and National Service during the war also stresses the fact that the relation between panel doctor and works' doctor should be that of useful co-ordination and co-operation; the works' medical officer is not expected to undertake treatment at home and only gives continued treatment at

1 Cf. Sir Morton Smart, *loc. cit.* 1939, pp. 7–8.
2 Cf. Industrial Welfare Society, *Medical Service in Industry*, 1936, pp. 18–19.
3 Cf. *ib.* pp. 33–4; also *Health Services in Industry*, 1942, pp. 18–23.

the works with the acquiescence of the patient's panel practitioner. On the other hand, the memorandum emphasizes that the medical officer may be able to inform the patient's medical attendant or the hospital almoner that the firm is willing to assist in procuring specialized treatment, which otherwise might not be obtainable. Physio-therapeutic treatment is again especially mentioned.[1] The growing demand for rehabilitation services to restore the worker's capacity for work by specialist treatment and special training to a much greater degree than is accepted as cure or recovery under National Health Insurance, is another proof of the recognition of the overwhelming role which specialists will have to play in any progressive reform of medical treatment and benefit.[2]

All these tendencies are welcome and merit the closest attention. But no attempt has yet been made by legislation to make even a start with embodying what is being suggested and tried out here and there—for example, the special rehabilitation by institutions working with the Central Council for the Care of Cripples—into a statute complementary to the National Health Insurance Act. The absence of positive and specialist treatment of this kind remains one of the gravest deficiencies of National Health Insurance medical benefits. It is surprising that the Report of the British Medical Association Committee on industrial health in factories did not consider the provision of specialist statutory services for injured workers, a step which obviously would greatly relieve the present unsatisfactory position as regards industrial injuries, by accident or disease, as they are dealt with under National Health Insurance. The Report[3] apparently does regard the medical officer in factories as a sort of 'forwarding doctor'; but it has to be kept in mind that these doctors are expected to deal with a great many other matters than first treatment and diagnosis.[4] They cannot be compared with a

1 Cf. *Memorandum on Medical Supervision in Factories*, Factory Department Ministry of Labour and National Service, Nov. 1940, pp. 2 and 5.

2 Cf. Wilson and Levy, *Workmen's Compensation*, vol. II *passim*; also Hermann Levy, *War Effort and Industrial Injuries*, Fabian Society, 1940, pp. 9–12; cf. also *The T.U.C. in War Time*, May 1941 (T.U.C. 5/5/41–13895), pp. 21–2, where, however, the matter is merely treated as 'A hospital Overhaul'—problem and inclusion in the National Health Insurance scheme is not suggested; for the continuous efforts of the Industrial Welfare Society to extend and accelerate the provision of works' doctors, also in regard to smaller firms, cf. 'Doctors in Industry', in *Industrial Welfare*, June 1941, p. 117.

3 Cf. *B.M.A. Report of the Committee on Industrial Health in Factories*, Nov. 1941, pp. 199 sqq. and p. 30.

4 See for particulars, *ib.* p. 36.

medical man solely concerned with the injury cases of a group or association of industrial establishments. The British Medical Association Report refers to the need for increasing the 'efficiency of the service which the patient's own doctor can give in the prevention and treatment of illness and accident, arising from, or aggravated by, industrial environment'. Here the 'solution seems to lie in improved medical education, continuous interchange of information during a patient's illness, and a closer association between the medical profession and industry'. The general practitioner is expected by the British Medical Association to add more to his knowledge of industrial medical conditions; to keep a constant good working relationship with the industrial medical officer; and to pay special regard to the occupational problems which confront the patient. This looks all very well on paper. But the Report does not explain how the general practitioner can possibly add all these duties and costly educational training in industrial matters to his already over-burdened day's work or how he can recoup himself for the inevitable increase in his expenses if he is to become a medical servant with such extended duties. The British Medical Association also lays stress on the need for closer contact between the general practitioner and hospitals and rehabilitation services; but we have already seen how, under existing conditions of National Health Insurance remuneration, the practitioner regards it as a relief simply to shift people for good to such institutions to avoid more work.

The general practitioner could never become the specialist in industrial maladies and specific injuries that is required. While it would be highly desirable, as we have shown, to allow the common practitioner to use, for a corresponding increase of remuneration, the specialist capacities he may have, a sharp distinction must remain between him and the specialist. For general sickness under National Health Insurance the hospital remains the focus of specialist treatment, where this is necessary; and National Health Insurance legislation should be improved to provide such treatment for the more serious illness. For industrial injuries, specialist care should be an obligation under Workmen's Compensation provided by industrially trained specialists of authority, paid by the insurance carriers and conversant with the special necessities of particular industries. No other way will provide the comprehensive solution required in this urgent matter. If the insurance carriers were—what they should be—associations or boards with equal representation of employers and employees,

no suspicion could arise on the part of the injured worker that the 'works' doctor' would show any bias. On the other hand, a comprehensive statutory scheme would embrace all undertakings, large and small. Both features are missing under the present system of medical officers in factories, as carried out through voluntary welfare by doctors employed by the firm and responsible to it alone—mainly limited to large undertakings.

CHAPTER XVI. DENTAL AND OPHTHALMIC SERVICE

'We wish to state very strongly that, in our opinion, the State cannot afford to allow the health of the workers of the nation to be continuously undermined by dental neglect.' *Report of the Departmental Committee on the Dentists Act*, 1919.

'O, loss of sight, of thee I most complain.' MILTON, *Samson Agonistes*, 1, 67.

In concluding our analysis of the doctor's part and position within the National Health Insurance scheme, so far as treatment is concerned, we must make some observations on dentists and oculists. We have already seen that dental and ophthalmic treatment are still the nearest approach to specialist treatment within the scheme; and they are so regarded by members of the medical profession.[1]

Since the Dentists Act, 1921, the professional standards and the average efficiency of dentists have greatly improved, though there still remain great numbers of unqualified dentists—'dentists 1921' as they are called on the register. There is, however, no panel of insurance dentists. Members of approved societies are free to go to any dentist who agrees to provide treatment under the conditions laid down by the Dental Benefit Regulations, except where the dentist has been declared unsuitable after an enquiry by the central department. One of these conditions is that the 'dentist shall employ a proper degree of skill and attention (not being less than he would apply in the case of a private patient)'. A maximum scale of fees which the dentist must not exceed is prescribed in the Regulations. This scale gives a detailed list of charges for various forms of treatment, and lays down standards of quality for the materials which may be used.

The number of insured persons who avail themselves of dental treatment under National Health Insurance is far from being

1 By Sir Arthur Newsholme, who considers both benefits to be in the direction of specialist treatment, the general absence of which he deplores, cf. *The Last Thirty Years in Public Health*, 1936, pp. 111–12.

satisfactory.[1] Less than 10 % of the insured population eligible for dental benefit apply for treatment in any year.[2] But the Report of 1939 of the National Union of Distributive and Allied Workers shows that, of a total sum of £141,457 expended on additional benefits, £110,452 was accounted for by grants towards the cost of dental treatment.[3] The experience of the Army Dental Corps has demonstrated on a large scale a fact of common knowledge: that the real need for dental treatment is far greater than the effective demand for it; and that, if this country wishes to become a really healthy nation, either the incidence of dental disease must be greatly reduced and its treatment simplified, or the number of dentists on the Register must be considerably augmented. Under existing conditions, expansion of the profession, writes a dental journal, 'cannot be expected to take place until its economic condition has been improved by an increase in the actual demand for dental service'.[4]

Dentists formerly resented the dental services of insurance practitioners which were still available under the National Health Insurance Act.[5] But, although a medical practitioner is entitled to practice dentistry, he is not a dentist within the meaning of the regulations under National Health Insurance, unless his name appears in the dentists' Register. He cannot, therefore, give treatment to an insured person or receive payment in respect of such treatment under a scheme of additional benefits.[6] While the patient seeking this 'specialist' treatment is thus safeguarded against unqualified treatment, the matter unfortunately does not rest here. Dental treatment varies widely from the crude treatment, where extraction is regarded as the quickest and easiest way, to the refined attempt to conserve the teeth at any cost and with all possible technical skill. There can be no doubt that dental treatment as an additional medical benefit leaves open a wide field of dispute about what the dentist should or should not do, and how far he may go in his specialized treatment. The dentist is always liable to find, in cases where he shows particular exertions

1 Cf. also *Beveridge Report*, p. 161, 'aversion to visiting the dentist'.

2 Cf. *The British Dental Journal* of 15 April 1940, p. 328, which gives an example of the part which dental benefit plays in approved societies.

3 As to the above figure see *ib.* 15 Aug. 1941, p. 57.

4 Cf. *ib.* 15 Aug. 1941.

5 Cf. Royal Commission, Evidence, Q. 9950: 'Suppose the patient requires ordinary fillings, the medical man is not able to say he requires them; probably he could not find the cavities in the teeth.'

6 Cf. Bynoe *v.* General Federation of Trades Unions Approved Society (1937) 3 All E.R. 397; also Foster and Taylor, *loc. cit.* p. 81.

coupled with high costs, that he will be denied extra payment by the approved society; and it even happens sometimes that he is unable to recover the fee, even if it has been justified formally by decision of the Dental Benefit Council.[1] Understandably, dentists are reluctant to risk especially elaborate treatment as part of their National Health Insurance work. Correspondingly, the patient may be again inclined to compare unfavourably the treatment in private and insurance practice, and become reluctant to seek the latter.

The small number of cases actually treated year by year is additionally explained by the various limitations surrounding this particular benefit. For instance, a contributor cannot receive this additional benefit until he has been a member for (on the average) $2\frac{1}{2}$ years. Moreover a society rarely pays the whole cost of approved treatment except where this is under 10*s*. Where the fee is more than 10*s*. the society's treatment must not be less than that sum. Higher payments are dependent upon the financial status of the society. But the procedure for getting this benefit is by no means simple. On making application for dental benefit, an insured person may be required to submit to an examination by a Regional Dental Officer. There is often a considerable delay before a member's claim is accepted;[2] the committee of management of every society administering dental benefit is required to fix a proportion of the cost of treatment to be paid by the society, and may vary the proportion from time to time, provided that it shall not be in any case less than one-half of the cost of treatment. These administrative conditions and circumstances do not tend to stimulate dental treatment on the part of a class which is in general inclined to take dental conservation lightly, and tries to avoid medical action in what in many cases is at first regarded more as an inconvenience than a sickness. It must, however, be stated that disciplinary action against dentists under the National Health Insurance regulations as exercised by the Dental Benefit Council is infrequent. In 1939 the Council recorded that the number of cases in which it was found necessary to issue warnings to dentists fell from 144 in 1937 to 73 in 1938.[3]

In general it can be said that the arrangements for dental benefit are satisfactory; more satisfactory, at any rate, than those

1 A case of this kind may be noted in the *British Dental Journal*, 15 April 1941, p. 317.

2 Cf. Foster and Taylor, *loc. cit.* pp. 74–5; *Approved Societies' Handbook*, 1933, paras. 885 sqq.; Fabian Society's *Memorandum*, p. 3.

3 Cf. *Annual Report of the Ministry of Health*, 1939, p. 285.

for normal statutory benefits. The deficiency in this case is far more in the financial arrangements than in any lack of willingness on the part of practitioners to give the best service. Dental benefit was recognized at an early stage as necessitating special treatment for which payment of a specified kind is necessary. The possibility of a capitation payment had to be ruled out.[1] On the other hand, dental service is necessarily restricted on account of finance. The Royal Commission recognized this very clearly. 'A complete dental service', observed the Report, 'would be eminently desirable'; such a (so-called) 'unrestricted dental service' was estimated to cost 4*s*. to 6*s*. in insurance per head per annum; and a complete dental service was estimated to cost £4·5 millions per annum or 1½*d*. on the contribution.[2] This was considered far too much to justify the inclusion of dental treatment in the statutory benefit. On the other hand, the Report regretted that it was necessary to come to this negative conclusion; for it fully recognized that large numbers of sufferers from teeth troubles were 'deterred from applying by the knowledge that they will have to bear part of the cost'.

Some very interesting experiments have been made by large private firms to encourage their employees to seek early dental advice and treatment. The firm of Marks and Spencer has instituted a dental welfare scheme for its employees. Contracts have been made with dental surgeons (26 in 1939). These are paid by the hour, each patient being allowed half an hour's treatment, and it is arranged that these 'session patients' should receive the same care and consideration that the dentist gives to his fee-paying patients (a significant proviso). The dentists work in their own surgeries. It has been stated (and documented by very elaborate statistical material) that this service has had the result of increasing dental treatment considerably and also of diminishing the ill-effects of neglect.[3] Arrangements and results such as these ought to impress the necessity for similar arrangements where they are lacking, that is, in the overwhelming majority of insurance cases.

Eyes require a far more specialized and scientific treatment than teeth. It is this aspect of the matter that constitutes the most difficult problem of ophthalmic benefit. There is a conflict between the doctor and the optician, between a profession and a

1 Cf. *Royal Commission Report*, p. 158: 'dental benefit does not lend itself to payment on a capitation basis at all'. 2 Cf. *ib*. paras. 358–61.
3 Cf. *British Dental Journal*, 16 Sept. 1940, pp. 215 sqq.

trade, just as for centuries there has been a conflict between doctors and pharmacists. This conflict does not, of course, affect ophthalmic treatment, which according to the regulations is 'treatment of the eyes by a medical practitioner having special experience of ophthalmic work', in other words by a specialist doctor. It arises in the matter of ophthalmic examination, that is, examination of the eyes; for the testing of sight and the supply of glasses to insured persons, an optician may be consulted instead of a doctor. This has created constant controversy. Direct resort to an optician is regarded by many responsible people as unsatisfactory.[1] On the other hand, it is for many people, and for the poorer classes in particular, the cheapest and least complicated way of getting eyesight deficiencies remedied. So it happens that approved societies have continued to allow their members to obtain glasses from opticians without producing a medical prescription. In 1923, the opticians, in order to facilitate co-operation with the approved societies, formed the Joint Council of Qualified Opticians, made up of representatives of three important bodies, the British Optical Association, the Worshipful Company of Spectacle-makers and the Institute of Ophthalmic Physicians. The Council drew up what they call a 'register', which is really a private panel, of men holding the qualifications of these societies; and entered into arrangements with many of the approved societies to send clients to opticians on the register. The optician on the Council's register displays a sign above his door with the letters J.C.Q.O. on it. Such shops are to be found in most parts of Britain. The Council was so successful that in 1927 it promoted a Bill to obtain state registration for its members. A Departmental Committee was set up to consider this question, but was unable to come to an unanimous conclusion.[2] Since 1937 a new body, the Ophthalmic Benefit Approved Committee, has been in action; it gives guidance to societies and opticians on many points of difficulty arising in the administration of ophthalmic benefit, and investigates complaints regarding the standard of service given by opticians recognized by the Committee. Conditions of service for recognized opticians have been formulated, and an undertaking embodying them has, since 1 January 1939, been the basis of an optician's recognition by the Committee.[3]

The Committee is composed of (1) optical representatives, and (2) representatives of Approved Societies. Six representatives out

1 Cf. *P.E.P. Report*, p. 187. 2 Cf. *ib.*

3 Cf. *Annual Report of the Ministry of Health*, 1939, p. 150.

of fourteen are members of the Joint Council of Qualified Opticians. The following arrangements are of importance: from 1 January 1938, onwards, an insured person was not allowed to obtain a grant from the society towards the cost of glasses unless he has obtained them from an optician recognized by the Approved Committee; a society must adopt a scale of charges drawn up by the Approved Committee, and no grant can be made towards the cost of glasses if the cost exceeds that laid down in the scale. Opticians who wished to be recognized by the Approved Committee were furnished with application forms embodying an understanding regarding the conditions of service to insured persons. The Committee prepared a list containing the names of about 6,500 individual opticians, 500 firms of opticians and 80 firms of dispensing opticians from whom insured persons may obtain glasses.[1] The main argument for this close regulation of the services of opticians has been the disadvantages to the insured person of a system including so many different agencies by which benefit can be provided; any person had been entitled to practise as an optician notwithstanding that he possessed no special qualifications, with the result that societies had sometimes obtained spectacles from persons with no technical qualification and training.[2] Opticians are now surrounded by regulations and arrangements which guarantee a high and progressive degree of qualification and, presumably, of efficiency.

Yet the essential point remains that a member of an approved society may resort to an optician, and not to an oculist, for testing his eyesight and for obtaining an optical appliance. A member is entitled to obtain an optical appliance from any optician who is recognized by the Approved Committee. He is not entitled to obtain it from any other optician. If a member has been examined by a doctor under the scheme of an organization which provides both ophthalmic examination and appliances, he may be required by the Committee to obtain the prescribed appliance from an optician associated with that organization.[3] The danger is that an insured person sees an optician when he should see a specialist. The situation has not altered since Carr-Saunders and Wilson made their apt observations on the subject[4] in 1933: 'It is generally admitted that the qualified opticians are skilled refractionists,

1 Cf. *Annual Report of the Ministry of Health*, 1937–38, pp. 180–81.
2 Cf. *ib.* 1936–37, p. 197.
3 Cf. Foster and Taylor, *loc. cit.* p. 79.
4 Cf. Carr-Saunders and Wilson, *loc. cit.* p. 143.

competent to measure and correct the refractive errors. It is also admitted that a small percentage of those who have eye trouble are suffering from disease, and not from refractory errors. Opticians are not competent to treat disease, and on this account it is held by the medical profession that persons with eye trouble should go to an oculist in all cases [sic!]. Otherwise there is danger that disease will be overlooked and treated as though refractive errors were the cause—a danger which is not lessened by the fact that the optician is a shopkeeper and that it is to his financial interest to prescribe spectacles rather than diagnose treatment.'

The authors strongly rejected the view of the Royal Commission, that 'It is essentially a task for the qualified medical practitioner to differentiate between cases requiring only mechanical treatment and other cases'; if such is the case, the authors argued rightly, 'it becomes the more difficult to exonerate the medical profession from the charge of indifference to the needs of the community until there seemed a likelihood that the State might call in others to fulfil them'. They further argued that, if the State was to finance ophthalmic treatment, this would imply registration, and the right to it should not be given either to medical men without ophthalmic qualifications nor to opticians, 'whether qualified or not'. It is significant that the Hospital Savings Association in their 'Eye Centre Voucher' state that contributors and their dependants are enabled to obtain at the centre an examination of their eyes by a doctor who is an ophthalmic surgeon by whom prescriptions for glasses will be issued when they are necessary. All such prescriptions will be dispensed at the Centre. But, at the same time, a contributor who is an insured person entitled to ophthalmic benefit must first apply to his approved society, and will only be examined by any surgeons of the Centre upon the authority of the approved society.[1] The arrangement clearly indicates what is considered as the necessary ophthalmic procedure for contributors to an insurance scheme other than National Health Insurance.

The position is not comparable with that of dentists, as the risk involved in the prescription of glasses where diagnosis and treatment of disease are necessary does not exist in dentistry.[2] The public as a whole are not yet educated to the point of insisting on a specialist medical examination before obtaining glasses, even where the glasses provided would cost them little more than under

1 Cf. The Hospital Savings Association, Eye Centre Voucher, Form O.S. 9.
2 Cf. also Carr-Saunders and Wilson, *loc. cit.* p. 144.

an optician service. It must be realized that the insured person will generally be inclined to follow the line taken by his approved society. Societies are given a fairly wide discretion as to the arrangements which they may adopt for the administration of ophthalmic benefit. They may be made either with an organization which provides a combined service including ophthalmic examination and the provision of any necessary glasses, or with an organization of opticians for the provision of glasses, including sight testing. On the other hand, a society, although it may have entered into an arrangement of this kind (such as the Joint Council of Qualified Opticians or the National Ophthalmic Treatment Board), is not allowed to prevent a member from obtaining ophthalmic services by other means. The application of a member may not be refused on the ground that he desires to be examined by a medical practitioner other than in accordance with the society's arrangements. But in that case the society is required to pay only such an amount in respect of the claim as it would have paid had the member obtained the benefit through its own arrangements.[1] The proviso is not calculated to stimulate the patient's personal desire to have some other diagnosis of his eyesight than that provided by the arrangements of his society.

The case of ophthalmic benefit is exceptional. But this should not lessen attempts to improve the conditions of ophthalmic service under National Health Insurance with a view to safeguarding the health and treatment of the insured and checking a further deterioration of the nation's eyesight. The functions of the doctor-specialist and those of the optician are quite distinct, and must be separated, and nothing should be left undone to draw the attention of the insured to the distinction and to prevent arrangements by approved societies that, either directly or indirectly, hamper a further socialization of the ophthalmic services. Ophthalmologists as a profession are in no way satisfied with the arrangements just described. The retention of opticians, whom they regard mainly as commercial interests, is viewed with misgivings, despite existing safeguards. Their aim is to see a national eye service established, which would place the entire responsibility of the treatment of people on ophthalmologists, including the testing of eyesight.[2]

1 Cf. *Approved Societies' Handbook*, paras. 922 and 927.

2 Cf. *Lancet*, 22 July 1939, article by R. Lindsay Rea, President of the Association of British Ophthalmologists: also *ib.* 29 July 1939, p. 273.

C. HOSPITALS AND OTHER INSTITUTIONS

CHAPTER XVII. NATIONAL HEALTH INSURANCE AND THE ORGANIZATION OF HOSPITAL SERVICE

'Those unable to afford the advantages of private practices have recourse to special departments of hospitals, but unfortunately the benefit of treatment is to a large extent negatived because of the many and varied difficulties with which such hospital departments are faced.'

SIR MORTON SMART, Manipulative Surgeon to H.M. the King, July 1939.

HOSPITAL TREATMENT under National Health Insurance is an 'additional benefit'.[1] The sum expended on it by the 2,246 existing schemes in 1939 was not more than £90,892. The approximate membership covered by the schemes was only 1,606,000. These facts illustrate the secondary role which hospital treatment plays under National Health Insurance.[2] To these figures those relating to benefits granted in respect of Approved Charitable Institutions (additional benefit No. 16) must be added; these, however, are of a trifling character.[3] We have already shown how the lack of contact between the panel doctor and the hospitals is much complained of; on the other hand, there are increasing signs that the panel doctor is in many cases only too willing to shift the patient to hospital and so get rid of the case altogether. The omission of hospital treatment as a normal medical benefit was, at an early date, criticized by expert writers. Dr Brend pointed out in 1917 that 'specialist services and institutional treatment are by far the most crying needs among the working classes',[4] and 'no system can be regarded as "adequate" (see p. 95), in any ordinary sense of the term, which does not provide these'. The insignificance of the amounts spent on hospital benefit under National Health Insurance emerges most clearly if they are contrasted with the contributions made by people to secure hospital benefit under voluntary schemes.

The most important voluntary organization, the British Hospitals Contributory Schemes Association, has now more than one

1 Out-patient treatment is not included in the benefit.

2 Cf. *Annual Report of the Ministry of Health*, 1939, p. 149.

3 In 1939, only £33,000 was allocated for this purpose, though the membership was over 7,000,000; in addition £27,978 was allocated in 1939 by societies under Section 10 (3) of the National Health Insurance Act, 1936, which permits of payments to 'hospitals, dispensaries or other charitable institutions, or for the support of district nurses, or for the purpose of medical research to institutions approved by the Minister'.

4 Cf. Dr Brend, *loc. cit.* p. 224 and *passim.*

hundred schemes, representing approximately four million contributors, and is responsible for an annual collection of nearly £3,000,000. About four-fifths of this sum goes to hospitals. The Hospital Savings Association has in recent years rapidly increased its contributory income, which has now reached the £1,000,000 mark. There are, besides, a considerable number of schemes which have not affiliated themselves to the Association, and many small schemes often associated with cottage hospitals, which are probably ineligible for affiliation with the bodies mentioned. It has been estimated that at least ten million persons are covered by these schemes, since the subscription is generally on a family basis. Contributions from employers are almost insignificant. In thirty schemes of the British Hospitals Contributory Schemes Association, which represented four-fifths of the total income of the contributory schemes, only 4·3 % of the total income was from contributions of employers, according to an investigation made in 1938.[1]

This sort of voluntary contributory scheme is the one way in which the working-class family can fill the gap left by National Health Insurance legislation. These voluntary schemes are administered by independent bodies operating in definite areas or by the individual hospitals for whose benefit the scheme has been started. The schemes differ considerably in detail; but their main features are that the workman makes a regular contribution which varies (according to the scheme) between 1*d.* and 4*d.* a week, and probably averages between 2*d.* and 3*d.* for adults and about 1½*d.* for boys and girls. The chief benefit is hospital treatment. Some schemes, again, provide 'additional' benefits, such as free use of an ambulance in stretcher cases, or free service by the staff of the District Nursing Association. The contributions are sometimes collected by the employer, without charge, by deduction from wages and paid over to the hospital; in some cases they are directly collected by the hospital. As in all 'thrift' schemes, this system of spreading the contributions over a period was arranged in order to make the contributions 'not appear as a burden'.[2]

Apart from these voluntary thrift efforts on the part of the working classes to secure what National Health Insurance as a social service has denied them, there has been a movement to start

1 Cf. *Memorandum presented by the British Hospitals Association Inc. to the Royal Commission on Workmen's Compensation*, April 1940, reprint, pp. 8 and 17; also *P.E.P. Report*, p. 234. For further interesting particulars cf. also Constance Braithwaite, *The Voluntary Citizen*, 1938, pp. 143–5 and *passim.*

2 Cf. British Hospitals Association's Memorandum, *loc. cit.* p. 8.

similar arrangements under the auspices of 'industrial welfare'. The purpose of these funds is quite openly declared by the Industrial Welfare Society to be 'to supplement the amount received from National Health Insurance'. From a Memorandum of the Industrial Welfare Society, it appears that the contributions made by the firms, if any, are relatively small in comparison with those of the employees, although in exceptional cases they reach sometimes 50–70 % of the employee's contribution or a smaller percentage of the amount expended in benefit. Often institutional treatment or attendance is secured for members of the fund, and for this purpose the fund becomes an annual contributor to local hospitals or to suitable convalescent homes.[1]

The 'thrift' movement for the provision of hospital treatment, viewed from the angle of individual forethought, or judged by the effort and skill of its organizers, deserves high praise. But it is not to the credit of a system of 'national' health insurance, which should be comprehensive. The voluntary system must be regarded, not as a solution, but as an attempt to avoid the necessary and obvious solution of including hospital treatment as a normal benefit in National Health Insurance. This does not exclude the possibility of using the voluntary agencies as they have developed in a scheme of compulsory insurance for hospital benefit.[2] The Royal Commission on National Health Insurance did not envisage this possibility at all. The inclusion of hospital benefit as a normal statutory benefit was rejected mainly on grounds of economy and finance. The Commission accepted the argument of the Ministry of Health that to include it would entail some guarantee that the required hospital accommodation would be available when it was needed. As regards voluntary hospitals, the Report observed, such a guarantee could not be given; the inclusion would necessitate priority for insured persons, who would have the right to hospital accommodation, and such preference might be prejudicial to the voluntary system.[3] The existence of the voluntary hospitals thus

1 Cf. Industrial Welfare Society, *Works Sickness Benevolent Funds*, 1934, pp. 4, 12 and 21–6.

2 Cf. W. H. and K. M. Wickwar, *The Social Services*, 1936, p. 148: 'When the time is ripe voluntary progress of this magnitude will perhaps serve as a useful basis for a compulsory measure, so that all may enjoy facilities which are at present available only to those who are able to think and pay for themselves.'

3 Cf. *loc. cit.* para. 264: 'In any case we must point out that so long as the hospitals treat the insured and uninsured on the same basis and retain, as they desire to do, complete independence in the management of their funds, it would be very difficult to justify a systematic and substantial support from the insurance scheme for this purpose.'

appeared as an obstacle to the inclusion of hospital benefit as a normal benefit under National Health Insurance. Paradoxically, the Royal Commission, while stressing the high cost of including hospital benefit, was struck by the 'low' cost of the system of the Hospital Savings Association, which for 3*d.* a week treated the contributor and his dependants, when admitted to hospital, without any distinction between insured and non-insured, without any enquiry as to means, and equally well as out- or in-patients.

Private saving is the one way open to the insured worker to secure necessary hospital treatment. If there are no such savings and no other finance available, the last resort must be to public charity and assistance. Treatment under such conditions is sometimes deliberately avoided. 'There is a certain amount of evidence that many insured persons are reluctant to go to out-patients' departments, as a charity, while they would not hesitate to avail themselves of the same specialist services if included in medical benefit, as they would then feel that they had a full legal and moral right to receive the services, when needed', observed the Royal Commission's Report.[1] The position is almost the same as the constant fear of a pauper burial which drives the poorer classes into the toils of industrial assurance. The fear of charity treatment in hospital is the background of voluntary saving for self-paid treatment. As it is, unless a patient is a member of a saving scheme, the almoner will ask him to contribute towards his maintenance and treatment, either in the out-patient department or in the wards; and the same applies to the public general hospitals. Patients in the latter and in the Poor Law hospitals pay according to their means, unless they are members of a contributory saving scheme which has an arrangement with the public hospitals to take its members, though of course the bulk of expenditure of public hospitals is met out of local rates and out of the 'block grant'; a local authority in England and Wales is compelled by Statute to recover from in-patients in hospitals, except infectious disease hospitals, the cost, or a proportion of the cost, of their maintenance.[2]

The Local Government Act, 1929, was responsible for many far-reaching changes. By 1930, when the Board of Guardians was abolished, many of the Poor Law institutions or hospitals were being used as public hospitals, although every patient remained technically a pauper. The Guardians also provided beds for patients in mixed workhouses; since that date, however, their

1 Cf. *loc. cit.* para. 274. 2 Cf. *P.E.P. Report*, pp. 237, 251 and 253–4.

powers and duties have been transferred to the Public Assistance Committee of the county councils and county borough councils. By the same Act, the county councils and county borough councils were given power to 'appropriate' former Poor Law hospitals and transform them into public hospitals, or alternatively to build general public hospitals.[1] The process of 'appropriation' is proceeding rapidly. In all, 54 authorities had, by 1939, appropriated 111 hospitals (the figure was 92 in 1936), and there were 137 hospitals provided by local authorities.[2] The aim of these changes has been to a large extent to expand the hospitals under this new order 'into places of scientific treatment rather than medical relief', as the Wickwars have expressed it.[3] This deserves the highest praise. After describing in some detail the great work done in these respects by the London County Council hospitals, Ritchie Calder calls their achievement 'one of the great reforms of our time', as the London County Council has actually been in a position to transform, since 1929, the 'bleak and mean inefficient hospital service'.[4] One may conclude that the public hospital is becoming so admirable, and incidentally so popular, an institution that the 'charity' stigma may soon vanish as regards those who cannot pay. But this point—important as it may be from the angle of the public health services—does not directly affect our point as regards National Health Insurance. The accruing advantage will only mean that charitable or quasi-charitable treatment to workers, who, though insured under National Health Insurance, are not entitled to specialist hospital treatment, will be lifted on to a higher plane than it occupied under the Poor Law. But this development can hardly exonerate National Health Insurance legislation for not providing such benefits under its statutory requirements.

Indirectly, of course, the hospital problem is very much linked with that of National Health Insurance. The Report of the Royal Commission stressed the point that statutory hospital benefit would entail a guarantee that the sick insured person would actually get hospital treatment. This seems a perfectly correct submission. The question is whether the conditions of hospital accommodation in this country are such as to make it possible to guarantee that the insured sick, if given the right under National

1 *Ib.* p. 250.
2 Cf. *Annual Report of the Ministry of Health*, 1939, pp. 64–5.
3 Cf. W. H. and K. M. Wickwar, *The Social Services*, 1936, p. 112.
4 Cf. 'L.C.C. Hospitals', in *The New Statesman and Nation*, 16 Aug. 1941, p. 154.

Health Insurance, could actually get such treatment, of the right kind and at the right time. The question of hospital accommodation and its availability is of primary importance. In fact, there is a very intimate connection between National Health Insurance and the question of institutional treatment, a connection which was certainly in the mind of legislators in 1911 so far as one type of institution was concerned, namely sanatoria for tuberculosis patients. Sanatorium benefit might have become something of a model for other institutional services under National Health Insurance.

The German law was frequently cited by the supporters of the 1911 scheme in regard to hospital treatment.[1] The recommendations concerning the general principles of sickness insurance, drafted by the General Conference of the International Labour Organization of the League of Nations in 1927, mentioned the desirability of 'treatment in hospital, where his [the insured's] family circumstances necessitate it or his illness requires a mode of treatment which can be only given in hospital'.[2] In a great number of countries, the insurance institutions are entitled to insist on the insured persons accepting hospital treatment. If the insured person refuses, he may be deprived of his right to treatment at home and to cash benefits; this rule applies when the disease is infectious or can be treated only in hospital, or when the patient must be under constant observation, or when he repeatedly acts in a manner contrary to the doctor's instructions.[3] In Britain, of course, a similar obligation rests on the authorities entrusted with the provision of adequate hospital treatment for infectious and particularly virulent diseases.[4] But in all the other cases which may necessitate the treatment of poor patients in hospitals there is, in view of the lack of provision under National Health legislation, no particular encouragement to hospitalization. As

1 Cf. Chiozza Money, *loc. cit.* p. 48: 'If the case calls for hospital treatment the patient is entitled to it, and to free removal to and from hospital.' The last-mentioned point reminds us of a sore point in the British medical services, even of to-day. We read in the *Medical Officer*, 23 Aug. 1941: 'It is strange that no apparent effort has been made to enable poor people requiring frequent attendance at hospital out-patient departments, which may involve long and expensive journeys, to be provided with cheap and free passes on public conveyances.'

2 Cf. *The International Labour Organization etc. loc. cit.* p. 141.

3 *Economical Administration*, 1938, p. 98.

4 The Local Government Act, 1929, section 63; also Public Health Act, 1936, section 185; a Justice of Peace may also order a person suffering from notifiable disease to be removed to hospital if he thinks that proper precautions are not being taken to prevent the spread of infection; cf. also *P.E.P. Report*, pp. 63 and 250–1.

the International Labour Office has pointed out, hospital treatment, if embodied into sickness insurance schemes, may be regarded as a means of securing the schemes' very purpose, which is to restore the insured person as quickly and as completely as possible to health and working power. In Britain, on the other hand, hospital treatment is regarded under National Health Insurance as a special privilege to the insured. This being so, no incentive exists on the part of the insurance carriers to promote hospital treatment, and to see that such treatment does not remain dependent on the availability of accommodation or on the particular in-patient treatment required.

CHAPTER XVIII. DEFICIENCIES OF HOSPITAL SERVICE

'Before all things, and above all things, special care must be taken of the sick, so that they be served in every deed, as Christ Himself, for He said: "I was sick, and ye visited Me"; and, "What ye did to one of these My least Brethren, ye did to Me".'

ST BENEDICT in his Rule.

THERE can be no doubt whatsoever that hospital treatment in this country is extending and improving. The aim of the authorities is high and creditable; it is the 'provision of an adequate number of hospital beds for all types of cases needing in-patient treatment and to ensure that this provision is of modern standard and is expanded to meet increased demands'.[1] The Ministry of Health made a review, in 1938, of the available beds in voluntary and municipal hospitals in England and Wales. The survey revealed that there were 292,592 beds for all purposes, including 24,370 in accommodation under construction or contemplated. Approximately two-thirds are in institutions or hospitals owned by local authorities, and of these approximately three-fifths are in hospitals not provided in connection with public assistance. There are in this country as a whole 7·14 beds for all purposes per 1,000 of population. But there are wide variations; the figure in London and the adjoining counties is 9·01, while in other groups of counties it falls to 5·18. The progress of hospitalization emerges from the following figures relating to local authority hospitals.[2]

1 Cf. *Annual Report of the Ministry of Health*, 1939, pp. 65 and 247.

2 The figures include the beds in general hospitals and institutions used for tuberculosis, infectious diseases, maternity and mental cases, but not beds in institutions which are used wholly for cases in one of these four categories.

It has, of course, to be taken into regard that there is a trend of transfer from voluntary hospitals to public hospitals which cannot be statistically estimated.[1] But this change certainly does not affect the local authorities' figures to such an extent as to invalidate the general result. The figures are as follows:

	1936	1937	1938
Number of admissions	729,096	781,191	778,301
Number of out-patients' attendances	1,683,522	1,921,769	2,288,140
Number of surgical operations under general anaesthetic	122,251	130,903	144,038

These figures show a conspicuous increase. But, satisfactory as they appear, they do not show the problems involved in what may be called 'access to hospitalization'. The question is whether the supply of hospital treatment available matches the demand. The figure of 7·14, even of 9·01 in the London district, does not appear particularly satisfactory when set against the statement of the International Labour Office that, in industrial centres where there is an extra risk of accidents and in ports, the ratio of beds has now risen to 10, 12, 15 or more per 1,000.[2] The Report of the Royal Commission drew attention to the fact that the extent to which specialist treatment and advice can be obtained at hospitals varies greatly in different parts of the country.[3] These variations result from differences in the accessibility of patients to hospitals. Complaints about the expense of travelling to hospitals or institutions far away from their domiciles have not become less since the sittings of the Royal Commission—although travelling is included under additional benefits (No. 10) for both in- and out-patients. There are different rules in different hospitals, and differences in the attitude of practitioners and in their relationships to consultants. The Royal Commission received a good deal of evidence as regards the inclination of patients to avoid treatment in Poor Law hospitals.[4] The position, as we have seen, is far better to-day,

1 Cf. *Final Report on Rehabilitation*, 1939, p. 113 for an example.

2 Cf. *Economical Administration*, 1938, p. 94.

3 Cf. *Report, loc. cit.* paras. 272–5.

4 Cf. Royal Commission, Evidence, Q. 20,621: 'We have had figures given to us that in many of the Poor Law hospitals over the country there may be vacant beds, whereas all other hospitals are overcrowded, people waiting for beds, and none for them, and that the Poor Law Hospitals are taboo because of the stigma of the Poor Law': also A. 22,067: 'But with regard to the Poor Law hospitals you may take the case of the London Hospital, which has a waiting list at the present time of round 1,000, and almost within reach of it is the Whitechapel Infirmary which has a considerable number of vacant beds.'

as Poor Law hospitals have been replaced by less unpopular institutions. The number of institutions or hospitals under the Poor Law Act declined from 423 in 1936 to 388 in 1938, and the number of sick beds under this category from 68,737 to 59,910.[1] But the position of overcrowded hospitals is not appreciably more satisfactory to-day than it was in 1928, when the Report emphasized that some people 'are deterred by the crowded state of the out-patient departments and the long time they may have to wait for attention'.[2] Mr Courtney Buchanan, speaking for the British Hospitals Association, declared in 1925:[3] 'There are not enough beds to go round. Some people who are not insured do not get into hospitals as soon as they ought to get because of the waiting list, and the same remark applies to the insured. We could not treat all insured and uninsured in our present accommodation.'

The Memorandum of Evidence submitted to the Royal Commission on Workmen's Compensation in 1940 by the Association of Industrial Medical Officers[4] pointed to the fact that 'the lack of hospital beds may mean additional movement of serious cases to other hospitals'. They submitted that the same lack is a 'frequent cause of premature discharge of the patient either to the out-patient department or to the panel doctor', a point which is made a frequent complaint by doctors and which is apt to show that it is not only the 'number' of beds which must be taken into consideration but the degree of their utilization for individual cases.[5] The Association observed that 'there is frequently no bed for the concussion case or the not-too-severe burn or for a patient with a fractured arm or wrist'. 'And in the absence of accommodation he may be sent home to fend for himself at a time when his wife or other members of the family may be out of work.' This very illuminating Memorandum pointed out that, if a case is treated—owing to these circumstances—as more or less trivial, later complications may turn it into a dangerous affliction; the lacerated finger with damage to tendon or nerve or the 'septic finger', if overlooked, may lead to permanent incapacity.[6] It is the scarcity of hospital beds and facilities that causes this premature

1 Cf. *Annual Report of the Ministry of Health*, 1939, p. 247.
2 Cf. *Report*, para. 274. 3 Cf. *ib.* Evidence, A. 17,136.
4 The Association is composed of a group of 70 medical men and women engaged in the whole-time practice of medicine in relation to industry.
5 Cf., for instance, Dr M. B. Ray, *The Treatment of Rheumatism*, Chadwick Lecture, 1930, separate print, p. 9: 'Very few hospitals are able to keep their patients long enough.'
6 Cf. Royal Commission on Workmen's Compensation, 20 June 1940, p. 1191.

distinction between severe and less severe cases to be made. The lack of hospital accommodation and the inconveniences resulting from the over-crowding of out-patient facilities have lately been described by other observers and investigators. The percentage of available beds to population is relatively favourable in London and the adjoining counties; but Robert Sinclair observes that the admission to the London hospitals for the poorer classes 'is far from easy'. They may have to wait three weeks before entering St Thomas's, a month before being admitted to Guy's; St Bartholomew's want pay-beds but cannot install them; Mount Vernon has 2,000 cancer patients on its files and the number is growing, yet it cannot afford more than 150 beds; the London hospitals had, in 1937, only 600 cancer beds in all; the Royal Northern Hospital had 43 beds closed for three years in spite of a long waiting list.[1] All this on account of financial requirements or difficulties. The pressure of work is overwhelming. (Some of the larger central hospitals deal with an average of 1,500 out-patients a day throughout the year.) 'There is no time to deal with all these people. Out-patients, who queue up in their daily hundreds at all the big hospitals, are sometimes less organized than queues of spectators at some of the football grounds', writes Sinclair; 'they just sit and stand and wait, and the minutes become hours.'[2] The Industrial Medical Officers called the attention of the Royal Commission on Workmen's Compensation to the fact that deficiencies which lead to this waiting, the absence of evening out-patient clinics or appointment systems, show 'that hospital authorities tend to forget the economic side of the patients' lives'.[3] But the blame must rather be thrown upon a system of hospitals which, with all goodwill on the part of those in administration, is faced with requirements over and above its technical limitations.

Two other medical authorities have lately expressed strong views about the 'sufficiency' of hospital accommodation. Arthur E. Raine, from the Health Department of the Durham County Council, wrote in 1940: 'Notwithstanding the steady growth of hospital accommodation, it still remains true that in many parts of the country there is considerable shortage of available beds, and in our own north-eastern district a recent survey showed waiting lists totalling over 4,000 at the various general hospitals, and this figure is probably an under-estimate. These long waiting lists . . . mean prolongation of suffering.'[4] Dr James Grant, Medical

1 Cf. Sinclair, *loc. cit.* pp. 105–6.
2 Cf. Sinclair, *loc. cit.* pp. 198–9.
3 Cf. *Memorandum, loc. cit.* para. 28.
4 Cf. *Public Health*, Feb. 1940, pp. 101 sqq.

Officer of Health, has written: 'The hospital accommodation for the treatment of disease is inadequate and unsatisfactory. This applies to all categories, including isolation, tuberculosis,[1] maternity, general, mental, and specialist institutions.' He complains, in particular, about the long waiting lists and the crowded outpatient departments.[2] The Central Council for the Care of Cripples in its Memorandum to the Royal Commission on Workmen's Compensation in 1940 assumed that 'treatment at or in a hospital can be secured without difficulty by the vast majority of the people'.[3] But it is doubtful in view of the above statements whether the contention is correct. One of the affiliated bodies of the Council, The Cripples' Training College at Leatherhead Court, stated in its Report for 1938, p. 7, that 'the waiting list has reached unmanageable proportions'.

From the angle of national health the conditions of access to hospitals are unsatisfactory and defective. Hospital benefit under National Health Insurance, being no statutory benefit, is in itself exceedingly limited and ineffective; and the lack of proper provision for hospitalization under National Health Insurance is in no way counterbalanced by the general facilities which exist for access to hospitals. The Royal Commission argued that statutory hospital benefit would imply some guarantee that the required accommodation will be available. This should have been a decisive argument for, not against, inclusion. If such an obligation existed, there is no doubt that the agencies under National Health Insurance would long since have developed institutions or arrangements with hospitals to remove the existing deficiencies, just as in countries where medical benefit is incumbent upon industrial accident insurance, much more detailed and specialized care has been given to the restoration of the injured worker. In countries where institutional treatment is an obligation under sickness insurance, 'insurance institutions try to make it easier to organise institutional treatment on economic lines by providing suitable establishments and seeing that they are rationally used'.[4] The 'guarantee' of which the Report spoke might prove not only an obligation, but also an impetus.

Progress in this matter, if it ever becomes a task of National

1 Cf. for this below, pp. 177–9.
2 Cf. *Public Health*, Dec. 1940, p. 38.
3 Cf. Evidence, p. 1242.
4 Cf. *Economical Administration*, 1938, p. 99. Examples for this are given by G. F. McCleary (late of the Ministry of Health), *National Health Insurance*, 1932, pp. 53–4.

Health Insurance, will only be achieved if due attention is paid to the many special medical problems which arise in connection with social illness. The drafters of the original National Health Insurance Scheme were particularly concerned with tuberculosis and sanatorium benefit. We may refer in this respect to two sets of problems, those arising from fractures as well as those arising from tuberculosis.

The Delevingne Committee, which issued its final Report in 1939, threw the first definite light on the importance of hospitalization in cases of fracture, and, by implication, on the need for more attention to the study of institutional treatment in other illnesses, particularly as they affect workers. The Committee received most valuable assistance from a committee appointed by the Council of the British Medical Association, which published figures relating to the treatment of fractures which presented a strong case for hospitalized treatment. From the statistical researches made by the British Medical Association it emerged that, while incapacity remained permanent in only 1 % of the cases treated in 'organized' clinics, that is, clinics in which fractures are treated in a department specially organized for that purpose, 37 % of the cases not so treated, in the sample investigated, were permanently disabled.[1] But the Interim Report of the Rehabilitation Committee had to make the depressing admission that, while the number of fracture cases treated annually in the hospitals of this country is well over 200,000, no more than 50,000 are treated in departments organized specially for that purpose.[2]

There are several bodies and institutions which take special care of fracture cases by organizing special clinics, training centres and rehabilitation work. The efforts of the Central Council for the Care of Cripples in this direction are admirable, and are constantly kept alive by the urgent complaints of institutions connected with the Council about the lack of accommodation.[3] Yet all such private and charitable efforts, outstanding as they are

1 Cf. B.M.A., *Report of Committee on Fractures*, reprint, Feb. 1935, p. 10.

2 Cf. *Interim Report of the Inter-Departmental Committee on the Rehabilitation of Persons Injured by Accidents*, 1937, p. 14.

3 Cf. Central Council for the Care of Cripples, *Annual Report*, 1940, p. 13, Report from Durham: 'Lack of orthopaedic hospital accommodation has been the greatest difficulty throughout the year...some improvement in the number of beds available for orthopaedic cases in existing hospitals was recorded as the year progressed.' As particularly valuable institutions the Mansfield General Hospital Fracture Clinic, the Orthopaedic and Fracture Department of the Royal Albert Infirmary, Wigan, and the New Accident Hospital in Birmingham may be mentioned.

as individual achievements, are almost insignificant when measured against the national necessity. As a famous surgeon recently pointed out, there is rehabilitation treatment available for some 30 patients here and some 30 there, but what does it amount to in comparison with the 200,000 fracture cases sustained in this country every year? 'The tragedy is', observes the writer,[1] 'that, knowing the solution to the problem, we are failing to apply it.' Undoubtedly there has been progress in this kind of hospitalization. But, although the main principles governing specific fracture clinics have been accepted in a number of large municipal hospitals, these are not such clinics.[2]

The Report on Rehabilitation fully recognized the possibilities of an extension of the benefits under National Health Insurance in order to improve access to hospitals and clinics; but unfortunately it refrained from making any definite recommendation, on the ground so frequently put forward on such occasions that 'large questions of policy beyond our competence are involved'.[3] It did, however, cautiously express the view that 'any improvement of treatment which reduces the length of the sickness period constitutes a relief to the funds of the Approved Societies'. In general, little interest has been shown by insurance institutions in assisting the physical restoration of the insured, as long as this remains outside the statutory obligations, and as long as a 'non possumus' policy remains the more convenient. The point is that to limit medical benefit expenditure to the utmost, even to the extent of precluding complete rehabilitation of the insured, may be regarded as more profitable than costly restoration—as long as legislation does not prescribe that the obligation of the insurance carrier does not end until the best possible medical treatment has been provided and the patient has actually reached or regained the highest obtainable degree of working capacity. Such an obligation is laid upon the shoulders of employers under all industrial accident insurance schemes which provide medical treatment and rehabilitation; but the vague and meagre phrase 'adequate treatment' does not tend to stimulate efforts of this kind under British National Health Insurance.

1 Cf. R. Watson-Jones in the *British Medical Journal*, 26 April 1941, p. 643. He is responsible for the most authoritative book on the subject, *Fractures and other Bone and Joint Injuries*, 2nd ed. 1941.

2 Cf. *Final Report on Rehabilitation*, p. 112; what the actual requirements of a model fracture clinic are can be gathered from Appendix II of the *Interim Report* and chapter VI of the *Final Report*, pp. 38 sqq.

3 Cf. *loc. cit.* p. 103.

The war has given a great stimulus to rehabilitation.[1] It remains, however, noteworthy that the measures now being taken were more dictated by consideration of man-power supply than by social consideration. On 24 November 1941, the Minister of Health could state that 426 establishments had been set up for the rehabilitation of fracture cases, and more were in preparation. There were 21 orthopaedic centres covering all aspects of fracture treatment. Their activities ranged from first remedial surgery, through massage, heat, light, games and exercise, to recreation, workshops and handicrafts.[2] How far these very laudable arrangements covered the actual need for rehabilitation, in Mr Watson-Jones's sense, was not divulged; but the scheme was made in connection with the Hospital Emergency scheme and related to war workers and air-raid casualties. It did not contain rehabilitation measures for injuries other than fractures, and the possibility of embodying such measures in National Health Insurance medical benefit was never discussed.

Under such conditions it can be well understood that the socialization of fracture treatment has not received the slightest impetus from National Health Insurance. But the treatment and cure of tuberculosis were very much in the mind of the original legislators of the insurance scheme. It was well recognized at that time that the lung diseases were among the deadliest enemies of the nation's health; twenty years ago, tuberculosis was killing a thousand people every week. By 1937 this figure was halved, and Sir Arthur S. MacNalty, Chief Officer of the Ministry of Health, acclaimed the fall of tuberculosis from its 'disgraceful pride of place' at the head of the mortality list as the most striking reduction in the mortality of any disease in our time. But tuberculosis still kills more people between the ages of 10 and 40 than any other disease. Moreover, it has to be taken into account that the reduction in tuberculosis mortality may be due to one or the other of two distinct improvements: improvement in the prevention of the disease, which does not concern our investigation; or improvement in the treatment, which we are here discussing.[3]

Sanatorium treatment of tuberculosis arose from the observed value of breathing pure air in the treatment of phthisis and was

1 Cf. *War Effort and Industrial Injuries*, Fabian Society, 1940; '*Back to Work*', *the case of the partially disabled worker*, Fabian Society, 1941.

2 Cf. *The Times*, 25 Nov. 1941, p. 2; cf. also Ministry of Labour, *Fracture Treatment and Rehabilitation*, P.L. 113/1942.

3 Cf. S. Mervyn Herbert, *loc. cit.* p. 162.

first developed on an extensive scale in Germany and the United States. It was from the experiences of Germany that Mr Lloyd George took the idea of introducing sanatorium benefit into his National Health Insurance scheme.[1] In 1921 (Public Health (Tuberculosis) Act, 1921), however, sanatorium treatment (or treatment for tuberculosis in other institutions) of insured persons suffering from tuberculosis, which had been administered by insurance committees, was discontinued as an insurance benefit, and the responsibility for institutional treatment was transferred to the public health authorities, by which tuberculosis treatment was greatly developed and made available to classes outside the insurance scheme.[2] Domiciliary treatment, however, remained part of the service which the insurance practitioner contracted with the insurance committee to give his insured patients. The Report of the Royal Commission observed that the removal of the institutional treatment of tuberculosis from National Health Insurance 'marked a distinct change in the conception of the responsibility of the State in this matter, as in place of provision for a restricted class, who in part paid by insurance contributions for the service provided, there was substituted a provision available for the whole population and supported entirely by rates and taxes'. The Report quoted in confirmation of this view the statement by a representative of the Ministry of Health that 'an effective scheme for the treatment of tuberculosis cannot be confined to one section of the community', while, apart from the matter of principle, the placing of the responsibility for treatment of all sections upon one local authority in each area entailed several advantages as regards more economical and unified administration.[3] Political and Economic Planning appears to have adopted this view, for it speaks of the 'artificial' distinction between the insured and the uninsured tubercular patient which the Act of 1921 had removed.[4] But why select just tuberculosis for this argument and not medical treatment altogether? As long as national sickness insurance grants benefits, in consideration of the insurance cover which uninsured do not enjoy, such 'injustice' must exist in all branches of medical treatment. There is no reason why, for instance, insulin treatment for diabetes, which is sometimes provided to insured people, should not be provided equally

1 Cf. Brend, *loc. cit.* p. 243, who contends that Mr Lloyd George had largely misunderstood the German statistics and over-estimated the effect of sanatorium benefit under the German law.

2 Cf. *Royal Commission Report*, pp. 49–50, and Foster and Taylor, *loc. cit.* p. 4.

3 Cf. *Report*, p. 50 and Evidence, Q. 24,092.

4 *P.E.P. Report*, p. 286.

to the whole 'community'.[1] If this particular argument for national tuberculosis treatment were valid all medical benefits under National Health Insurance would logically entail 'injustice'. But in 1911 the idea was to grant to at least one, and that the most important, section of the nation, the working-men and working-women, provision through insurance for securing the most efficient institutional treatment for the most formidable and tragic type of illness. Insured persons contracting tuberculosis were to have the 'right' to suitable treatment in sanatoria or otherwise; but, as matters developed, this guarantee was very inadequately fulfilled by those administering National Health Insurance, and this ought not to be concealed when the transfer of sanatorium benefit from them to other bodies is explained and applauded. Mr G. H. Walmisley, chairman of the Public Health Committee of the London County Council, made the very definite statement before the Royal Commission that 'the change over to the new arrangement at the time when it was put under the Local Authorities came about because the scheme under the Insurance Authorities had more or less broken down. That was the reason why it was handed over to the Local Authority. . . they [the Insurance Authorities] could not provide the treatment, because the amount available for sanatorium benefit was insufficient.'[2]

Mr Brock, from the Ministry of Health, stated that 'there have been complaints that insured people have been required to make contributions towards the costs of their sanatorium treatment'.[3] The position led to a very lively discussion before the Royal Commission when witnesses of the National Amalgamated Approved Society were heard; Sir Thomas Neill declared:[4] 'The position is this. When the Act came into force provision was made for insured persons to have special treatment for which a certain contribution was provided in payments that they were making. For certain reasons this treatment could not be obtained. It was a very thorny subject because Insurance Committees and those interested were making trouble with the Local Authorities and other people, and with the Government, in order to get this benefit to which insured persons were entitled and for which they were paying. It was found they could not deliver the goods, to use the homely phrase, and therefore this particular benefit was lifted out of insurance and the sufferers were handed over as citizens to get their share of what the Local Authority could provide.'

1 The question as regards diabetes was raised in the House of Commons, on 15 July 1941, by Mr Collindridge; see *H.C. Debates*, 15 July, col. 512.
2 Cf. Evidence, QQ. 21,004–5. 3 Cf. *ib.* Q. 955. 4 *Ib.* Q. 10,489.

These statements look very different from the statement of the Report to the effect that the transfer took place because tuberculosis treatment in sanatoria should be open to the entire community. If effective treatment had been provided under National Health Insurance, no such change would have been envisaged; and if the arrangements for sanatorium treatment under the insurance scheme had been satisfactory, they might have been an example and a stimulus to similar provisions for the uninsured.

Seebohm Rowntree mentions the 'invalid' who goes to a sanatorium 'perhaps for six months, and before being completely cured is sent back to a poverty-stricken home where sunlight and fresh air are sometimes sadly lacking. Such conditions virtually spell death to the tubercular patient.'[1] Such conditions should not be ignored even if it appears from general statistics that progress is being made in treatment.[2] Crude death rates from tuberculosis per million living were 896 in 1931, but 635 in 1938. The figures also show that the treatment period is slowly lengthening. The figures were:

Period of treatment	1934	1938
Over 28 days to 6 months	68·0	63·9
Over 6 months	32·0	36·1

But too much should not be inferred from these figures, which may be due to various causes. The Report also mentions a slight falling off in the numbers dealt with under the tuberculosis service between 1936 and 1938: 'the reason for this falling off is almost certainly due to all available accommodation being fully occupied together with the increase in the average duration of treatment'.[3] Sanatorium benefit for tuberculosis is no longer a statutory benefit under National Health Insurance; but the question remains whether the insured worker can feel sure to-day that, if he contracts tuberculosis, he can get the 'suitable' treatment which was once promised him by the National Health Insurance Act. The legislature has seen fit to take this obligation away from National Health Insurance instead of insisting on a more efficient fulfilment of the original pledge. Accordingly it is the duty of the State to see that this obligation is now being fully endorsed and made effective in the new arrangements.

The war has again drawn particular attention to the treatment

1 Cf. B. Seebohm Rowntree, *Poverty and Progress*, 1941, p. 84.
2 Cf. 'On the State of Public Health', *Annual Report of the Chief Medical Officer of the Ministry of Health for* 1938, 1939, pp. 130 sqq.
3 Cf. p. 137.

of tuberculosis. As in the last war, there has been a considerable increase in cases over the 'normal' level. In 1914–18 there had occurred 25,000 deaths in excess of the 1913 level. In the present war, the same unfortunate development can be stated; deaths due to respiratory tuberculosis increased from 3,291 for males in the second quarter of 1939 to 3,849 in the corresponding quarter of 1941, and from 2,249 to 2,640 for females, deaths from other forms of tuberculosis from 635 to 778 and 520 to 758 respectively.[1] Beds for tuberculosis cases rose from 5,700 in 1912 to 31,600 in 1938.[2] Then there were 80 dispensaries; to-day there are over 500. But the need still exceeds the supply of beds. This, the author was told by an authority on the subject, would be apparent if more of the early cases came under medical care, instead of being grossly neglected, either because of late diagnosis or because of carelessness on the part of the sufferer.[3] The Annual Report of the Ministry of Health emphasized, in 1939, that medical practitioners no doubt were making increasing use of the dispensary service, but it was regretted that the figures did not give any indication 'that a greater number of persons are diagnosed in the early stages of the disease. This is probably due to a continued reluctance on the part of those suffering from the disease in its early stages to seek advice in good time.'[4] In spite of progress the supply of beds appears to be inadequate. It is contended that local authorities send 'hopeless cases' back to their homes to keep their available beds for cases in which curative treatment is likely to be successful.[5] This would surely not be the case if beds were plentiful; and there can be no doubt that if new methods of early diagnosis, such as by mass radiography, were introduced, the immediate scarcity of beds would at once become evident.[6]

One of the principal deficiencies is still the lack of agencies for

1 Cf. *The Policy*, 26 Feb. 1942.

2 P.E.P., *Planning Health in War Time*, 29 April 1941, p. 4.

3 Cf. for instance, E. L. Sandiland, Medical Officer of the East Lancashire Tuberculosis Colony, in the *Journal of the Royal Institute of Public Health and Hygiene*, vol. 1, 1938, pp. 46 sqq.

4 To-day, owing to the increasing use of X-ray examination, tuberculosis officers can give more assistance to practitioners than formerly. The number of X-ray examinations increased from 138,081 in 1937 to 167,735 in 1938, i.e. by 21 %. In 1938 53,306 contacts were examined against 48,411 in 1937: cf. *Annual Report of the Ministry of Health*, 1939, p. 30.

5 Cf. R. B. Thomas, *The Health Services*, Fabian Society, 1940, p. 39.

6 Cf. Report prepared by a committee of the Socialist Medical Association of Great Britain on *The War, Tuberculosis and the Workers*, reprint from *Medicine To-day and To-morrow*, June 1941, p. 9.

proper after-care, which is extremely important in tuberculosis cases. In countries where medical treatment in hospitals and sanatoria is included in sickness or disablement (pensions) benefits under insurance schemes, or where, as in Germany, industrial accident insurance imposes an obligation upon insurance carriers to try by all possible means to restore the working capacity of the injured, to secure his physical and occupational rehabilitation and to assist him in getting work,[1] a definite stimulus to after-care is given. In Germany the Federal Insurance Office constantly stressed the necessity of early and speedy treatment;[2] and it was in the interest of the insurance carriers themselves to see permanent invalidity prevented.[3] The possibilities of restoring health by proper after-care are widely and increasingly recognized, for instance, by the International Union against Tuberculosis.[4] But in this country we hear from an authoritative source that 'it is regrettable that no very great progress has been made in the after-care and re-employment of tuberculosis persons during the last ten years'.[5] The burden of the benefit, so far as it is available, once more rests largely on experiments by voluntary bodies. The National Association for the Prevention of Tuberculosis does invaluable work and propaganda, just as the Central Council for the Care of Cripples does in the case of fractures. There is the excellent sanatorial village settlement at Papworth, an entirely new type of institution, where the tuberculosis person is treated as a permanent sociological problem as well as a temporary medical one.[6] Papworth will be always connected with the fame and work of Sir Pendrill Varrier-Jones. There is Preston Hall, established in 1920 by a body of philanthropic workers and taken over in 1925 by the British Legion, a daughter-settlement to Papworth. There is Barrowmore Hall Sanatorium and Colony. All these enjoy the constant praise and assistance of the Ministry of Health. Yet, as in the case of the training and rehabilitation centres for fractures, they remain model schemes to be highly praised, but of very small importance in the socialization of after-care treatment for tuberculosis workers. The number of beds provided by Papworth, for instance, was 490 on 31 March 1939.[7]

1 *Reichsversicherung*, III. Unfallversicherung, para. 558a.
2 Cf. Circular issued by the Federal Insurance Office on 21 Oct. 1937.
3 Cf. *Economical Administration*, p. 197.
4 Cf. International Union against Tuberculosis, Committee for After-care and Rehabilitation: *After-Care and Rehabilitation*, by E. Brieger, Oct. 1937.
5 Cf. Sandiland, *loc. cit.* 6 Cf. Brieger, *loc. cit.* pp. 119 sqq. for the following.
7 Cf. *Annual Report of the Ministry of Health*, 1939, p. 30.

Local authorities may take advantage of such institutions. It has even been suggested by Sir Pendrill Varrier-Jones that a central organization should be created to take over the village settlements and be responsible for the construction of new ones. The local authorities should be directed to send all suitable cases into the settlements and be asked to pay 10*s*. a week for each settler and member of his family. Unfortunately such aims appear to be chimerical. It is true that some local authorities have included the populating of after-care tuberculosis settlements in their programmes, as the London County Council in the case of Papworth and Preston Hall, but local authorities in general appear to have little interest in the matter. In 1935, although five years had gone by since the Ministry of Health required local authorities to establish village settlements or to attach them to their sanatoria, there had been only one isolated plan which received the support of the Ministry.[1] And even the extension of the most important of these after-care institutions, such as Papworth, is hampered by 'lack of capital'.[2] Actually, the success of Papworth and Preston Hall and similar medico-industrial organizations has been largely due to the constant flow of orders into their factories and workshops. 'Those who know best the inner histories of Papworth, Preston Hall, Wrenby Hall and other schemes for rehabilitation of the tuberculous, are well aware of the apathy which characterized a large number of local authorities in supporting the work both from the medical and industrial aspects', recently observed a writer in the *Lancet*.[3]

The International Labour Office in its Report on the Economical Administration of Health Insurance Benefits declared in 1938,[4] in connection with the treatment of tuberculosis, that 'the British Health Insurance Scheme may be cited as an instance of a centralized, uniform system'. This may easily lead to misconception. It is true that the tuberculosis officer must be notified of all cases of the disease, and that in this respect a close and useful contact exists between him and the insurance practitioner. Moreover, the Ministry of Health urges insurance practitioners to report such cases, so that the officer can also examine them and, if necessary, have suspects cared for by the tuberculosis dispensaries. The treatment may then be carried out at home or in an institution. This, however, is only the formal side of the matter. The

1 Cf. Brieger, *loc. cit.* pp. 125–7.
2 Cf. *Annual Report of the Ministry of Health*, 1939, p. 30.
3 Cf. *Lancet*, 27 Jan. 1940. 4 See *loc. cit.* p. 131.

practical question is whether or not sufficient institutional accommodation exists for the tuberculosis patients; and the point is that, if tuberculosis treatment were a statutory obligation under National Health Insurance, existing facilities for institutional treatment and after-care might be far greater than they are. The so-called 'centralized' system has nothing to do with this; and a decentralized system might, in districts with a large incidence of the disease, prove more effective in providing the necessary comprehensive and adequate institutional service. Moreover, the tuberculosis worker is still dependent for cash relief on the meagre benefits[1] under National Health Insurance. The great majority of potentially curable cases go to a sanatorium (if accommodation is available) for three to six months. During this period most scheme-making authorities make no charge to the patient, and the cost per bed per week may be as much as £5. This is generous indeed. But once the patient leaves the sanatorium, the position changes. Although he has now to undergo a period of home treatment and dispensary supervision, of convalescence and rehabilitation before he is fit to return to work, his National Health Insurance benefit will have been dropped to 7*s.* 6*d.* per week, which will not suffice to keep him, even with the extra nourishment supplied (though not as a right) through the local authority. This will increase the temptation to start work too early.[2] The separation of treatment benefit from cash benefit thus creates a gulf which must have a most undesirable effect upon the worker's health and social conditions.[3] If there is deterioration or relapse the old problems come up again. 'Much needless hospitalization results from failure to restore patients fully to health after illness', is a dictum particularly applicable to this case.[4] It may well be submitted that the insured worker in Britain has not found in the extended facilities for treatment outside National Health Insurance any satisfactory compensation for the medical benefit which, at the inception of the National Health Insurance scheme, was contemplated.

The position of out-home treatment seems to be more satisfactory as regards convalescent homes, the cost of which, as we have seen, ranks third in the amount annually allocated as additional treatment benefit. The amount was actually more than

1 See p. 87. 2 See below, p. 205–6.

3 Cf. for some very interesting details as to this point, *Medicine To-day and To-morrow*, June 1941, *The War, Tuberculosis and the Workers*, pp. 6–8.

4 Cf. Report of the New York Academy of Medicine in *Lancet*, 13 January 1940.

twice as large as that spent on hospitalization. Yet, important as convalescence certainly is, cure and medical restoration proper should be the first concern of any sickness insurance scheme. It is not to the credit of such schemes if the easier tasks are better tackled than the more complicated and difficult ones. Treatment in convalescent homes has as its object the provision of maintenance and treatment to persons who have been ill and have not completely recovered. The home is generally recommended to the patient by the panel doctor. Sometimes approved societies may purchase premises suitable for convalescent homes (Additional Benefit No. 12), but such procedure only recommends itself 'in exceptional circumstances' and where societies 'have a sufficiently large number of members'.[1] To-day there are between 400 and 500 convalescent homes in Great Britain, with some 24,000 beds, that is about 54 per 100,000 of the population, and some 250,000 persons per annum make use of them. As Political and Economic Planning points out, there is one bed in convalescent homes to eight beds in all voluntary hospitals and in all public general and infectious diseases hospitals.[2] The number is not adequate, and more homes are needed. Here again the lack of a statutory provision necessitates the efforts of charitable aid. 'The provision of homes for adults and children recovering from illness is one of the most popular as well as one of the most valuable forms of charity', writes Elisabeth Macadam in her very suggestive study on the social services.[3] While she stresses the fact that some homes are all they should be, she draws a very gloomy and disturbing picture of others and puts forward the case for unified standards of administration. Such standards and general efficiency can hardly be expected on a merely voluntary and charitable basis; were treatment in convalescent homes a statutory benefit under National Health Insurance the prospects of such standards being developed would be far greater.

The pioneers of sickness insurance foresaw the growing importance of hospital treatment, for both in- and out-patients. The services actually rendered by National Health Insurance have not proved worthy of that foresight. Hospital treatment has probably been the scheme's greatest failure. It has not been possible to include hospitalization among the statutory benefits. Where special hospital treatment has come to appear unavoidable, there has

1 Cf. *Approved Societies' Handbook*, pp. 230–31.
2 Cf. *P.E.P. Report*, p. 269.
3 Cf. E. Macadam, *The New Philanthropy*, 1934, pp. 122–3.

been a tendency to withdraw it from National Health Insurance altogether, as in the case of tuberculosis; and this tendency looms in the background of the expected reforms in fracture treatment and physical and vocational rehabilitation. Nowhere has any stimulus come from National Health Insurance. The sick worker tries to fill the gap by contributions to other, voluntary, schemes; a reversion to methods which were the rule before 1911 and which National Health Insurance was meant to supersede. Where self-insurance is not provided the sick worker is treated as a destitute person, in so far as he is not able to pay at least part of the costs of hospitalization treatment. The great moral worth of social insurance by collective contributions against common risks is thus lost. Whether he is in one of the former Poor Law hospitals or in a public municipal hospital, he remains a non-paying patient with the appropriate stigma. The idea of social insurance is nullified.

We have examined whether the deficiencies of National Health Insurance have been compensated by the progress of institutions outside of National Health Insurance, and the result of our enquiry has been disappointing. The basic fact is that the supply of hospital accommodation is insufficient. Insufficiency of beds, long waiting lists and overcrowded out-patient departments remain, and all affect the sick worker most. 'Institutions for the care of the sick have developed particularly rapidly in countries in which the insurance scheme provides institutional treatment as a benefit in kind or enables the insured persons to enter institutions by paying part or the whole of the cost, or where the insurance institutions direct their investment policy towards the erection, maintenance or improvement of hospital institutions and their equipment', writes the International Labour Office in the light of its far reaching investigations.[1] England is not among such countries. It has more and more dissociated hospital benefit and treatment from the insurance scheme.

From the English practice of separating hospitalization from National Health Insurance has sprung the further disadvantage of separating the panel doctor from the hospital stage of treatment. The lack of connection between panel doctors and hospitals is due to the fact that National Health Insurance ranks hospital benefit as a secondary matter under additional benefits. Moreover, the system of payment of panel doctors has further encouraged the tendency to get rid of their patients by sending them to hospital whenever possible. The contact between panel doctor, patient and

1 Cf. *Economical Administration*, 1938, p. 97.

hospital is broken; yet contact 'between those who have the clinical concern with patients and those responsible for the improvement of their domicilary, environmental and social circumstances' is a fundamental condition of proper treatment.[1] The panel doctor is isolated from both hospitals and specialist medicine.[2] The International Labour Office has pronounced that 'the practitioner must try to make the best use of the possibilities of the hospital for the patient at any given moment and keep in constant touch with the hospitals in his district so as to discuss diseases and obtain further knowledge'.[3] In England, we read: 'The individual passes from local authority to voluntary body, from consulting room to clinic or hospital, from private to official doctor and often back again, to obtain from many unrelated agencies a service which could be more efficiently provided as one co-ordinated whole.'[4]

The development of National Health Insurance is to a large extent responsible for this chaotic state of affairs in medical treatment. The Royal Commission evaded the issue and declined to include hospital treatment among normal benefits. It applauded the work of private saving or thrift, instead of raising compulsory thrift to a level, which in conjunction with the contributions of employers and the State might have guaranteed adequate treatment in hospitals and similar institutions. Is it to be wondered that the British Medical Association asserts that 'the hospital situation in this country has become exceedingly complicated'?[5] It is hardly explicable how, at the same time, the British Medical Association could come to the conclusion that, on account of 'practical considerations', the opinion of the Royal Commission,[6] and of the Departmental Committee on Scottish Health Services of 1936, should be upheld 'that the inclusion of hospital provision in an insurance service is not possible'.[7] The reasons mentioned by the British Medical Association are the co-existence of the two hospital systems and the special character (historical, administrative and scientific) of the voluntary system; the inadequacy of hospital accommodation; and the existence of large contributory schemes. This means that the National Health Insurance scheme as far as hospital provision goes is considered a complete fiasco.

1 Cf. the most illuminating article in *Public Health*, June 1941, p. 153; cf. also B.M.A., *Report of Committee on Industrial Health in Factories*, 1941, pp. 21 and 30.
2 Cf. *Report on National Health Insurance*, para. 280.
3 Cf. *Economical Administration*, 1938, p. 96.
4 B.M.A., *A General Medical Service etc.* 1938, p. 7.
5 Cf. *ib.* p. 21. 6 See above, p. 171. 7 Cf. *ib.* para. 44.

Instead of trying to remedy this failure, it is suggested that National Health Insurance should be left as it is, and that the co-ordination of the two systems of hospitals should be developed to secure efficient co-operation with each other, and to make the available hospital accommodation adequate. Apparently the hope that the deficiencies can be remedied by a reform of National Health Insurance has vanished.

It should, however, be evident that the lack of any comprehensive hospital service under National Health Insurance is due in the first instance to the system of National Health Insurance itself as, in contrast to other countries, it has been adopted in Britain.

D. PHARMACEUTICAL BENEFITS. NURSING. THE ROLE OF THE INSURED.

CHAPTER XIX. MEDICINES AND APPLIANCES

'Dios que dá llaga,
dá' la medicina.'
('God who sends the wound sends the medicine.')

Don Quijote, II, 19.

'Though I hate doctors, I love medicines.'

OSCAR WILDE, *Lord Arthur Savile's Crime*.

'The cripple, and still more the potential cripple, no longer has to face a future of pain and wretchedness. He hears instead the inspiring words "Arise and Walk" which were said to his prototype 2,000 years ago, and knows that modern orthopaedic methods can make good the cheering message.'

From the *Handbook on the Welfare of Cripples*, The Central Council for the Care of Cripples, 1937.

DIAGNOSIS and treatment by the doctor, the dentist, the ophthalmologist and the specialist, and access to hospitals, sanatoria and convalescent homes, these are everywhere the primary needs of medical benefits under national insurance schemes. We have tried to describe and analyse how far, and how far not, these needs have been sufficiently provided by the British legislation. Second in significance to these, though in many ways of fundamental importance to the patient in regard both to the efficiency of his cure and to the degree of his future capacity to work, are those medical benefits which may be described as pharmaceutical benefits. They consist in the supply of medicine and appliances. The latter, again, comprise a great variety of aids, such as surgical

appliances, artificial limbs, dentures, glasses or even perambulators. (All these very different benefits may be usefully grouped together under the heading of pharmaceutical aid or benefits.)

The supply of medicine offers very real difficulties. In 1911 the idea was to build up, as Mr Lloyd George proudly proclaimed, a system giving the best drugs in the market in ample quantities to the insured. In a few years it was recognized that financial considerations nullified this expectation.[1] Actually the supply of drugs deteriorated. Reforms have been carried through, and the radical evils described by Dr Brend in 1917 have been eliminated. The problem is to balance the supply of medicine, which on purely medical grounds may appear to be necessary, with the financial resources of the National Health Insurance scheme.

We are not, at this stage of our enquiry, interested in the question of what is called 'excessive prescribing', which is of importance as regards the economical administration of National Health Insurance. At this juncture we are merely interested in what medical benefits the insured is entitled to and what he is actually able to get. We can also pass with a few words over the question of the quality and kind of medicine and drugs supplied to the insured. Fortunately, the conflicts which are still prevalent between pharmacists, doctors and what are sometimes called 'other vendors' in the general sphere of the supply of medicine[2] have been avoided under National Health Insurance. Medicines, as well as simple appliances, are ordinarily prescribed by the panel doctor and supplied by a chemist; only in specified circumstances are they supplied by the practitioner himself.[3] For the service of chemists is drastically fenced so as to provide a full guarantee for the insured that he will get what he should get according to the doctor's prescription.[4]

1 Cf. Brend, *loc. cit.* pp. 232–3.

2 Cf. for instance, *The Economist*, 12 July 1941: 'The Druggists' Dilemma'.

3 In 1939 insurance chemists received £2,308,900 for the supply of drugs and appliances; only about £211,000 was paid to doctors for medicine and appliances supplied by them personally for medicines dispensed by them in country districts where patients are out of reach of chemists, *Annual Report of the Ministry of Health*, 1939, pp. 141–2.

4 The National Health Insurance Act provides that the insurance committees shall prepare and publish lists of persons willing to supply drugs, medicines and appliances to insured persons; but those who may be included on these lists are registered pharmacists or authorized sellers of poisons within the meaning of the Pharmacy and Poison Acts, 1933, and who undertake that all medicine supplied to insured persons under these arrangements shall be dispensed by or under the direct supervision of a registered pharmacist (or by

There may be differences of opinion as to whether an article ordered by an insurance practitioner is a drug or appliance forming part of pharmaceutical benefit. In questions of doubt the matter is referred to the panel committee of the area in which the question has arisen, or, on appeal by the practitioner, by the insurance committee or by the pharmaceutical committee from the panel committee's decision, to a body of referees appointed by the Minister; when it appears to an insurance committee that what was ordered is not a drug or a prescribed appliance,[1] they may notify the practitioner that they propose to withhold the cost of supply from his remuneration, but the practitioner may require the question to be referred to the panel committee for a decision. A special 'advisory' committee on the definition of drugs for the purpose of medical benefit, appointed by the Minister, has classified a large number of substances upon which the question has from time to time arisen, under three heads:

(*a*) Never a drug.
(*b*) Always a drug.
(*c*) Sometimes a drug.

It is evident that this provision, too, relates more to the danger of over-prescribing than to that of limiting the supply of medicine under National Health Insurance. At any rate, there is no reason to assume the contrary, although a complaint[2] mentioned recently by Dr Morgan in the House of Commons shows that disadvantages of a too narrow interpretation of what medical supplies actually are may arise. In principle, the National Formulary of the Insurance Acts Committee of the British Medical Association which has been worked out for this purpose does not restrict the panel doctor rigidly to its list. No definition of the requisite 'drugs' has yet appeared to be admissible. There is no wish to stereotype prescribing, and any practitioner may write extemporaneous prescriptions whenever he desires, independently of the formulary of the drug tariff.[3]

The possible deficiencies in the supply of medicine under National Health Insurance arise not in regard to special types of medicine but far more in a general way. Section 39 of the Act

a person who, for three years immediately prior to 1911, has acted as a dispenser to a practitioner or public institution). (Cf. N.H.I. Act, 1936, section 41 and N.H.I. (Amending) Act, 1937, which deals in particular with the matter of medicine supply.)

1 See below, Ch. XXXI. 2 Cf. *H.C. Debates*, 15 July 1941, cols. 519–20.
3 Cf. *National Formulary of the B.M.A.*, p. 6; cf. also *P.E.P. Report*, p. 147.

places insurance committees under the obligation of making arrangements for the supply of proper and sufficient drugs and medicine, while 'medical attendance and treatment' is interpreted as including 'the provision of proper and sufficient medicines (including such chemical reagents as may be prescribed').[1] The practitioner by his terms of service is required to 'order such drugs and prescribed appliances as are requisite for the treatment of any patient'. The Ministry of Health in 1936 emphasized that the practitioner in charge 'must decide what is "requisite in a given case", and if he is satisfied that a particular drug or preparation is necessary for treatment, it is his duty to order it. The fact that the drug is expensive should not deter him if it is really required; the criterion is not cost, but necessity.'[2] So far it appears an ideal arrangement for the insured person. Unfortunately this is not the end of the matter. 'But while the practitioner', continues the official Report, 'may order drugs as he considers requisite, he is not entitled to go beyond what is necessary, either in character or quantity. The Drug Fund is sufficient for all reasonable requirements, but it is not unlimited in amount, and it is the duty of the Minister to see that, so far as possible, it is expended to the best advantage.' There is after all a limitation placed upon the insurance practitioner on financial grounds.[3]

Even if due regard is paid to the dangers of excessive prescribing and the necessary limitation of the doctor's freedom to prescribe in that respect, there remains the fact that this freedom may become restricted, to the disadvantage of the insured, by the machinery of administration. Far-seeing sickness insurance may lay great stress on dietetic treatment.[4] Doctors may be inclined to prescribe pharmaceutical brands which are on the borderline of medicine, such as certain beverages, stimulants and laxatives.

1 Cf. N.H.I. Act, 1936, Part XII, section 226.

2 Cf. *Annual Report*, 1939, pp. 142–3.

3 Cf. also Foster and Taylor, *loc. cit.* p. 150. The Minister determines the amount appropriated for this purpose (the provision of drugs) out of the moneys available for defraying the cost of Medical benefit. The amount thus appropriated forms the Chemists' Central Fund. Each insurance committee is required, for this purpose, to furnish the Minister with information as to accounts tendered to them each year by persons supplying drugs. The Chemists' Central Fund is apportioned amongst the several insurance committees by the Minister after consideration of the Pharmaceutical Distribution Committee's Report on the matter. This Committee is appointed by the Minister and consists of registered pharmacists and other persons.

4 In some States the insurance funds have organized dietetic kitchens at which meals in accordance with various types of diet are served at given hours, cf. *Economical Administration*, pp. 87–8.

In Germany wine and other alcoholic beverages are allowed, if they have a therapeutical effect, others only where life is in danger; similar arrangements relate to effervescent salts and mineral waters. The test for the prescribing doctor is absolutely the therapeutical efficiency of such 'medicine'. In Czechoslovakia, wine and other beverages may be prescribed in special circumstances. In Great Britain food-like substances are not included in pharmaceutical benefit, and the Scottish Memorandum on Prescribing makes a special point that preparations which are in the nature of foods or mineral waters are not a proper charge on the drug fund.[1] It may well be argued that the inclusion of food-like medicines might lead the doctor, in poor districts, to administer not so much pharmaceutical aid as social assistance. On the other hand, if a progressive scheme of workers' sickness insurance should be envisaged the 'social' doctor ought to be able to lay stress precisely on this point, the improvement of the patient's health, if possible by improvement of his nourishment. The International Labour Office holds the opinion that therapy should include improved food, as a medical benefit related to treatment by the insurance practitioner, but it adds that this presupposes, not only an understanding on the part of the practitioner, but also a contract with the institution which can take the necessary measures, and the support of the insurance fund.[2] In many cases, because of the insufficient means of the insured, transfer to a hospital is the only way to secure the proper food necessary for his cure. There seems no logical reason why, in such cases, the food he needs should not be prescribed as a medical (pharmaceutical) benefit at home—within certain limits. The panel doctor may find himself between two stools. On the one hand he may feel inclined, very naturally, to prescribe whatever he thinks necessary or desirable. 'Trammeling the practitioner's freedom of treatment and prescription', as a meeting of International Labour Office experts put it in 1934,[3] is certainly not desirable. On the other hand, the need for strict economy acts like a brake. Here is the scylla and the charybdis of pharmaceutical benefit.

1 Cf. *Economical Administration*, pp. 191, 159 and 219; *Memorandum on Prescribing and Tariff for Drugs etc. of the Department of Health for Scotland*, p. 15.

2 Cf. *Economical Administration*, pp. 85 and 88.

3 In 1934 the I.L.O. decided to call a meeting of experts to study the question of medical and pharmaceutical benefits under sickness insurance with a view to comparing the experience made in various countries. Cf. *Economical Administration*, p. 301.

Before the doctor is blamed for having been too liberal in prescribing medicine, the State should take into account the fact that a vast industry producing pharmaceutical commodities has arisen with no other object than to increase the medicine-mindedness of the population. The effort to do this does not altogether spring from consideration of the public's need. Frequently, the fear and ignorance of sufferers are exploited for commercial gain. There have been improvements as regards the sale and advertisement of these 'medicines' since the first revelations of the British Medical Association at the beginning of the century and the Report of the Select Committee on Patent Medicines in 1914.[1] Yet the International Conference of National Associations of Health Insurance Funds and Mutual Aid Societies observed in 1933 that 'preparations of particular make, so called pharmaceutical specialities, and preparations sold under trade mark bought in the market in large quantities and widely advertised, frequently raise the cost of prescribing without any benefit to the patient'.[2] Hardly any Bill goes through the House of Commons touching pharmaceutical matters where complaints of this kind are not brought forward.[3] It is very difficult to say what the real reason is for the pharmaceutical infatuation of the working classes. The motives seem to be so heterogeneous that there is no general explanation. Even geographically there are wide variations. Mr E. G. Bearn, Deputy Controller of Health Insurance, Ministry of Health, told a Royal Commission, when asked whether the amount of illness or the number of prescriptions or the amount of medicine dispensed had got more or less in recent years, replied: 'That varies in a large degree according to the place where the insured person lives. In Scotland they drink less medicine than in England, where they are particularly fond of medicine. I would hesitate to take as an index of the effect of medical treatment under the Insurance Act the actual amount of medicine consumed.'[4] The Under-Secretary of State for the Home Office, Mr Peake, said, during a debate on the Pharmacy and Medicine Bill of 1941, that he thought the practice was 'common in the north of England, of taking along to the chemists a prescription not provided by a doctor but taken out of a newspaper or handed down from one's grandmother'.[5]

1 Cf. *More Secret Remedies*, B.M.A. 1912; *P.E.P. Report*, p. 57.
2 Cf. *Economical Administration*, p. 307.
3 One of the latest examples was the discussion on the Pharmacy and Medicines Bill, House of Commons, debate of 15 July 1941, cols. 563 and 558.
4 Cf. Royal Commission on Workmen's Compensation, 30 March 1939, Q. 1199.
5 Cf. *H.C. Debates*, 15 July 1941, col. 555.

The *Lancet* reported in 1937 that, while in Manchester and Salford the cost of 'prescribing' under National Health Insurance was 54·7*d.* and 56·6*d.*, in Middlesbrough and Darlington it was only 27·8*d.* and 28*d.* Such discrepancies cannot yet be explained.[1] The panel doctor's prescribing is very closely scrutinized, and no consideration is paid to the fact that he may feel inclined to give way to the people's demand for medicine in a liberal way. But there cannot be the smallest doubt that one of the ways of reducing self-medication by unprescribed and much advertised patent medicines and drugs would be to exhort panel doctors to point out to patients that they should take prescribed medicines only, and to warn them of the dangers of swallowing pharmaceutical 'remedies' indiscriminately and without the knowledge or advice of a doctor.

It is to be regretted that the Royal Commission's Report paid little attention to the matter of pharmaceutical benefit, and even refrained from dealing with the important statements made in evidence. The most important was that of the representatives of the National Medical Union:

Q. 15,881. 'Is there any reason why you should not if you were on the panel do everything for your patients which you at present do?'

A. (Dr Comber). 'Yes, distinctly.'

Q. 15,882. 'What?' A. 'There is the question of the restriction of the drug bill, a most iniquitous thing, I think.'

Cm. 15,883. 'Tell us about that. Supposing you prescribe a drug, what happens?' A. 'You must remember this, areas vary, and if you have an area with a large number of 6*d.* dispensaries the average cost of prescription must go down in that particular district, and even if in a particular district I thought a more expensive drug ought to be used there would be an enquiry. No doubt I should be exonerated, but there would be all the worry and trouble of it.' The witness then explained that the so-called 'drug limit' would be regarded as having been exceeded if 'prescriptions were a fraction of a penny, or a penny and some fraction, over the average of that particular area'. The witness stressed that, while 'as a matter of law there was no restriction of the drugs to be prescribed, in practice there distinctly is'.[2] Prof. William Russell, Vice-president of the Scottish Medical Guild, told the Commission that a chemist had told him 'that he was out of pocket

1 Cf. *Lancet*, 14 Aug. 1937.

2 Cf. *ib.* QQ. 15,890–94.

in the drugs he dispensed to insured people, and to be in pocket he would require to get an inferior quality of drug, which he refused to do, and he came off the panel of chemists'.[1] A representative of the Joint Committee of Approved Societies declared:[2] 'As regards drugs, miserable petty surcharges have been made upon some doctors because in their discretion, which would have been unchallenged with a private patient, they prescribed a 5-grain pill, and it was alleged—I am speaking from personal knowledge—that a 4 or 3-grain pill would have been as efficacious. It is a sin too for a flavouring essence to be put into an insured person's medicine.'

The statement is suggestive in many ways. It adds to what we have already seen of the distinction in treatment between private and insured persons. But here the distinction is certainly not the fault of the doctor but of the regulations. It explains why insurance patients may be driven to prefer un-prescribed medicine which, on account of better flavouring, may appeal to them more. This witness tried to make it quite clear to the Commission that deficits in Drug Funds were not to be regarded as the result of over-prescribing, but of 'the doctor. . .prescribing as his conscience directed him'; and that 'it is only the process of surcharging which has compelled him to alter his own personal freedom in that matter'.[3]

If one compares this evidence with the debate on National Health Insurance of 15 July 1941, one is struck with the similarity of complaints in the twenties and now. Actually nothing has changed since the Royal Commission's Report. A doctor said in the debate[4] that he gave to a hay-fever patient an order for a 25 c.c. bottle and was challenged by a Ministry of Health official as to why he had not given it in one drop or two drop capsules. The doctor had to explain that a series of doses had to be given and that it was cheaper to do it in the way he had chosen. The official, however, wanted to know what the doctor had done with two minims he could not account for. 'I had to explain for nearly

1 Cf. *ib.* QQ. 16,019–20. 2 Cf. *ib.* A. 8029.

3 Cf. *ib.* Q. 8094; the complaints we have mentioned were denied by representatives speaking for the other side, i.e. the Pharmaceutical Committees, cf. QQ. 18,678 sqq. Yet even they had to agree that it happened that a chemist suggested to the patient 'that he would make this up according to the doctor's prescription, but if they were paying for it he [the chemist] would be able to use better drugs', cf. A. 18,684; such cases were, however, represented by this side of the evidence as merely 'exceptional examples'.

4 Cf. *H.C. Debates*, 15 July 1941, col. 520.

an hour to this man—he ought to have known—that in giving hypodermic injections one occasionally lost a drop or two.' In such circumstances panel doctors will be inclined to err on the side of safety and restrict pharmaceutical benefit. They must be anxious to avoid the worry and costliness of proceedings and interrogations which, even if they fail to disclose any fault on the part of the panel doctor, are a source of great inconvenience to him. In 1938, for instance, there was a case where the panel committee were of opinion that there had been excessive prescribing. In view of the explanations given by the practitioner, the Committee found itself unable to assess the amount of excess and recommended that no action should be taken. The Minister, dissatisfied with this decision, appointed persons to hear and determine the matter in accordance with the provisions of Regulation 43 (6) of the Medical Benefit Regulations, and the persons appointed estimated the excess cost to be not less than £10. In two other cases (compared with 1 in 1937 and 6 in 1936) the Minister informed doctors that, while it appeared to him that notwithstanding their explanations there was a prima facie case for referring the matter to the panel committee for determining whether an excessive charge had been made on the funds 'available for medical benefit,'[1] he would refrain from that course because 'he was satisfied of their intention not to give occasion for such reference to be considered in the future'. The cases where action was taken were few: 8 in 1936, 6 in 1937 and 7 in 1938. Of four cases which the Minister referred to panel committees for general consideration, the panel committees were in three cases of opinion that excess cost had been incurred but that no further action should be taken. There were also three appeals against the panel committees' decision, and in one it was found that the excess cost imposed was less than found by the panel committee. Regional Medical Officers, however, had paid 602 visits in 1938 (compared with 861 in 1937), which is not a small number when compared with the paucity of the result as to action taken. On the other hand, the Report of the Ministry spoke of 'most cases' as 'relatively minor departures from a reasonable standard of prescribing', which seems to corroborate the view that doctors have to be in constant anxiety about overstepping the narrow limits of too much or too little.

1 It may be noted again, not the necessity but the financial expediency was emphasized, though the Ministry had explained before that 'the criterion' should always be 'not cost, but necessity', cf. *Annual Report*, 1939, p. 143.

Restrictions of this kind contrast badly with the wide freedom left to propagation of drug and medicine-taking by advertisement and the exhortation of an ignorant public. While far too little is done to restrict this excessive and detrimental use of medicine, the strictest limitations are set on grounds of financial necessity to National Health Insurance pharmaceutical benefit wherever it may appear even slightly in excess of what appears to be 'necessary'. From the national point of view the position is highly paradoxical.

There can be no doubt that the difficulties as they exist are to a large extent due to the administrative structure of National Health Insurance. In other countries the safeguard against excess-prescribing is far more sought in general criteria of the panel doctors' methods than in investigations of single cases of prescribing. In Germany, for instance, there is a certain standard of prescribing fixed between the central federation of the sickness funds and the association of panel doctors (Kassenaerzliche Vereinigung). The standard represents the average amount per case treated. If the cost of prescribing medicines exceeds the so-called standard cost, the doctor can be liable for part of the excess. But there is a degree of elasticity in so far as the central federation must claim a refund of any repeated excess. Such a claim, however, can only be made in respect of an insurance practitioner whose 'average' cost of prescribing exceeded the standard cost of prescribing or amounted to at least 80 % of that cost. The practitioners are then warned 'that their average cost of prescribing is high'. But they can only be made liable for any repeated excess within the two years following the quarter for which they have been so warned. The test, then, is not the single case, but a period of experience with the particular doctor's habits of prescription and a comparison of his average cost with the standard cost laid down. A territorial fund intending to claim damages computes the practitioner's average case expenditure for the quarter of the year under review. If this expenditure is in excess of the standard cost of prescribing (see above), i.e. the average amount per case treated, the fund submits a claim for damages to the doctor's association. But the important factor is that the panel doctor must have overstepped on an average what he was expected to prescribe.[1] In Britain, however, it is the single case that must be adjudicated.[2] Here lies a decisive difference.

1 Cf. for further details, *Economical Administration*, pp. 208–9.
2 Cf. *ib.* p. 237.

Under the English system[1] stress is laid on extravagance in single cases of treatment when a consideration of the general attitude of the doctor to prescribing over a period would be fairer and more reasonable, so that the honest panel doctor could feel that he does not run the risk of costly and worrying enquiries when, now and then, he oversteps the so-called 'necessary' prescriptions without making a regular practice of it.

While, at least in theory, no definite limitation is imposed on the panel practitioner as regards prescribing, this is not so in respect of appliances. Here several arrangements have to be distinguished. Appliances can be supplied as part of medical benefit or as part of additional benefits. In the first case, only those appliances can be supplied which are included in the 'list of prescribed appliances'. This list contains all the dressings, such as ice-bags, splints, etc., which are in common use, and additions are made, from time to time, after consultation with representatives of the profession in order to bring in such things as elastic adhesive bandages, wound-dressings, etc.[2] But a sharp distinction is drawn between these 'appliances' and things, which in ordinary parlance, would be considered as appliances proper, such as artificial limbs, crutches, trusses, spectacles, dentures and so on, which are required not so much for treatment as to compensate for physical defects by mechanical means. All such appliances are available to the insured only as additional benefits. In general under number 13: 'The payment of the whole or any part of the cost of medical and surgical appliances, other than dental and optical appliances, and those provided as part of medical benefit.' Dental and optical appliances, mainly dentures and glasses, which are already included in these special additional treatment benefits, do not come under this heading. Here, then, is the same old limitation that applies to all additional benefits, namely that they depend upon the financial position of the insurance carrier.

The distinction drawn between the two kinds of appliances appears to medical men and others as absolutely arbitrary. This point was stressed by Dr Smith Whitaker before the Royal Commission. In the case of a truss, for instance, the question is not only that of remedying a defect, but also, if it is a case of hernia, of protecting the person against a serious risk of life. In the case of spectacles a man's entire working capacity may be risked if he

1 Cf. *ib.* p. 236.

2 Cf. section 39 of the Act; also *Annual Report of the Ministry of Health*, 1939, p. 142.

has to do without them.[1] The justice of including in the ordinary benefits the appliances that are only included to-day among additional benefits was not disputed by the framers of the British legislation. When the list of prescribed appliances was first drawn up in 1912, the question of these appliances was carefully examined. The Commissioners[2] took the view that, as Parliament had given them complete discretion as to the appliances that should be prescribed, they must have regard to the kind of burden that would be imposed on the Insurance Fund by a very wide list of appliances. There were other scruples: a liberal inclusion of mechanical appliances in benefits might, it was argued, be an inducement to extravagance. This apprehension was carried so far that it was suggested that a truss could even be sold by the disabled; apprehensions which were repeated by officials of the Ministry of Health before the Royal Commission.[3] Not to include these appliances, observed one of them, was 'guarding yourself against very serious abuse'. The position of the insured people was hardly taken into account; such things as trusses 'are usually easily obtainable through charitable organizations, such as the Surgical Aid Society', it was argued. This argument, unfortunately, finds a refutation in the Annual Reports of the Society; in its 1940 Report, for instance, it was stated: 'if they had enough things to go all round it would be easy, but there never was enough to go all round, that was the trouble. It was up to them to find out, first, which were the urgent cases, then the very urgent, and then the most urgent, and finally they got those who were to be helped.' It appears, therefore, that just the reverse is happening to what was suggested to the Royal Commissioners. Not only are appliances not 'easily obtainable' through the efforts of this institution, the services of which are beyond praise, but only a section of the actual need can be satisfied.[4]

Certain regulations which apply to the provision of medicines and drugs also relate to the provision of appliances as additional benefits. Before authorizing any application for the additional benefits, the approved society must carefully satisfy itself that it is not included in the schedules which set out certain 'prescribed' appliances as part of medical benefit. The cost of repairing appliances also comes within the scope of additional benefit. But

1 Cf. Royal Commission, Evidence, A. 1319.
2 See above, p. 19 for their functions.
3 Cf. Evidence, A. 1313 and A. 1319.
4 Cf. The Royal Surgical Society, 77*th Report*, 1940, p. 45.

in the case of applications for more expensive appliances, such as invalid chairs, the society may find it economical to authorize hiring instead of purchase. On the other hand, a society is not entitled to limit benefit of this kind to specified appliances to the exclusion of others. There are regulations as to the part-payments to be made by the society. Ophthalmic benefit includes the provision of optical appliances, including payment for the provision of artificial eyes (additional benefit No. 13 also includes aids to hearing). Repair or renewal of glasses is included, with certain safeguards against abuse; this does not exclude the provision, where necessary, of two pairs of glasses. Under dental benefit the provision of artificial dentures, their repair and remodelling, is expressly provided by the Dental Benefit Regulations (see Statutory Rules and Orders, 1936, No. 426). There are Regional Dental Officers among whose advisory duties it is to examine for Approved Societies the quality, workmanship or fitting of dentures. In contrast to the arrangements under ophthalmic benefit, there is a statutory form of 'letter' for dental benefit.[1] The formal framework, apart from the limitations set in principle, seems satisfactory; but the effect of these limitations is to render the scope of the benefits insufficient.

The Royal Commission completely disregarded this very important matter of appliances. A small paragraph of fourteen sentences was devoted to it,[2] containing such statements as that 'for the most part it is not an expensive benefit, though the average cost per case in some societies has been between 30*s*. and 40*s*.' But the small amount of money spent on the average case only demonstrates the insufficiency of the benefit in practice, for everyone knows that artificial limbs or complicated surgical appliances are not inexpensive, and an enquiry to the Royal Surgical Aid Society would have furnished the Commissioners with ample evidence of this. In any case reference to the 'average' cost per case is beside the point: it is the lack of proper help in the more serious cases, which inevitably require a substantial outlay, that is the main substance of complaint. But the Commissioners were apparently so impressed by Dr Whitaker's arguments about the necessity of preventing 'luxury' and reckless exploitation of the benefit that they did not pay much attention to the position of

1 Cf. for all particulars relating to points in this paragraph: *Approved Societies' Handbook*, *loc. cit.* paras. 921–33, 884 sqq., 891, 886 (II); Foster and Taylor, *loc. cit.* p. 74.

2 Cf. *Report*, para. 101.

the insured persons in need of appliances.[1] Yet Dr (later Sir Henry) Brackenbury, speaking for the British Medical Association, said very plainly that 'all appliances which can be described as necessities should be available to the insured person under the doctor's prescription out of the Insurance Fund'; he laid particular stress on the need for crutches and elastic stockings.[2]

The Royal Commission on Workmen's Compensation of 1939–40 revealed a very different picture of the lack of surgical appliances of all kinds. Industrial accidents take a heavy annual toll of limbs which may be artificially replaced or readjusted; as medical treatment in these cases comes under National Health Insurance it was no less the duty of the Royal Commission on National Health Insurance to investigate the matter than it was the duty of the Royal Commission on Workmen's Compensation. In 1939 the approximate membership covered under Additional Benefit No. 13 was as high as 11,348,000; but the amount spent was small—£203,207, or just about one-tenth of the sum spent on dental benefit.[3] 'Very few Approved Societies', observed Mr L. Bowden speaking for the T.U.C., 'pay the whole cost of anything such as an artificial limb.'[4] Witness speaking for the Ministry of Health observed that even when a worker can claim an artificial limb under an additional benefit 'the society would suggest first going to the employer'.[5] It was stated before the Royal Commission that insurance companies sometimes supply artificial limbs; but that they never would supply trusses.[6] The Reports of the Royal Surgical Aid Society contain ample evidence of the long periods during which workers in need of surgical appliances may have to wait. A miner, aged 30, thanked the Society in 1939 for an artificial arm for which he had been waiting for fifteen years. 'Already I am able to do many jobs that were impossible before', he writes.[7] A dockyard pensioner expressed his gratitude for now being able to do with his artificial leg what he has not been able to do for six years.[8] One gathers that all is

1 Dr Whitaker went so far as to claim that patients were actually not 'handicapped' by not having trusses as part of medical benefit, A. 1361.

2 Cf. Q. 15,061 and Q. 1361.

3 Cf. *Annual Report*, 1939, p. 149.

4 Royal Commission on Workmen's Compensation, Evidence, Q. 4000, 15 June 1939; cf. also Q. 1395: 'At present a man who requires an artificial limb may not be able to get it because the Society cannot pay the additional benefit?' A. (Mr Wackrill, Ministry of Health): 'Yes.'

5 Cf. *ib.* Q. 1389; cf. also *Approved Societies' Handbook*, para. 920.

6 Cf. Evidence, 18 May 1939, QQ. 2656–2657 A.

7 Cf. *Annual Report of the Royal Surgical Aid Society*, 1939, p. 23.

8 Cf. *ib.*

left to chance; it may be the approved society, it may be the employer, or an insurance company, or any charitable body that will produce the much needed appliance. The insured person may be left without it or it may come too late.

A Memorandum of the International Labour Office has pointed out that[1] 'Artificial limbs are an important but expensive aid to the restoration of earning capacity, and are specifically referred to in the laws as an element of compensation' in Belgium, Canada, France, Germany, Italy, the Netherlands, Sweden, Switzerland, the U.S.S.R. and the United States (except in Ohio); the European laws mostly go so far as to give the workman a right to have them repaired or renewed. The German industrial accident insurance law expressly mentions, as the object of providing orthopaedic or other appliances, that of 'making secure the success of medical treatment or alleviating the effects of injury'.[2] But in Britain the position remains insecure even as regards dental and ophthalmic appliances. Local authorities are sometimes called upon to make up the deficiency when approved societies are unable to provide these benefits;[3] mainly spectacles and dentures. The whole question of appliances requires detailed and exhaustive investigation, which should be carried on with the help of such bodies as the Royal Surgical Aid Society, the Central Council for the Care of Cripples and dental and ophthalmological bodies of a purely social service type. The results of such an investigation would doubtless reveal on a much larger scale the deficiencies which we have tried to sketch. They would show the urgent need to consider the inclusion of the provision of appliances as a statutory or ordinary medical benefit without any further call on insured persons or third parties to supplement the benefits provided.[4]

1 Cf. Royal Commission on Workmen's Compensation, 20 July 1939, p. 599.
2 Cf. *Reichsversicherungsordnung*, Buch III, para. 558b.
3 Cf. *H.C. Debates*, 15 July 1941, Mr David Adams, M.P. (Consett), col. 517.
4 Cf. for a similar view B.M.A., *A General Medical Service*, 1938, p. 19, where it is said that as regards dental benefit in most cases members have to find half the costs, while as to ophthalmic benefit the benefit only 'amounts to a proportion of the cost . . . of spectacles'.

CHAPTER XX. NURSING

'There was a lack of women's nursing,
There was a dearth of women's tears.'
G. E. S. NORTON (Lady Stirling-Maxwell).

FINALLY, among the means of medical assistance to the insured, also as an additional benefit (No. 15), we may mention nursing. In 1939 there were 643 schemes for nursing benefit and over 6,000,000 insured were covered. But the actual amount allocated by approved societies amounted only to £31,273.[1] The German word 'Haus-Pflege' is the equivalent of nursing under National Health Insurance, caused by the necessity of keeping the sick person at home and with his family.[2] With the agreement of the sick, the sickness fund is entitled to provide such nursing by either male nurses, female nurses or other qualified persons, in particular where hospitalization is not advisable, or there exists a valid reason for leaving the sick man at home or with his family. The law thus recognizes that sickness may greatly disturb the workingman's (and woman's) daily household routine and that in many cases there is actually nobody to take proper care of the sick person. No payment may be made in respect of the provision of a nurse to members, unless the nurse is registered under the Nurses Registration Act, 1919 (or the corresponding Act relating to Scotland and Northern Ireland), or is a person who habitually undertakes nursing services for fee or reward. Societies may make arrangements with nursing associations for the provision of nurses to members, but application for nursing benefit may not be refused on the ground that a member desires services of some other nurse. Except where an arrangement has been made with an association, the approved society must pay the whole of the nursing services where the cost does not exceed £1. Where the cost exceeds this sum, the excess may be paid as is reasonable, having regard to the available funds;[3] under the German law the sickness funds are entitled to deduct 25 % of sickness benefit for payment to nurses, see para. 185, *loc. cit.* The Report of the Royal Commission, referring to evidence given by the Queen Victoria's Jubilee Institute, stated that there was already in existence a national

1 Cf. *Annual Report*, 1939, p. 149.
2 Cf. *Reichsversicherungsordnung*, Buch II, Krankenversicherung, para. 185.
3 Cf. Foster and Taylor, *loc. cit.* pp. 79–80.

service which does provide skilled nurses for all kinds of illnesses at an economical rate, a service which, though not completely covering the whole country, could be made to do so. The Institute 'urged' that nursing should be provided for all insured persons, and that in doing so advantage could be taken of the existing organizations.[1] Witnesses who appeared on behalf of the College of Nursing also suggested the need for a much wider extension of nursing benefits to insured persons, describing the existing arrangements for additional benefit as 'inequitable, fragmentary and wholly inadequate'.[2] Again, the spokesman of the Ministry of Health protested. He thought that 'the ground is already to a considerable extent covered' by the associations, and that it would not make a great difference if the benefit were changed from an additional to an ordinary statutory benefit—an argument that very much resembles the one used with regard to appliances, which were alleged by the same witness to be so completely and easily obtainable outside the National Health Insurance scheme.[3] Apparently the evidence impressed the Commissioners, for they had no comments to add. In their Report they ignored several important statements which had been made. A witness speaking for the National Insurance Benefit Society stated, for instance, that insured persons did not find it necessary to appeal to their approved society to provide for a nurse, 'having made in a large percentage of cases their own arrangements for the purpose'.[4] It should have been the task of the Commissioners to discover why this was so, since nobody who could obtain nursing as a part of medical benefit would make 'his own arrangement'. Miss J. P. Watt, a member of the Council of the College of Nursing, made it quite clear what the reasons were:[5] 'a nursing benefit such as we seek has never yet been provided by any Approved Society for its members'. The National Insurance Benefit Society, she claimed, only made it available 'where the staff was available'. With regard to the Prudential and the National Amalgamated, only 25 % of the care given to their members was paid for; insured persons under 24 years of age were not eligible for this benefit; nor were those suffering from chronic illnesses. The witness emphasized that, for these and other reasons, 'the value of the service is unknown and unsought'. The same witness estimated

1 Cf. *Report*, p. 48; Appendix LXXII, 16.
2 Cf. *ib.* Appendix LXIII, 3, 9, 14 and 15.
3 Cf. Evidence, Smith Whitaker, Q. 23,968.
4 A. 9114. 5 Cf. *ib.* Q. 19,601.

that not more than 62 % of the need for nurses was actually met.[1] She explained the absolute failure of the 'voluntary district nursing administration': a mining or manufacturing community of 3,500–4,000, for instance, might by contributions provide one nurse, but from 4,000 upwards the difficulty began, as a second nurse would require extra money, while the number of contributors would not be large enough to pay for it by voluntary contributions.

It was the duty of the Royal Commission to go fully into the causes of the obvious lack of nursing under National Health Insurance. It contented itself with the argument that the small use which was made of nurses was a justification for the opinion that no further extension of the service under National Health Insurance should be made. The small expenditure by approved societies on nursing benefit goes far to show that conditions have scarcely changed since. In view of the fact that the principal nursing associations in England and Wales dispose of an annual income of more than £1,000,000[2] for their services, some £30,000 spent on nursing benefit by approved societies is negligible.

As in the case of hospitals and similar institutions the question arises whether the people insured under National Health Insurance can adequately get the nursing they need under other schemes. The Political and Economic Planning Report rightly paid particular attention to this point. It quoted a survey carried out in 1934 by the Queen's Institute according to which it was found that, although some 7,000 nurses were employed in district nursing in England and Wales, another 1,600 were required. In the administrative counties of Wales, only 84 % of the population had a nursing service.[3] In the meantime the problem of nurses has been discussed by the Athlone Committee,[4] but its attention was mainly focused on institutional nursing. During the war the Royal College of Nursing has, under the chairmanship of Lord Horder, set up a reconstruction committee with the particular object of examining the steps necessary to carry out some of the Athlone Committee's recommendations as to the recruitment and training of nurses, the legislative control of assistant nurses and conditions of service. Vital as all such measures and improvements are, the position of the insured under National Health Insurance has been left in the background. No attention at all is paid to the fact that, under the necessity of providing adequate home nursing

1 Cf. *ib.* Q. 19,602.
2 Cf. *P.E.P. Report*, p. 177.
3 Cf. *ib.* p. 179.
4 Cf. *Interim Report of the Interdepartmental Committee on Nursing Services*, 1939.

as a statutory benefit the insurance carriers could long ago have been made the driving force of an improvement of the nursing service, of its technical efficiency as well as of its socialization.[1]

CHAPTER XXI. THE ROLE OF THE INSURED

'A healthy body is the guest-chamber of the soul; a sick its prison.'

FRANCIS BACON.

WE have tried to give a picture of the grave deficiencies, gaps and bottlenecks in the present arrangements for medical benefit and treatment under National Health Insurance. But even if things were much more perfect than they are, the socialization of these benefits would in some measure depend upon the willingness of the insured to make use of the given means and opportunities. The will of the patient to get better is always an outstanding condition of restoration to health. In the same way, this subjective factor is a necessary condition for the full use of what a law may actually provide in medical benefits. The attitude of the insured worker may be influenced by a number of circumstances, which may be related either to the general attitude of the insured towards his health, or to the sickness insurance law itself.

Usually the part which the insured plays in this matter, by his personal attitude, has been discussed from quite another angle. This is the fear of insurance institutions that the insured might exploit existing medical benefits in an unjustified manner. Much more attention has been paid to 'malingering' than to the question whether the insured person is disposed to make full use of the benefits. We need not deal here in any detail with malingering, which concerns, not the socialization or full use of medical benefits, but rather the question of costs and economical administration. Malingering is a wide term. Sir J. Collie has called attention to its very wide scope. It may be gross deception; it may be simply a tendency to exaggerate an illness or its symptoms. 'Only a comparatively small proportion of the vast number of sick people are out-and-out malingerers, but it must be remembered that, although the number is a relatively small one, there is, in the aggregate, a

1 Attention may be called to the very illuminating observations about nursing, and the various economic and social problems connected with it, as they may be found in Constance Braithwaite's *The Voluntary Citizen*, 1938, also the *Interim Report* of the Rushcliffe Committee, and Dr Stark Murray, *loc. cit.* pp. 102 sqq.

large number of working-class men and women who, in returning, linger on the threshold of work', observed Collie in 1917.[1] Dr Norris, who carefully studied all sides of the problem and actually found three cases of malingering among 15,000 he had examined, claims not only that cases of malingering are very rare, but also that 'an allegation that a patient is a malingerer often reflects more unfavourably on the doctor than on the patient, and means no more than that the examination of a difficult patient was carried out with insufficient care'.[2] Official opinion in England has always been averse from accepting the view that malingering or quasi-malingering was frequent. This was the view of a Departmental Committee in 1911, as well as that of the Holman Gregory Report, which observed that, after careful enquiry made from employers and insurance companies, the committee 'is satisfied that the average workman is anxious to return to his work as soon as he is able, and is not disposed to malinger'.[3] The Ministry of Health in a Memorandum, published in 1931, also drew attention to the need for caution and issued a warning against holding patients 'responsible for the estimates of their own incapacity, except in the rare cases in which they seek to deceive'.[4] Under Workmen's Compensation, with its higher cash benefits, the tendency to exaggerate may be more probable than in National Health Insurance. But in neither case is the worker who has a job really likely to give up that job and deliberately go sick in view of the fact that the benefits are so much lower than his average earnings. It is, of course, true that in many cases an insured person may claim treatment where the case is slight and an uninsured person would perhaps not go for treatment at all. But it has to be remembered that many of the so-called 'unnecessary' cases may be cases where prompt treatment, in the first and slightest stage of sickness, is an important and necessary step to prevent complications.

1 Cf. Sir John Collie, *Malingering and Feigning Sickness*, 1917, pp. 2 and 9.

2 Cf. Presidential Address before the Hunterian Society, *Some medical problems in Accident Insurance*, reprint, 1937, p. 19; also Dr D. C. Norris, 'Malingering', in the *British Encyclopaedia of Medical Practice*, 1938; cf. also Dr Brend, *Traumatic Mental Disorders in the Courts of Law*, 1938, p. 47: 'Malingering, in my experience, has been rare, whether I have been dealing with serving soldiers or ex-service men or workmen. Occasionally I have seen the deliberate exaggeration of a real symptom, but even that is not common.'

3 Cf. Wilson and Levy, *Workmen's Compensation*, vol. I, p. 186, vol. II, pp. 142–3 and *passim*.

4 Cf. Ministry of Health, *Memorandum on Certification of Incapacity for Work*, Memo. 329/I.C. 1931.

There are a number of signs which suggest that the socialization of benefits under National Health Insurance is impeded by a reluctance on the part of the insured to make full, proper or speedy use of the facilities offered. If the figures of medical benefits and treatment are on the increase, this should not be taken without special justification to mean that working-class people are more prone to sickness because of the benefit offered, but rather that they are more prone to seek treatment when it is necessary, which was one of the main objects of the Insurance Act. Any effective insurance scheme must bring to light illness that otherwise might have been ignored. It may lead to the recording of prolonged cases of sickness—figuring as a statistical 'increase' in illness—with the ultimate result of full or partial cure, where these cases, without sickness insurance, might simply have swollen the mortality figure after relatively shorter periods of illness. In the words of Dr Marion Phillips before the Royal Commission, one must 'remember that the fact that the insured person has a doctor who is paid the same amount, however many visits they make to him, has led to a great many more preventive visits than of old, and so the better care of people's health has started'.[1] Abuse of doctoring can be guarded against by administrative measures and by the conduct of the panel doctor himself. Neglect of treatment by the insured cannot, and is the greater evil. While the former danger affects the financial side only, the latter endangers the socialization of medical benefits.

(Unfortunately there is a great deal of evidence to show that neglect of medical treatment by insured persons, either at the proper time or at all, or for a sufficiently long time, is still very prevalent.) It has diminished since the days of the Royal Commission. Their Report did not pay much attention to the matter, although it was not entirely overlooked. The Report expressed the opinion that specialist treatment would result in 'a greater disposition on the part of the insured person to obtain benefit'.[2] In a general way, witnesses speaking for the Executive Committee of the National Federation of Rural Approved Societies mentioned the point.[3] Another witness emphasized that 'a militant attitude to disease is not yet awakened in our people'.[4] One

1 Cf. Royal Commission, Evidence, Q. 23,173; the same viewpoint, Dr (later Sir H.) Brackenbury, *ib.* QQ. 14,613–16.
2 Cf. *Report*, para. 279.
3 Cf. Royal Commission, Evidence, Q. 11,626.
4 Cf. *ib.* Q. 19,601.

witness, in particular, mentioned the reluctance of women to go to panel doctors.[1] In general, the Commissioners did not ask many questions about it; but there is a good deal of evidence to show that the reluctance of the insured person is still a constant source of worry to those who are concerned with their physical well-being. The Report of the Ministry of Health for 1939, for instance, spoke of 'hospital-consciousness', which is greater in London than elsewhere, so that the population 'more readily resorts to hospital treatment'.[2] Political and Economic Planning complained in 1937, in regard to ophthalmic benefit, that 'the public as a whole are not yet educated up to the standard of insisting on a specialist medical examination'.[3] The Royal Commission on Workmen's Compensation received a Memorandum by the Ministry of Health in which it was stated that many injured workers refused to claim compensation for fear of losing their employment and did not wish that action should be taken by an approved society on their behalf. In such cases societies have no option but to withhold payment of any benefit to which the insured person would be entitled, and the insured person is, therefore, left without either compensation or benefit.[4] Witnesses giving evidence for the Ministry emphasized how very much the demand for medical treatment depended upon the insured: 'One person goes when he has a headache, another not until the illness is advanced.'[5] In many cases the insured goes on with his work, though he knows only too well that he should seek medical treatment; 'they had families to keep and they worked on under enormous disability and discomfort'.[6]

'Doctor, I cannot afford to be ill', is a saying well known to doctors.[7] The very laudable efforts made to develop medical supervision in factories will certainly assist greatly in diminishing the ill-effects of reluctance and in increasing treatment-mindedness. 'The doctor's scope for preventive work will be enormously increased if the employees consult him on their own initiative with regard to any symptom of ill-health', the Industrial Welfare Society emphasized in writing about works' medical officers.[8] The

1 Cf. *ib.* Q. 15,796. 2 Cf. *loc. cit.* p. 66. 3 Cf. *P.E.P. Report*, p. 189.
4 Cf. Royal Commission on Workmen's Compensation, p. 159.
5 Cf. *ib.* Q. 1203.
6 Cf. 'Discussion on Miner's Nystagmus', in *Transactions of the Ophthalmological Society*, vol. LIX, Part II, 1939, p. 757.
7 Cf. Dr Edith Summerskill, *H.C. Debates*, 15 July 1941, col. 507.
8 Cf. *Medical Service in Industry*, 1936, p. 9; cf. also Ministry of Labour and National Service, *Memorandum on Medical Supervision in Factories*, 1940, Form 327.

recognition of the need for such a service is a confession that treatment-mindedness is not sufficiently developed under the insurance scheme, although its object is supposed to be to promote better health by giving the worker facilities for proper, quick and sufficient treatment.[1] Medical officers in factories are, at present, only feasible in big undertakings; they cannot easily be introduced into the overwhelming number of small and very small firms. Here the responsibility will remain and rest with the insured person himself.

We are far from pretending that the reluctance of the insured to make full use of the medical facilities offered by National Health Insurance should be regarded as a primary ground for complaint. The main complaint must be about the insufficiency of the benefits themselves. There is an inter-connection between the two. The reluctance of the insured to seek proper treatment, though it may be due merely to personal and individual reasons, may also be attributable to lack of confidence in the panel doctor and the treatment provided, to such motives as the fear of losing a job.[2] It may be even due to illogical administrative provisions, such as the higher benefits given under unemployment insurance which may induce a sick person to seek unemployment benefit rather than National Health Insurance benefit.[3] There can be no doubt that the very structure and degree of adequacy of a sickness insurance service must react upon the attitude of the insured to make use of it. The low level of cash benefits increases the insured worker's fear of falling sick. 'Sickness' must be postponed as long as ever possible. When, as in the case of slowly developing tuberculosis of the lung, the process of the disease is difficult to discern, this danger is still greater.

Doctors and welfare promoters constantly assert that confidence in the medical service and treatment is one of the fundamental factors in making the sick person treatment-minded. The service under National Health Insurance has not won such confidence. Medical science has a high standard in Britain; but its socialization under National Health Insurance has been poor and defective. Under National Health Insurance whenever special medical needs are recognized, such as tuberculosis or fracture treatment,

1 Cf. also Orr and Orr, *loc. cit.* p. 97; the authors give a very interesting single case which they have studied in detail and which reveals all the ill-effects of the 'I kept working' fallacy.

2 Cf. for this the details given in Hermann Levy, *Back to Work, the case of the partially disabled worker*, 1941, *passim.*

3 See above, pp. 65-6.

they are dealt with *outside* National Health Insurance—in itself a grave indictment of the scheme.

Confidence in sickness insurance is undermined by the fact that the insured person is constantly urged to secure more and better services by other means. He is exhorted to insure with a friendly society or other body to supplement his allowances in time of illness, to join a hospital savings association to secure hospital treatment, to get appliances by charitable means, to contribute to dental, ophthalmic and other 'special' benefits or to 'see' the works' medical officer. The incompleteness of medical benefit and treatment, and of benefits in general, may be alleviated in these ways, but it and the confidence in National Health Insurance are not increased.

No investigator of the actual conditions of 'social security' can escape these facts. Mr Seebohm Rowntree calls attention to the insufficiency of National Health Insurance, even if the possibility of additional insurance through friendly societies is taken into account.[1] In the words of the Industrial Welfare Society: 'It is generally found necessary to supplement the National Health Insurance benefits.'[2] Yet there are responsible writers who welcome the fact that the State scheme has not been able to replace 'friendly societies'. It has been the policy of friendly societies to oppose greater benefits under National Health Insurance lest their own activities should be curtailed. Mr W. Blackshaw reassures his readers 'that it would be a mistake to suppose. . . that because the State took over Health Insurance, the trade unions or friendly societies ceased to function or function less widely. The opposite has actually been the case.' The author does not recognize[3] that it is the lack of comprehensive State insurance that makes necessary this continued recourse to the system of friendly society 'welfare', the defects of which were the very reason for introducing the State scheme. The effect is a deplorable multiplicity and diffusion of the sources of sickness and medical benefits as available to workers.

To these circumstances have to be added many formal inconveniences and administrative complications. Lord Horder writes of the citizen, in connection with the health services, as

1 Cf. Seebohm Rowntree, *loc. cit.* under 'Conclusions'.

2 Cf. *The Introduction of a Works Welfare Scheme*, 1930, p. 12.

3 We have noted Mr Blackshaw's attitude to friendly societies elsewhere, see p. 226. Cf. W. Blackshaw, *The Community and Social Service*, 1939, p. 66 and whole Chapter XIV.

'the victim . . . of all this intricate and expensive machinery'.[1] One of the causes of this complicated and cumbersome working, which so much reduces willingness of the insured to seek treatment, is the incompleteness of benefits under National Health Insurance, which has necessitated an ever-growing number of agencies outside it to make up its deficiencies. We should never fail to recognize that the actual scope and efficiency of benefits and treatment primarily account for the success or failure of sickness benefit? Upon these must depend its popularity with the insured, which in its turn is a necessary condition for ensuring the fullest utilization of what the scheme and its administration are prepared to provide.

Note to Chapters XIII–XV

The British Medical Association has lately devoted much labour to the problem of doctors, panel doctors in particular, and to the health of the worker. In their Report on Industrial Health in Factories, published in 1941, stress is laid on two main points: the general practitioner, and the panel doctor in particular, should acquire more specialist knowledge in industrial medicine; and the medical officer in industrial establishments is recommended as a general institution. These recommendations are made without any attention to the statutory changes that would be involved; nor are the actual conditions under which doctors work taken into account. The British Medical Association thinks that a solution of the question how 'to increase the efficiency of the service which the patient's own doctor can give . . . seems to lie in improved medical education, continuous interchange of information during a patient's illness, and a closer association between the medical profession and industry'. But we have seen[2] that the panel doctor is already overworked, burdened with many duties and in a financial position which by no means spurs him on in his National Health Insurance work. If he is now asked to devote even more time to this work, to incur even more costly specialized education and to devote much of his time to the personal and even sociological care of his panel patients, he cannot do it, under the present conditions of payment by capitation fees. Moreover, even if it were possible, it is doubtful whether he would ever acquire more than a superficial knowledge of industrial illnesses. It is not sound policy to obscure by half-education the demarcation between practitioner and specialist. It would be quite a different matter under some other system of National Health Insurance, say, a system of territorial funds, in which the funds would draw up panels containing the services of specialists in the district—a matter to which we shall revert later. Under the present system, it is very doubtful indeed whether the deficiencies of special treatment can be attributed to the panel doctors.

1 Cf. in *Britain's Health*, *loc. cit.* p. x.

2 See pp. 134–5.

The proposal to employ medical officers in all industrial establishments is not less liable to criticism. The position of these would be to some extent similar to that of a 'forwarding' doctor. But here again, in the British Medical Association scheme, the duties expected from these officers are so wide—ranging from emergency treatment in the establishment itself to inspection of safety measures, examination of entrants and workers returning from illness, scientific research in various branches of industrial medicine and even into the processes practised in the particular place of their employment—that they can hardly be compared with, say, the forwarding doctor employed by a Berufsgenossenschaft for the cases of industrial injury by accident and disease.

Moreover the medical officer in the factory is envisaged by the British Medical Association as an employee of the firm. It is overlooked, by the Industrial Welfare Society as well as by the British Medical Association, that such medical officers will be suspected by workers of lack of impartiality. The Stewart Report (see p. 50) stressed the fact that the Home Office now refrains from appointing as certifying surgeons either full-time works' surgeons or doctors holding retaining fees as advisers to employers. Yet, the Industrial Welfare Society mentions, apparently without any criticism, that 'there are instances where a part-time medical officer is also certifying factory surgeon of the district'. The British Medical Association, on their part, suggested that the medical officer in the factory should remain in 'continuous interchange of information' with the private doctor of the sick worker (see para. 46) and also the hospital (see para. 73). As long as the medical officer remains an employee of a particular industrial establishment, such relations with doctors and hospitals in their treatment of insured workers is highly objectionable. Questions of compensation may arise, and from the workmen's viewpoint the factory doctor is an interested party. The Stewart Report observed (see p. 56): 'We have had complaints that workmen's interests have been adversely affected by the unauthorized disclosure of medical information by doctors who have had the workmen under their care and treatment as patients. The cases in which it was alleged that this had occurred were said to be, for the most part, cases in which disclosure had been made by a panel doctor who was acting both as the man's medical attendant and as adviser to the employer or insurance company, and cases where the information has been furnished by the medical staff of the hospital. We understand that complaints of this character have also been made to the Home Office from time to time.'[1] The doctor's impartiality is a fundamental condition of medical treatment. In this respect, any improvement in treatment must involve major statutory and administrative changes which the British Medical Association Report on industrial health in factories does not take into account.

1 Cf. also *B.M.J.* 20 Dec. 1941, letter by E. H. Strange.

PART VI. *THE ADMINISTRATION OF NATIONAL HEALTH INSURANCE*

1. APPROVED SOCIETIES

CHAPTER XXII. SOME GENERAL PROBLEMS

'. . . the interest of the Community, considered as an aggregate, or in the democratical point of view, is that each individual should receive protection; and that the powers which are constituted for that purpose should be employed exclusively for that purpose.'

JAMES MILL, *Essays on Government*, 1828.

THE administration of National Health Insurance offers three sets of problems. The first is mainly concerned with the insurance carriers as the instruments of carrying out the objects of legislation; the problem is here mainly structural and organizational. The second is concerned with the various legal implications involved in administration. These, of course, result to no small extent from the structure of the insurance carriers and their relationship to official control, but they also include the legal rights of the insured, on the one hand, and those of the insurance administrators, on the other. Both these aspects of administration have a close bearing upon the third set of problems: the economical administration of sickness insurance. Admittedly, economical administration depends to a large extent simply on the technical efficiency of the insurance carriers; but the economical working of sickness insurance must also be influenced for good or evil by the structural foundations of the scheme and by the organization of insurance carriers resulting from it, while the legal regulations for control over expenditure obviously constitute another important condition of economical working, which, to some extent, they are devised to safeguard. The organizational and the legal conditions of National Health Insurance determine the scope of its activities as a social service and set the limits of its financial capacity—though they leave room for greater or lesser economy and efficiency within those limits. The special problem of economical administration is 'to strike the best balance they can between the special needs of those insured with them and the limited means at their disposal (*rational* administration)'.[1] 'The principle of

1 Cf. I.L.O., *Economical Administration*, pp. 13–14.

economy requires constant improvements in the details of *internal* administration and its supervision', as the International Labour Office aptly observes.

Thus the questions to be answered are: first, how far this particular system of administration of sickness insurance by its very type and structure appears to be favourable for economical administration; and secondly, how far, within this system, insurance carriers have actually tried and succeeded in attaining the greatest economic and social efficiency. Both problems are of fundamental importance to the understanding and criticism of National Health Insurance in its present shape. They both involve a detailed analysis of the organizational and legal structure of National Health Insurance.

The British sickness insurance scheme is administered by approved societies, or as they are sometimes termed, 'approved mutual benefit societies', managed by representatives of the insured persons, and by insurance committees (so far as medical benefit is concerned). The insurance committees are not entirely unconnected with approved societies, as they mainly consist, apart from doctors, of representatives of approved societies. In Northern Ireland medical benefit is administered by the central authority. People may be insured without being members of approved societies; but of some 17,000,000 of persons insured under the National Health Insurance Acts at the end of 1938, not more than 256,000 were deposit contributors not belonging to[1] an approved society.[2] Moreover, the insurance committees also administer the benefits of members of the Depository Contributors Fund—so that, to some extent, the sphere of approved societies is indirectly extended even to the class of insured who are not members.

It is necessary also to draw attention to the links which connect approved societies with higher bodies of control. There is a central government department in each country of the United Kingdom which is responsible for the general administration of the scheme: the Ministry of Health in England and Wales (in Wales, the Ministry operates through the Welsh Board of Health), the Department of Health in Scotland, and the Ministry of Labour for Northern Ireland. These departments also control the financial arrangements and management of the National Health Insurance funds, into which are paid all health insurance contributions and moneys provided by Parliament, and from which are disbursed

1 Through inferior health or who have been expelled from a society, etc.

2 Cf. *Annual Report of the Ministry of Health*, 1939, pp. 138 and 155.

the sums required to meet expenditure incurred by approved societies and insurance committees in respect of either benefits to insured persons or administrative expenses. For the co-ordination of these Central Departments (see Section 160 of the Act) there is a National Health Insurance Joint Committee, made up of the Minister of Health, as chairman, together with the Secretary of State for Scotland, the Minister of Labour for Northern Ireland, and a person appointed by the Minister of Health who has special knowledge and experience of National Health Insurance in Wales. The Joint Committee makes the necessary financial adjustments between the funds under the control of the central departments. It also issues regulations, including those relating to reserve and transfer values and the valuation of approved societies and branches. Another statutory body is the Consultative Council. Its members consist of persons appointed by the Minister for their particular knowledge of the administration of National Health Insurance; it is usually consulted when information is desired as to the practical working of new or amending regulations which the Central Department proposes to issue. There are similar Consultative Councils in Scotland and Northern Ireland. The accounts of approved societies, insurance committees and the National Health Insurance Funds are audited by a special department, the National Insurance Audit Department, which is a department under the Treasury. The functions of this important body of control are various: the conducting of a cash audit; enquiry into cases appearing to suggest fraud or loss of funds through ignorance or unsatisfactory accounting; ascertainment that the expenditure charged to the Administration Account is proper, and that benefits have been paid to persons with a proper title; the reporting of sums found to be improperly paid; and general examination with a view to seeing that registers, records and accounts are kept in correct order. The Post Office is indirectly connected with the administration of health insurance, since it is the medium through which the contributions are collected by means of the sale of insurance stamps. From the Post Office, too, can be obtained the half-yearly contribution cards required by insured persons who have not received them from societies, or who have just become insured for the first time and not yet joined an approved society.[1] Lastly we may refer to the duties of the Government Actuary in

1 Cf. for more details on the matters treated in this paragraph the very instructive account by Foster and Taylor, *loc. cit.* pp. 9–12.

regard to the financial administration of approved societies.[1] If, on the valuation of a society or branch, it appears to the valuer that a deficiency will be disclosed, he must report the fact to the Government Actuary, who will then estimate the amount by which the financial position of the society has deteriorated in consequence of the provisions of the National Health Insurance Act, 1926 (relating to reduction of the State grant and increased charges in respect of medical benefit) and estimate other losses as they may have happened.[2] From all these wide-reaching measures of administrative control by 'higher' authorities it emerges that the general administration of sickness insurance by the approved societies has been thoroughly fenced against maladministration and abuse. No really important deficiencies have been made known in respect of the administrative duties exercised by approved societies in general, although occasional unsatisfactory cases are disclosed.[3] In 1938 a total sum of not more than £3,024, covering 261 items and being about 1 % of the aggregate expenditure on approved societies' administration, was reported as not being in accordance with the provisions of the National Health Insurance Acts and regulations, a most satisfactory result.[4] On the other hand the National Health Insurance Joint Committee (see above, p. 213) is constantly watching smaller deficiencies and trying to apply remedies.[5] Criticism of the administration of National Health Insurance cannot be levelled against the working of the machinery so far as its prescribed functions are concerned.

1 Cf. below, Chapters xxv and xxvii.

2 Cf. Foster and Taylor; cf. also the regulations as concerning the Government Actuary's duties in regard to National Health Insurance and in connection with the National Health Insurance Joint Committee in the National Health Insurance, Contributory Pensions and Workmen's Compensation Act, 1941, 4 and 5 Geo. 6, c. 39, section 6 (3) (*a*) and (*b*) and (4); also *Annual Report of the Ministry of Health*, 1935–36, p. 174 for particulars.

3 Cf., for instance, *Annual Report of the Ministry of Health*, 1938–39, p. 153: 'The Minister, having received information which suggested that the affairs of a certain Approved Society were administered in a manner prejudicial to the interests of members, ordered an Inquiry, made under Regulation 126 of the Approved Societies Regulations, 1938, into the affairs of the Society. As a result of the Inquiry the Secretary of the Society was dismissed from office, and the Minister appointed a Manager to take charge of the affairs of the Society for a period of six months.'

4 Cf. *ib.* p. 153.

5 Cf. *Annual Report of the Ministry of Health*, 1939, pp. 134–5, where it is noted that the Committee was dissatisfied with information relating to the migration of insured persons from one country to another, and appointed a committee to formulate a scheme for the correction of existing records and for the maintenance of accurate records of such migration in the future.

Criticism of the general structure and organization of National Health Insurance administration is apt to start from quite another angle, and is essentially bound up with the organizational framework of the British system of sickness insurance as such. The two fundamental conditions laid down in that framework were that the societies should not work for profit and that they be representative of their members in a democratic way and under the absolute control of members. We have mentioned the apprehensions raised in 1911 as to the possibility of putting the first condition into practice in the existing arrangement of insurance carriers; we have also noted that on the question of the second condition the Report of the Royal Commission arrived at a somewhat negative result. These are the points that we must now examine.

CHAPTER XXIII. NO PROFITS. DEMOCRATIC CONTROL

'The question is not really whether we are intelligent enough to plan our social life, but whether we are good enough to restrain the selfish passions which divide us, and wise enough to co-operate for the realisation of a common aim.'

HAROLD MACMILLAN, M.P., *The Middle Way*, 1938.

THE two conditions, the obligation placed on Approved Societies not to work for profit and the demand for control by members, seem to have a common aim. This is to prevent the commercialization of a great national social service. If this is to be realized, it is not only necessary to prohibit the making of profits; control by members can work in the same direction by preventing individuals from reaping the benefit of collective institutions. The friendly collecting societies which cater for industrial assurance are non-profit-making bodies; yet, the Cohen Report did not hesitate to state that, as members 'have very little voice in the management of these societies', it is 'not a matter for surprise that the real control has fallen into the hands of those whose relation to the societies should be that of servants'.

Approved societies under National Health Insurance are certainly not run for profit. But we have already observed that, by being related to industrial assurance offices—companies as well as friendly collecting societies—they may contribute indirectly to the profits of the latter. It is obviously possible for approved societies to contribute to the reduction of general expenses or to the overhead charges of the industrial assurance offices, the vast

and rich life assurance companies in particular. How far this may be, or is, done it is impossible to tell, as no material on the point is available. Actually we do not believe that the point is of any considerable importance to the offices.[1] The point that does affect the finance of life assurance offices very materially indeed, when they are concerned with National Health Insurance business through approved societies, is the fact that their agents can do industrial assurance business simultaneously with National Health Insurance business.

The Cohen Committee was well aware of this and expressed its uneasiness about the interlocking of the life insurance agents' canvassing activities with 'the administration of the State system of National Health Insurance'.[2] It was not the Cohen Committee's business to criticize the matter from the angle of National Health Insurance; but it should have been the business of the Royal Commission on National Health Insurance. However, the whole position was ignored by the Report of the Royal Commission. This does not mean that it played a small part in the evidence which the Royal Commission received. Indeed, witnesses were eager to defend the dual capacity of agents on the ground that they were giving so much 'home service'. Sir Alfred Watson, who had a very intimate knowledge of the individual elements of the administration costs of social insurance, put some very pertinent questions on the point to witnesses giving evidence for insurance offices, among them Sir Thomas Neill, the chairman of the Executive of the National Conference of Industrial Assurance Approved Societies. What actually is this 'home service'? 'On the average they are in the homes of these people once each week, and they are available to notify changes', a witness explained, 'they are there to collect their claim; they are there to pay the claim; there is nothing that the person has to do unless he wishes to do it. He need not leave his house or lose a single hour of home work or duties in connection with his claim.' But Sir Alfred was not satisfied with the explanation. 'But an insured person under the Act does not need any service rendered to him except at the time of changing the card or when he wants sickness benefit?' he asked.[3] The witness replied that notification of removal from one district

1 Workmen's Compensation business is retained eagerly by insurance offices, although the profits are small and the business cannot possibly contribute much to a general reduction of overhead expenditure, cf. Wilson and Levy, *Workmen's Compensation*, 1941, p. 338.

2 Cf. *Cohen Report*, 1933, p. 42.

3 Cf. Royal Commission on N.H.I., QQ. 4456–64.

to another was also needed, but he had simultaneously to agree that such changes happened on the average once in five years. Sir Alfred doubted whether agents were necessary 'for such an elementary duty of informing their society', to which the witness gave the bizarre reply that for the insured person to give the information would mean 'a cost of a ½*d.*, and the writing of a card which is saved'. The witness then tried to defend the position by emphasizing that the public had to be educated to its duties under the National Health Insurance Acts. Sir Alfred remained adamant; he declined to agree that the industrial assurance agent was a necessity for this: 'Is the performance of these necessary functions training the people at all, or is it making them more and more dependent on the home service?' he asked.[1]

To those who know the main argument which is advanced for the necessity of the distasteful system of canvassing under industrial assurance, with all its dangerous features of pressure by the offices on the agents for increased business and by the agents on the insured,[2] it should have been surprising that witnesses argued in this way. For they usually pretend that house to house canvassing is a necessity in industrial assurance because the system is voluntary and people would not insure against the contingency of death if they were not canvassed. Yet in the case of National Health Insurance where the system is compulsory, they brought forward the same argument of 'training the people', because it is the stock defence of industrial assurance interests. This ought to have been illuminating to the Commissioners. In cold fact, industrial assurance agents are under an economic necessity of combining the 'State work' with their burial insurance canvassing, being 'moved by the consideration that if they did not, somebody else might come in contact with their Life Insurance clients and their families'.[3] Life insurance agents, in other words, have a lively interest in doing National Health Insurance business because without the latter they might lose the former, the life business, which is by far the more important to them. By the purchase of the 'book' or the 'book interest', life insurance agents become capitalists, owners of a property. The performance of these 'home service' functions under National Health Insurance fortifies their

1 In its Memorandum of Evidence to the Beveridge Committee the National Conference of Industrial Assurance Approved Societies has again emphasized that, in their view, there exists such necessity. Cf. *Memoranda to Beveridge Report*, 1942, pp. 52–3.

2 Cf., for full details, Wilson and Levy, *Industrial Assurance*, 1937, whole chapter XVIII and *passim*.

3 Cf. Royal Commission on N.H.I., QQ. 4555–64.

position as property owners in their main business. There are over 70,000 agents and canvassers of industrial assurance; but 'book interest' is mainly confined to collecting societies.[1] Obviously the 'wastefulness' of the National Health Insurance administration by approved societies cannot be deduced (as T. S. Simey does in his suggestive study on *Principles of Social Administration*, 1937, p. 152) from the large number of insurance agents involved in approved society work; there are so many of them because they are mainly employed for their industrial assurance activities. The argument is sometimes heard that this means a cheapening of the National Health Insurance 'home service'. This overlooks the fact that the system of burial insurance is correspondingly wasteful because some 70,000 agents are employed. It is misleading to argue, as Simey does, that this army of agents 'must be paid for out of the contributions of the insured', while actually only a part of their services are so paid for, and, under the existing system of National Health Insurance, it would certainly be much more expensive to employ agents merely for that purpose.

It is sometimes suggested that the dual duties of insurance agents may lead to actual evils when money paid out for sickness or maternity benefit may be used, under pressure from the agent, for the payment of arrears of burial premiums. The matter was fully discussed before the Cohen Committee, and witnesses speaking for the National Amalgamated Union of Life Assurance Workers could not deny that they had 'heard of arrears being deducted from claims, including maternity benefit', and that, as a matter of fact, they had 'complaints and the matter was raised in the House of Commons'.[2] On the other hand, the witnesses contended that people were less able to pay arrears where they are in receipt of sickness benefit, and even more when they receive maternity benefit, because the expenses of the household in such conditions are still higher than normal. While, however, the witnesses strongly deprecated such practices, it must be remembered that a great number of agents and canvassers work under most unsatisfactory social and economic conditions, which, particularly when they are 'building up' their book, drive them to press for the payment of arrears and to prevent policies from lapsing.[3] It is not surprising

1 Cf. Wilson and Levy, *loc. cit.* p. 226 and *passim.*

2 Cf. Cohen Committee, Minutes of Evidence, QQ. 5673–78.

3 Cf. Wilson and Levy, *loc. cit.* p. 302: 'the agent may be obliged to refund what he has received in respect of policies which have subsequently lapsed, or else, being paid on increase, he may have to make good to the office, in the

that agents may be tempted to help the major section of their business by taking premium money from the National Health Insurance source if the insured are willing to give it.

It can hardly be denied that the arrangements by which industrial assurance agents act as National Health Insurance agents are a plain commercial advantage to the insurance offices. This is the point that matters in the first instance. Canvassing by agents and others plays a decisive part in the commercial structure of industrial assurance; the entire business, with its gigantic premium income of £70,000,000,[1] would not be possible were it not for these 70,000 persons constantly engaged in persuading people to enter new industrial life insurance commitments and so replacing the enormous number of millions of policies which lapse every year.[2] The army of agents works under very competitive conditions (reduced somewhat where the 'block system' has been introduced by some offices) and in many cases is paid on commission, which is neither secure nor satisfactory. Were this 'wage' reduced by the abolition of the emoluments accruing from the National Health Insurance 'home service', either a great number of marginal canvassers would have to drop out or the offices would be under the necessity of increasing their income to guarantee them a fairly decent living. This is what the National Amalgamated Union of Life Assurance Workers had to say about it:[3] 'There is another factor which makes possible the cheap working of the Prudential Block System with its small charge upon the Industrial Branch business and which has allowed the development of the block system and the growth of the business on a reduced expense ratio,[4] namely, the undoubtedly large National Health Insurance connection of the Prudential Approved Societies worked by the Agency staff. Were it not for this National Health Insurance connection, which brings to the agent a substantial addition to his weekly wage, ranging from 15*s.* to 25*s.* and more per week, and had he to rely solely upon earnings from his purely Insurance as apart from National Health Insurance work, it would

form of new business, what has been lost in lapses'. Against 10 million policies issued approximately each year the number of 'lapsed' policies amounts to some $4\frac{3}{4}$ million, cf. *Cohen Report*, p. 34.

1 For figure see *Report of the Industrial Assurance Commissioner*, 1940, p. 3.

2 See Wilson and Levy, *loc. cit.* chapters XVI–XIX.

3 Cf. Cohen Committee, Appendix III, Minutes of Evidence, 1931, p. 7.

4 Under the block system each agent of the particular office is allotted a particular area within which he may canvass and collect on behalf of the company; it was first introduced by the Prudential in 1913; this system, at least, reduces competition between agents of one and the same office.

be almost impossible for the agent to meet the many responsibilities associated with his calling, without there being grave and serious danger of bringing into existence a position that would result in deficiencies and wholesale dismissals.'

No clearer proof could have been given of the practical commercial interest which life assurance offices have in National Health Insurance. The argument sometimes heard in favour of this arrangement, that without the assistance of life insurance agents approved societies would have to secure their own special staff for the 'home service', does not concern us at this juncture; it relates to the problem of the costs and expenses of National Health Insurance and the possibility of their reduction.[1] Here, our concern is to show that, through their affiliation with the business of National Health Insurance, life assurance offices derive a distinct, though indirect, commercial advantage. It would be to their financial disadvantage if this connection should cease to exist or be broken up. Inasmuch as a proportion of these offices, precisely those which play the most important part in the approved society system, are private companies, the administrative arrangements of National Health Insurance do contribute to the making of private profit, which is contrary to the very principle on which the idea of the approved society system was based. The question whether insurance companies are making profits out of the block-grant arrangements made with approved societies for the service of their agents does not imply any suggestion of an improper mode of calculation of the division of such services.[2] As each of these contracts comes under review by the National Health Insurance Joint Committee which controls and supervises the general finance of the Insurance Acts any such suspicion is unjustified. But this fact does not, as the Deputy Controller of Health Insurance of the Ministry of Health apparently suggested before the Royal Commission on Workmen's Compensation, imply that insurance offices do not profit in an indirect way by the opportunity of employing their agents simultaneously for the dual purpose,[3] just as any parent company may profit by leasing a part of its services to a subsidiary, if it is only by decreasing overhead charges. Writers with a good inside knowledge of the insurance business assert:[4] 'a number of experienced agents canvass primarily for

1 See below, Chapter xxx.

2 Cf. the make-up of the average weekly remuneration of agents in *Beveridge Report*, p. 251. 3 Cf. Royal Commission on Workmen's Compensation, Q. 1449.

4 Cf. Albert E. Sharpe and Charles Taylor, *Industrial Insurance Salesmanship, in theory and practice*. London, 1926, pp. 176–7.

National Health Members, in order to open the way for introducing other and more profitable business.' Insurance offices would undoubtedly incur higher costs in connection with the administrative expenses of burial insurance if the use of their agents for National Health Insurance purposes were non-existent.

We come now to the second fundamental condition of the approved society's structure, which again has not been fully realized in practice; that is, the representation of members. On the face of it, once more, everything appears to be quite satisfactory and persons reading general descriptions of the set-up, even in well-balanced text-books or other books, will get the impression that there is such representation in actual practice.[1] The arrangements for 'absolute control' by the members[2] are legally unassailable. Every society must make provision by rules for its proper government, and such rules must receive the sanction of the Minister. This applies to all types of societies, whether they have a central administration and are without branches, or whether they are societies with branches, known as 'affiliated orders' or lodges or courts. There are some exceptions, which do not change the general picture. The Act permits the approval of Employers' Provident Funds, notwithstanding that an employer is entitled to representation on the governing body administering the fund. But such representation must not exceed one-quarter of the total number while, on the other hand, the employer is substantially responsible for the solvency of the fund. Then, there is the Seamen's National Insurance Society expressly created by the Act of 1911. This is an insurance society which may act as an approved society, although it is managed by a committee comprising representatives of the Board of Trade, ship-owners, and members of the society, in equal proportions. Any masters or seamen who are employed within the meaning of the Act are entitled to become members of the society, although there is nothing to prevent them from joining another society.[3] Neither

1 Cf. for instance, McCleary, 1932, *loc. cit.* p. 106: 'Approved Societies . . . are managed by the insured persons only, the employers taking no part in the management, etc.' No mention is made of the practical working of this management.

2 Cf. N.H.I. Act, section 73 (2) (*b*): '. . . the affairs of the society being subject to the absolute control of its members being insured persons, or, if the rules of the society so provide, of its members whether insured persons or not, and for the election and removal of the committee of management or other governing body of the society, in the case of a society whose affairs are managed by delegates elected by members, by those delegates and in other cases in such manner as will secure absolute control by its members'.

3 Cf. N.H.I. Act, section 136.

exception contravenes the principle applicable to the overwhelming number of approved societies that they must be controlled and managed by their members. In practice this regulation is carried out by provision contained in the rules which every approved society is required to make regarding the particular administration of its affairs, either for the society or its branches. These rules may vary considerably, but they must meet the satisfaction of the Minister. They usually contain provision for the election of a committee of management by members or by delegates themselves elected by members, and also for the appointment of officers, such as a treasurer, secretary and trustees. Every society is required to give such security to the Minister as he considers sufficient to provide against any malversation or misappropriation of any funds coming into the hands of the society under the Act. In the case of a society with branches (see above, p. 76), security is required in respect of each branch. It should also be noted in this connection that a person may not be a member, for the purpose of the Act, of more than one approved society, nor can he be a member of such a society and at the same time a deposit contributor.[1]

The principle of control by members is well safeguarded administratively and legally. In practice, however, the object is not reached. The Majority Report of the Royal Commission left no doubt that 'the semblance of self-government is at least respected' and that 'in theory' there was such control.[2] But the signatories of the Minority Report came 'definitely' to the 'conclusion . . . that probably ⅔ of the insured population cannot exercise any real control in their societies'.[3] One of the principal reasons is that the approved societies have tended to become centralized and so detached from the interest of the individual member. In 1912, the scheme had about 14,000 separate financial units administering it. The Fourth Valuation disclosed the total number of units valued as 6,955, and this was a further decline from the 7,608 of the Third Valuation.[4] Of the total 16,053,146 members no

1 Cf. Foster and Taylor, *loc. cit.* pp. 120–21 and 129–31.

2 Cf. *Report*, para. 212. 3 Cf. *ib.* pp. 306–7.

4 Cf. *Report N.H.I.*, p. 249; further: N.H.I. *Report of Government Actuary on the Fourth Valuation*, Cmd. 5496, 1937. A total of 7,000 approved societies and branches were valued. A society without registered branches or a separately registered branch of a society constitutes a unit for valuation purposes. Further, a society or branch with separate funds for men and women comprises two units and has been treated as such in all statistics relating to the Fourth Valuation.

fewer than 4,641,729 men and 3,224,900 women belonged to approved societies of the type of industrial assurance companies and friendly collecting societies; and the Actuary's report emphasized that the trend of increase in membership was, as far as male membership was concerned, definitely towards the friendly societies without branches (the centralized societies) and the life assurance offices. The Third Valuation showed increases of 7·4 % and 6 %, respectively, in the membership of these two categories. The Government Actuary gave the following main reasons for the decline—or, rather, the concentration—of units:

1. The transference of members to another and usually larger unit (391 cases).
2. The centralization of administration (this accounted for a reduction of 321 units).

The addition of new administrative units between the Third and Fourth Valuations was insignificant. The tendency of friendly societies in the past was always from their local character towards the structure of big centralized bodies necessarily alienated from the original 'friendly' and fraternal neighbourly contact with members; they became organizations on the ordinary private business pattern. The process has been the same with approved societies; nor is there any evident reason why this process of centralization should have been deliberately checked on economic or financial grounds. The view of the Royal Commission was not dissimilar from that of certain supporters of industrial quasi-monopoly who accuse outsiders who will not join of hindering national development—an argument, which in cases where the concentration of industrial undertakings is economically sound, may be justified.[1] The Report drew attention to the fact that 'any single Branch has absolute autonomy and can decline to fall in with any proposed reconstitution of the Society, however strong may be the desire throughout the Society, as a whole, to effect that reconstitution'. The Report even mentioned the suggestion made to them that some means should be provided by which the decision of the society in cases of this kind should be made binding on all its branches.[2]

'In the large industrial societies', observes the Political and Economic Planning Report, 'there is virtually no machinery for membership control.'[3] The Minority Report of the Royal Com-

1 Cf. Hermann Levy, *The New Industrial System*, 1936, pp. 262–3 and *passim*.
2 Cf. *loc. cit.* para. 607.
3 Cf. *P.E.P. Report*, p. 207.

mission quoted, as examples of the large industrial approved societies, the National Amalgamated and the Prudential. In the former, with some two million members, the requisite number of members that must be present to constitute a valid meeting is 50 in England and 20 in Scotland, including the officers and committee men, who themselves numbered about 20; with the two large Prudential societies, each with over one million members, the rules provided for a quorum of 50 members, including any officers and members of the committee present.[1] Before a recent Commission, it was stated on behalf of the Prudential approved societies that the quorum was now 40; that the annual meetings never had a large attendance—except on one occasion; and that 'two or three outside individuals' attended. If members of approved societies wished to submit motions this could be done, but to do so would require the calling of branch meetings which would be costly, and to which members would only resort if 'a great number of people in a particular area should feel very strongly on some particular subject'.[2] The ordinary, fundamental conditions for the representation of members are lacking in the case of the big offices. No notices of the annual meeting of the Prudential Approved Society for Women are issued to members; it is advertised in the press. Members receive neither a report of the meeting or the report of the committee of management to the meeting.[3] When Sir Walter Kinnear made suggestions to the Royal Commission about the possibility of keeping members, at least to some extent, acquainted with the proceeding at such meetings, he was asked by a Commissioner whether such suggestions would not entail 'considerable expense'.[4] He gave the illuminating reply: 'I think we ought to make an effort to give the members of these large societies better machinery for expressing their views on matters which affect their interests.' But he met the stoutest opposition from Sir Arthur Worley, who observed

1 Cf. *Report N.H.I.*, p. 307.

2 Cf. Workmen's Compensation Commission, Evidence, 4 April 1940, QQ. 9869–79.

3 Cf. *P.E.P. Report*, p. 208.

4 Cf. N.H.I. Evidence, QQ. 23,571 sqq.; one of Sir Walter's suggestions referred to the advisability of requiring the large societies to issue to members periodically, with the contribution card, a short summary of the annual report of the society and other important information. He also suggested that enquiries should be made from time to time 'as to the views of the members on certain matters in regard to which it might be helpful to the Committee of Management to know the feeling of the members'.

that it was known 'in theory that they are supposed to control, and that in practice they do not'; that members 'could control if they wish to'; and 'district meetings with the necessary printing, and statements of account and so on, the ballots going on would all be costly things'; and that, apart from that, it would be 'trying to compel them to do something which they do not wish to'.[1] Apparently Sir Arthur overlooked the fact that the whole National Health Insurance system is based upon compulsion. He did not see that people must sometimes be placed in a position to make use of their rights and not only to possess them, and that such facilities are entirely lacking in the big approved societies. Not all Commissioners agreed with Sir Arthur Worley; but it is not to their credit that it was left to the Minority Report to state outright that 'the intentions of Parliament' as to the control by members and the democratic management of approved societies 'have not been fulfilled'.[2]

It would be a mistake to assume that this deficiency is confined to large offices and is merely a result of the movement towards concentration and centralization. Witnesses before the Royal Commission generally agreed that apathy among insured persons is an undeniable fact. Sir Walter Kinnear stated that the framers of the law 'did not reckon with the amount of apathy which exists among insured persons';[3] 'a very large proportion of the insured persons did not take any interest in the management of the Approved Societies'. But he added that, if there were really important grievances, members would seek and find a way of redress—a fact which does not, of course, make up for the absence of 'control' by members. The degree of 'interest' which the individual member is prepared to show in the government of his society is rather elastic. In the days when the local secretary of a society knew everybody by their first name, observed Mr Joseph L. Cohen before the Royal Commission, and went to their homes to tea, when they were pals and helped each other in distress, the member's interest in the management of the society and the drafting of rules and schemes certainly did exist.[4] But these conditions have disappeared in almost all societies, small as well as large, and with them a good deal of the personal interest of the member has gone. The absence of really 'democratic' control relates just as much to the approved societies affiliated to industrial assurance offices as to those connected with friendly societies

1 Cf. N.H.I. Evidence, Q. 23,575.
2 Cf. *Report N.H.I.*, p. 307.
3 Cf. Evidence, Q. 23,571.
4 Cf. Evidence, Q. 19,885.

proper and trade unions.[1] It matters little whether the 'soullessness of the private organizations' or the fact that the members are treated merely as 'cyphers'[2] is the cause or the effect of members' apathy. The point is that the system of administration by approved societies has proved incapable of realizing the intention of legislators to see the rank and file of insured persons in control of the administration. The powers given to members are not sufficient to secure this object; and it is doubtful whether the incentive of members to make use of their right would be materially enhanced if access to committee meetings were facilitated. The detachment of members from the affairs of 'their' approved society is materially increased the further centralization proceeds; the interests of the insured are largely local, regional or professional. It is remarkable how little attention is paid to these fundamental changes in the aspect of friendly and approved societies by modern writers. Miss E. Macadam[3] hails the 'alliance between the State and voluntary service' through the functions of approved societies without paying attention to the fact that the approved societies are an annex either to private insurance companies or to friendly collecting societies which in their practical outlook have hardly anything in common with the original idea of a voluntary cooperative and democratically ruled association. It is emphasized that friendly societies 'have a very honourable place in British social history'.[4] There is, admittedly, a dilemma. Nobody would suggest that the trend toward centralization should be stemmed if it leads to rationalization and the reduction of costs; the insured would be better off for such improvements in financial organization. On the other hand, every such step makes the original intention of the law to establish 'control by members' more and more remote.

1 Cf. Royal Commission, Evidence, Q. 7603 (Mr Alban Gordon): '. . . you allude to the Friendly Societies and the interest which is taken or not taken by their members. You say that even in Friendly Societies and Trade Unions the members take very little interest in Health Insurance?' A. 'Yes.' Q. 7604. 'Do you think there is any real incentive to conserve the funds of the society?' A. 'Not upon the members themselves, because the members have nothing to do with the administration of Societies to-day.' Q. 7605. 'There is no incentive on the part of the insured generally?' A. 'Not from the point of view of administration.'

2 Cf. Evidence, Q. 19,885 and *P.E.P. Report*, p. 208. 3 *Loc. cit.* pp. 133–4.

4 The same applies to W. Blackshaw, *The Community and Social Service*, 1939, p. 244, who declares that 'the friendly society movement is a remarkable indication of the vigour, the courage, and initiative of our people in the endeavour to meet chances and accidents of life and death, not by the way of charity, but by way of right'.

Not for the first time in history the co-operative and associative ideal of the friendly societies clashes with the trend towards economic centralization and concentration. The way out of this dilemma might appear a simple one. It would seem to lie in State control of the administration of National Health Insurance, thus taking the whole problem of administration out of the hands of the persons concerned and replacing it by the strong and just hand of the State, which would guarantee the exact execution of the law. Certainly one can agree with Mr Joseph L. Cohen, that the present approved society administration hardly differs from officialdom, and that the argument that the societies retain individualistic traits in contrast to bureaucratic machinery has become valueless.[1] On the other hand, it must be kept in mind that even the German system, a system of 'National' Health Insurance which is sometimes taken as an example of good administration by the State, is by no means simply a centralized system of State administration.

CHAPTER XXIV. GERMAN AND BRITISH SYSTEMS

'. . . the country possessing the most complete system of sickness insurance—Germany.'
I. M. RUBINOW, 1912.

A SOMEWHAT more detailed analysis of the administrative structure of the German system of sickness insurance will be helpful. (It should be noted that all observations in this book as they relate to a comparison between the British and the German systems are strictly limited to the German sickness insurance system and its administration as it existed in pre-Nazi days. Indeed, the greatest part of the German legislation as it existed before 1933 had been created decades ago and thus was before the eyes of British legislators in 1911. The Hitler regime actually destroyed many of the characteristics of the system by introducing the Fuehrerprincip, by limiting the extent of benefits in practice and curtailing the administrative functions of the sickness funds. The basis of our comparison therefore must be pre-Nazi organization of German health insurance, and in all comparative statements the reader must keep this basis in mind.)

1 Cf. Royal Commission, Evidence, Q. 19,883; also his book, *Social Insurance Unified*, 1924, *passim*.

At the time of the beginning of National Health Insurance in England it was pointed out by Mr I. M. Rubinow that the German legislators, like the English, thought it 'good politics in the best sense of the word, not to create unnecessarily a strong opposition to the National scheme among the very class whose interests it was to serve, by appearing to wish to destroy the existing institutions'. In all the important branches of social insurance in Germany, the elements of State compulsion and State regulation were present; but, except for old-age pensions, the State did not directly assume the business of insurance.[1] There is, however, this fundamental difference between the German system of health insurance administration and the British. In Britain the institutions used were friendly societies with a scattered and diversified membership; in Germany the traditional institutions were to some extent the remnants of the mediaeval guilds, while, where no such professional organizations existed, tradition recommended their resurrection in some local or regional form.[2] The still predominant insurance carriers are the Ortskrankenkassen. The German sickness funds are organizations combining workmen along the most natural lines—workmen of one locality or of one occupation, or of one industry or a correlated group of industries, according to the exigencies of the local situation. There has, it is true, been a strong tendency towards consolidation ever since the decades of the insurance law. But the administrators have been well aware that such consolidation may mean sacrificing the advantages of occupational division for the advantages of greater efficiency.

The creation of such local sickness funds was in the mind of the pioneers of British sickness insurance. 'We can imagine', wrote Sir Leo Chiozza Money in March 1912, 'the whole working population naturally grouped in local sick funds, democratically governed.'[3] We have seen in detail the particular circumstances that led to a rejection of this system, and the adoption instead of approved societies on the friendly society tradition (cf. pp. 10–13).

1 Cf. Rubinow, *loc. cit.* pp. 249–50.

2 Cf. also I.L.O., *Voluntary Sickness Insurance*, 1927, p. 394: 'In Switzerland, as elsewhere, the sickness insurance institutions owe their origin to the guilds and mutual aid funds set up by the brotherhoods, etc.' An interesting example of continuity is given: the communal compulsory sickness fund of the town of Lucerne, which was organized in 1914 on the lines of the workers' sickness fund, but whose activities date back to the year 1560 when it was created by the 'Brotherhood of Bachelor Journeymen'.

3 Cf. Chiozza Money, *loc. cit.* p. 118.

It may be that the British legislators found it a disquieting feature of the German system that there were a number of different types of administering bodies which, on the face of it,[1] might seem to be competitive. Actually the diversity is explained by reasons of organizational expediency. There are:

A. Territorial Funds (local and rural)

These are the genuine Ortskrankenkassen which comprise by far the majority of the insured. Of some 19 million insured persons in 1936 no fewer than 12,749,000 were covered by the Ortskrankenkassen and 1,813,000 by the Land (rural) Krankenkassen.[2] Each of these funds covers the same area as an insurance office, and includes all the insured persons in the area who do not belong to an occupational or substitute Fund.

B. Occupational Funds

1. *Works' Funds* (Betriebskrankenkassen). These are established in undertakings employing not less than 150 persons liable to insurance (50 in agricultural undertakings), if the majority of the employers and works concerned consent. In 1936 more than 3·5 million insured belonged to the Works' Funds. Since 1919 the establishment of new rural funds has not been allowed.

2. *Guild Funds.* These are set up by the 'Innungen' as Innungskassen, for persons employed in members' undertakings. In this case, too, the consent of the employers and employees is required. Each fund must insure at least 150 persons. The membership was about 650,000 in 1936. Originally provided only for journeymen and apprentices they have been made, under the insurance law, to provide insurance for all employees of guild members.

3. *Miners' Funds.* These comprise miners only; they are called Knappschaftskrankenkassen—the word 'Knappschaft' indicating their mediaeval descent. They represent the oldest form of sickness aid organization in Germany. They have a peculiar character of their own, primarily in that, for historical reasons, these funds are not limited to sickness insurance only, but combine it with invalidity, old-age insurance, and pensions for survivors. They are, however, frequently works' funds, limited to one large mining undertaking.

1 The mistake was also made by Sir Leo Chiozza Money, *loc. cit.* p. 118.
2 Cf. for these and similar figures as given later *Amtliche Nachrichten für Reichsversicherung*, 25 Dec. 1937, IV, 670 and *passim.*

4. *Seamen's Funds.* These comprise seamen only. They are called 'See-Krankenkassen'.

C. Substitute Funds

These funds are Ersatzkassen. They are in some ways a parallel to the 'contracting-out schemes' under Workmen's Compensation in Britain. They administer sickness insurance on somewhat different lines from the communal Ortskrankenkassen. They comprise not only workers, but also office employees; and originally they resembled in some ways the British friendly societies. It seems that they were also retained for traditional reasons, for some of them had their origin in the first half of the nineteenth century;[1] but they must allow benefits at least equal in value to those regularly allowed by the funds set up directly under the Insurance Code. In 1936, thirty-six of these funds had somewhat over 2 million members. They were in general regarded as a kind of 'private' insurance; since 1935, however, they have almost become an integral part of the Reich's insurance administration. They have become themselves the carriers of the Reich's sickness insurance; they are Körperschaften des Oeffentlichen Rechts (bodies with legal personality) and subject to the control and jurisdiction of the departments of social insurance (Versicherungsbehörden).[2] The status of a substitute fund can only be obtained by means of a special permission by the competent authority and no provision is now made for the admission of new funds.

It is the Ortskrankenkasse or local communal sickness fund which deserves the principal attention. It has been always recognized by British writers that the local sickness fund with its wide autonomy of administration represents a democratic institution in which members have part control. The local or rural sickness funds are established by decision of the communal authority (Gemeindeverband); they are expected to administer their duties within the borders of a regional insurance department, the Versicherungsamt, every regional State administration being under an obligation to establish a separate department for the administration of the various duties of the Reichsversicherung.[3] This linking-up

1 For instance, Hanseatische Ersatzkasse of 1826 (Hamburg) or the Krankenkasse des Breslauer Kaufmaennischen Vereins of 1834.

2 Cf. *Amtliche Nachrichten, loc. cit.* pp. 674–5, also *Reichsversicherungsordnung,* 1938 (edited by Dr Eichellbacher), p. 719: *Zwölfte Verordnung zum Aufbau der Socialversicherung* (Ersatzkassen der Krankenversicherung) of 24 Dec. 1935.

3 Cf. *Reichsversicherung,* Buch 1, paras. 36 sqq.

of sickness insurance administration with decentralized or regional State departments means that the Krankenkassen are actually semi-State institutions, though the routine administration of the Krankenkassen leaves enough liberty and elasticity to the territorial or professional funds. The system contrasts decidedly with the English system which provides only control by the central authority. Apart from the regional Versicherungsamt, there is the Oberversicherungsamt if a local or rural fund has not been established 'at the proper time'.[1]

The important factor, however, is that while the Krankenkassen are the insurance carriers under the Reichsversicherung, they are, in contrast to the English system, definitely related to what may be called the occupational interests of employers and employees. Local sickness funds may only be established if the majority of the employers and the majority of the adult employees, by their vote, agree to it. The vote is secret. It is the Versicherungsamt that administers the ballot and reports the result to the department which is concerned with the establishment of the fund;[2] but administration remains the affair of the fund itself, largely dependent on the particular scheme embodied in the rules or statute (Satzung) of the particular fund.[3] The rules require the assent of the Oberversicherungsamt, again the State authority, and relate among other things to the kind and scope of benefits, premiums, the composition of the board of management, etc. But the associative element is again retained. The drafting of the rules is not limited to the discretion of the communal authority; in the case of the local and rural funds the interested employers and insurable persons must be heard; in the case of works' funds the employer has to report to and hear his employees in the matter, while as regards the Innungen (guilds) a meeting of the association under the journeymen's committee must give its assent.

There is a Board of Directors (Vorstand) and a Committee (Ausschuss), to administer the business of each local sickness fund. A wise rule lays down that the members of the Committee shall not belong to the Board of Directors. The 'Vorstand'[4] is mainly concerned with the current administration of income and expenditures, accounts and technical administration. The 'Ausschuss' has

1 Cf. *Reichsversicherungsordnung*, Buch II, paras. 226–32.
2 Cf. *ib.* para. 225*a*. 3 Cf. *ib.* paras. 320 sqq.
4 The 'Fuehrerprincip' has widely changed the aspect of the 'organs' of the insurance carrier, cf. *Reichsgesetzblatt*, I, 21 Dec. 1934, p. 1274 and *Reichsgesetzblatt*, I, 25 April 1936, p. 400.

duties of a far wider scope. It has to prepare the budget of the Fund and to give its assent to the annual account and report; it has to represent the members of the fund in their dealings with the Board of Directors; it deals with questions of sickness benefit administration by setting up a 'Krankenordnung' (dealing with certain regulations relating to the insured members in time of sickness); and it is also concerned with agreements with other funds.[1] One-third of the members of this important body are the employers concerned with the fund and two-thirds insured members; but its membership may not exceed 90.[2] Adult employers and employees choose their representatives to the committee by ballot; which has to be organized separately for the two parties, with a member of the Versicherungsamt in charge of one ballot, and the Vorstand in charge of the other. Employers vote according to the number of insurable employees in their establishments.

There can be no doubt that the administrative structure of sickness insurance in Germany provides a representation of interested parties, which unlike 'control of members' in Britain is really democratic in nature. This is not merely theoretical. The whole set-up is based on the idea that sickness insurance must be related to some definite grouping, based on certain common interests. The rationale of a sickness fund must be directly or indirectly occupational. It is presumed that a given region or locality may constitute some integrated unit of occupational conditions; where this is not the case works may form their own funds for a group of workers linked by similar occupational or professional conditions. In Britain friendly societies or industrial assurance offices may cater for members anywhere and everywhere. The limit is merely set by competition for business. Approved societies may range from 100 to 1,000,000 members. We have already noted the tendency to concentration or centralization in the British approved societies. This does not, however, alter the scattered competitive position of the societies themselves, but merely implies an extra degree of co-ordination within the borders of the centralized units. The Royal Commission did not investigate how far such centralization tends to destroy still further the sense of partnership of individual members in the administration of approved societies. Representatives of the Ancient Order of Foresters, which at that time had 2,430 courts used for the administration of National Health Insurance,[3] told the Royal Commission that

1 See p. 234. 2 See *Reichsversicherungsordnung*, Buch II, paras. 327–37.
3 The branches of this society are generally called 'Courts'.

they regarded their society as affording 'a personal association which is not possible in a large centralized society. The members themselves are enabled to take a more direct interest in their own affairs and in the management of their branches.' It was contended that 'a more humane administration' was possible in a system with many branches than in a 'completely centralized system'; '. . . our officers are taught to regard, and they have the habit of regarding, their members, not as so many cases, but as individuals, and they treat them as such.'[1] Asked whether it was expedient 'that throughout the country there should be thousands of little Committees of Management administering the purely local side of a great National Health Insurance Scheme', the witness emphasized that he considered this as very much 'in the public interest' and that when attending conferences of branch offices, he was impressed by the special knowledge and keenness of branch officers: 'The interest which is developed locally produces what I may call "thinking centres" throughout the country which cannot have anything but a good influence. These people are brought together. They discuss their own problems intelligently and they become more responsible-minded individuals as consequence'.[2] This was the experience of a society which had kept aloof from concentration. Evidence on the social effects of concentration was not entirely lacking. Witnesses speaking for the Ancient Shepherds, which for reasons of finance and accountancy had greatly centralized their lodges since the inception of the Act, could not deny that there had been opposition by the lodges, particularly where 'districts' were to be grouped into an 'area', because members 'felt that they were going to a certain extent to lose their identity in the district'.[3]

Two distinct problems have to be distinguished. One is the purely economical question: How far can centralization, concentration or amalgamation reduce the cost of administration? The other is administrative and social: How far is decentralization to local or regional units desirable from the point of view of democratic control? Confronted with the existing very large number of single administrative units (see p. 235), writers and investigators are apt to see in concentration a remedy for the multiplicity of offices. They do not see that this multiplicity may have two causes. One cause may be the multiplicity of localities or districts for which National Health Insurance is needed. If the requirements

1 Cf. Royal Commission, Evidence, QQ. 3795–6.
2 Cf. *ib.* Q. 3860.
3 Cf. *ib.* QQ. 14,062–3.

of these localities, because of inherent economic and social differences and because of the necessity of interesting members locally, make individual administration of the approved societies necessary, no objection should be raised against the multiplicity of units. If, however, the multiplicity of insurance carriers is due to a merely competitive struggle of various bodies, companies, societies, trade unions, etc., for membership—the second cause—the question of units presents quite another aspect. From the members' point of view, there is no social justification for this at all.

There is a dilemma. On the one hand, the economic position of the insurance carriers may demand concentration. On the other hand, concentration may react unfavourably on the social structure of sickness insurance administration. In the German law this difficulty is recognized. While it has retained the relationship of sickness insurance to certain territorial and occupational exigencies—and, to that extent, retained decentralization—it has also recognized the desirability of concentration. In contrast to the system in Britain, certain limits were set. Sickness funds, if their committees (see above, p. 232) agree, may unite themselves into one Fund-Association (Kassenverband) if they are situated in the district of the same Insurance Department (Versicherungsamt). But it is only in special circumstances, and with special permission by higher departments, that an association of sickness funds may be established over a wider area than this. The various types of 'Kassen' are also grouped into 'Reichsverbände' or Federations, but these are mainly advisory bodies with only a few functions of administrative control. Moreover, each fund-unit may, at the end of the business year and with due notice, leave the fund association or Kassenverband—an important factor in maintaining the individual freedom of the fund in the matter of centralization.[1] Under the British law no such arrangement exists. The Act merely provides for the making of regulations governing the procedure to be followed for the purpose of the amalgamation of two or more societies or the transfer of the engagements of one society to another, and for the amalgamation or transfer of branches of societies.[2] There have been, however, certain provisions since the inception of the legislation for the making of associative arrangement in the case of deficiencies. Under the 1911 Act all approved societies which, at the date of valuation, had less than 5,000 members were required for the purpose of meeting the deficiencies

1 Cf. *Reichsversicherungsgesetz*, paras. 406 seq.

2 Cf. Foster and Taylor, *loc. cit.* pp. 126–7 for particulars.

revealed on valuation to be associated with other societies in an association formed for the purpose, or if they had not joined an association to be compulsorily grouped on a geographical basis. The 1918 Act amended these provisions; the existing legislation provides for the approval of associations of societies formed for mutual assistance against adverse results on valuation by means of a pooling of the contingency funds (see below, ch. XXVII) of the constituent societies. The association in effect acts as a society, and the constituent societies as its branches for the purpose of dealing with surpluses and deficiencies. There are special regulations in the case of societies with less than 1,000 members.

These associative arrangements, however, have no relation to the general problem of the concentration of units under National Health Insurance. Their multiplicity and variety remains the outstanding feature of a system which leaves 'any body of persons' free to start an approved society if the legal requirements are fulfilled. A recent Memorandum of the Ministry of Health spoke significantly of the 'business' of National Health Insurance which any such body 'may undertake'.[1] It is a business far more comparable to a private undertaking than to a social service. According to the Fourth Valuation the picture is of 16,953,146 insured members covered under National Health Insurance in the following ways:[2]

Type of Approved Society	Men	Women
Friendly Society with branches	2,236,164	735,546
Friendly Society without branches	3,125,029	1,437,980
Industrial Assurance Offices	4,641,729	3,224,900
Trade Unions	1,177,042	261,391
Employers' Provident Funds	80,131	33,234
Total	11,260,095	5,693,051

This distribution is not dissimilar, on the surface, to that of the German system with its local and rural funds, works' funds, guild funds, miners' funds and substitute funds. But there is a vast difference in the number of 'units', that is, the self-governing single bodies administering these various units. The Fourth Valuation was concerned with not less than 7,000 approved societies and branches. The German system, at that time, covered, so far as Reichs-insurance was concerned, almost 19,000,000 members. Yet, the number of funds was 4,690. To this must be added 36

1 Cf. Royal Commission on Workmen's Compensation, 30 March 1939, p. 152.
2 Cf. *Fourth Valuation Report, loc. cit.* p. 11; cf. also *Beveridge Report*, p. 25.

substitute funds with 2,000,000 members, so that some 4,700 units covered some 21,000,000 insured persons, while in England, 7,000 units of administration were required to insure 17,000,000 persons.[1] Here is the fundamental difference in the administrative structure and organization of the two systems. In Germany some 15,000,000 of the insured population were covered by no more than 1,310 units of administration; the works' funds accounted for more than 3,000 units, as any single establishment which sets up a State sickness insurance fund is generally a separate administrative unit. While, under the German system, the large number of units cannot be said to be unnecessary, as each unit is related to either a territorial or occupational complex with its own specific needs, in Britain the much greater number of units is largely due to the fact that considerations of necessity have been overruled by other motives. The British situation, indeed, resembles in many ways the state of affairs in retail trade, where the number of outlets or selling points may increase because of the mere anticipation of profitability, with the result that a definite over-supply of distributive agencies is brought into being. As Prof. Alexander Gray submitted to a witness before the Royal Commission: 'Half of them [the societies] say the other half should not exist.'[2] This question reveals the purely commercial aspect of units which are expected to serve the non-commercial objects of a social service. In any moderate-sized town the insured persons may be scattered amongst some hundreds of societies and branches. The Royal Commission, for instance, was informed that in Liverpool 488 societies had members: in Bolton 285, in Brighton 304, in Norwich 213, in Reading 245 and in Tynemouth 168.[3] In Glasgow some years ago it was discovered that 98 societies were represented by only one member each, and Political and Economic Planning prepared a table not long ago showing that 337 employees of a medium-sized undertaking in the South-West of England belonged to no fewer than 36 societies.[4] It was the aim of the early legislators of National Health Insurance to avoid such a patchwork system of administration. Though they did not have it in mind to relate the number of units strictly to territorial or professional grouping, they did require, in the first draft of the statute, a minimum membership of 10,000 insured persons as a condition of the approval of any society. It was only natural, in view of the attitude

1 For German figures, see *Amtliche Nachrichten, loc. cit.* pp. 670 and 675.
2 Cf. Evidence, Q. 22,515. 3 Cf. *Royal Commission Report*, p. 96.
4 Cf. S. Mervyn Herbert, *loc. cit.* p. 97.

taken by friendly societies and industrial assurance offices, that such a condition met with insuperable obstacles. The result is the present multiplicity and the un-planned scattering of units all over the country.

The original idea of National Health Insurance was to eliminate private interest and to secure democratic control by members. It has not been realized. The administrative system is largely linked up with industrial assurance companies that have other money-making interests which, in an indirect way, may derive profit from the connection. In the case of friendly societies, and particularly friendly collecting societies, which are not profit-making concerns, there is no commercial gain in the affiliation with approved societies. But the friendly societies have long since lost their original associative character; they have developed an ambition for financial expansion and financial power which is not different in character from that of private concerns.[1] Their entire structure and government resembles that of a private undertaking. In so far as this is the case, their interest in approved societies is the same as that of life assurance companies—the connection with approved societies is regarded as a valuable asset to their 'business'. This being so, democratic control, apart from technical reasons, has ceased to exist in practice. If the scheme had been limited to territorial or occupational units, such as industrial or commercial establishments, there would have been no room for this competitive expansion of insurance offices and friendly societies.

It was unfortunate that the Report of the Royal Commission paid little attention to a thorough comparison of the British system with that of other countries. This omission led the Commission to the erroneous belief that the only alternative was between autonomous administration by approved societies or a centralized State administration with a common fund. 'We feel', the Report emphasized, 'that if a centralized system were adopted it would compel the dissolution of approved societies,[2] since the reduction of societies to mere paying agencies would involve the separation of administration and financial responsibility, a result which could not, in our opinion, be defended . . . we feel that it is to the advantage of the public that this great Scheme should be administered by the representatives of the insured persons them-

1 Cf., for some details, Wilson and Levy, *Industrial Assurance*, pp. 388–9 and *passim*.

2 Cf., for similar argumentation, *Beveridge Report*, pp. 33–5 and *passim*.

selves.'[1] But, as we have seen, the German system, while widely differing from the system of approved societies, leaves administration to local and occupational institutions. The International Labour Office has made it quite clear that 'self-government by the persons concerned' is essentially desirable; and it has also stressed the fact that territorial funds under public supervision of the public authority are, in its opinion, the best method of realizing this object. It is between such funds and the scattered multiplicity of British approved societies that the true contrast is to be sought, not between approved societies and centralized administration.[2]

CHAPTER XXV. SURPLUS AND BENEFITS

'A great deal has been said about the approved societies, but the House must not forget 30 years after the start of insurance that voluntary effort was first in the field of social insurance. It may be that at this stage in history the evidence may show that there must be another solution.'

MR ERNEST BROWN, Minister of Health, House of Commons debate of 15 July 1941.

IT is not surprising that there is a constant risk of financial difficulty in the case of a number of approved societies. Their formation is not due to a strict assessment of some territorial or other necessity. It is rather influenced, in many instances, by the desire of insurance offices of various sorts to increase or maintain their business. Thus, financial risk is inherent in the very structure of National Health Insurance organization in Britain. In competition some are fortunate, others are not.[3] In the case of insurance schemes based on territorial funds, or funds covering a group of workers, such competition is excluded. This does certainly not mean that monopolistic funds must necessarily be solvent. The German law, for instance, lays down definite regulations to deal with cases of financial deficiency.[4] But it is evident that, where certain absolute tests exist by which the solvency of a fund can be calculated, the danger of deficiencies is far less than with an organization which leaves the profit and loss account to no other

1 Cf. *Report*, pp. 101–2.

2 Cf. I.L.O., *The International Labour Organization*, 1936, pp. 54–5: 'Insurance Institutions'.

3 See for more details chapters XXVI–XXVII.

4 See paras. 267 sqq. of *Reichsversicherungsgesetz*: a local sickness or rural fund, erected for districts of the insurance department, for instance, will be closed, if its membership sinks permanently under one thousand and no amalgamation is forthcoming, or if the income of the funds is not sufficient to cover the statutory benefits, etc.

checks than those existing in private business where a venture is successful or unsuccessful according to the amount of business which may be got or not got. It has been the deliberate policy of National Health Insurance administration by the central authority not to interfere with the process of competition; there has been no attempt to discourage the competitive increase in the number of administrative units.[1] Evidence before the Royal Commission left no doubt that with many of the smallest units there was a permanent latent danger of insolvency: 'the time may come when, although they are all right at the moment, they may have a sickness wave which will swamp the whole of their funds'.[2] The principal barometer to judge their future with some certainty, the number of members for which they would cater under a monopolistic system, is absent. The future of many societies depends purely on chance or ill-chance, in the same way as somebody might deem it profitable to start a sports ground, in spite of existing competition, and with no accurate standard to judge beforehand the chances of commercial success.

Unfortunately, neither the Report of the Royal Commission nor, ten years later, the Political and Economic Planning Report paid any attention to the factor of 'business-getting' National Health Insurance. The attempt to create or maintain business, at whatever price, where it may be subject to great financial risks, and where, at the best, only units with marginal surpluses can be started, always entails financial danger. Mr Alban Gordon told the Royal Commission very frankly:[3] 'We spent hundreds of pounds on advertisements, Press and otherwise. We have spent thousands of pounds on procuration fees for members; we have spent thousands of pounds on internal expenditure, merely for the sake of counteracting the veiled attacks made on our Society to capture our members, and in our turn to do a little capturing of our own . . . there is this element of competition . . . every society is at war with every other society, and that leads to expense . . . .'

Though members speaking for a large society denied that agents were 'poaching on anybody else's membership', it could not be denied that agents were eager to get new members.[4] Everybody

1 Cf. Royal Commission, evidence by Sir Walter Kinnear (Insurance Department, Ministry of Health), Q.614: 'The Department has no policy in the matter, and it rarely acts except on administrative grounds.' Another view of the official policy was given by Cohen, *loc. cit.* p. 32, but no proof was adduced that the abolition of smaller units was 'actually the official policy'.

2 Cf. Evidence, Q.6661.

3 Cf. Q.7473.

4 *Ib.* Q. 10,596.

conversant with the methods of business-getting by industrial assurance agents[1] knows what such canvassing means. As long as there is a chance of getting or retaining members by means of propaganda and canvassing the 'business' of approved societies remains speculative—and uncertain.

The result has been the enormous number of approved societies which sprang up during the first years of National Health Insurance, a number now considerably reduced—but, as we have seen,[2] formidable when compared with the number of administrative units in systems of territorial or occupational grouping. At present the problem is not that the approved society will again lead to an increase in the number of units; actually, the Fourth Valuation disclosed only an insignificant number of new units.[3] The problem is rather the exceedingly large number of units that still exist. The Fourth Valuation disclosed the following results as to the conditions of the various units:[4]

	Number of Members
Entitled to additional benefits	
Members of units with disposable surplus	14,733,621
Not entitled to additional benefits	
Members of units	
(*a*) with surplus but not disposable	739,565
(*b*) with equal assets and liabilities	812,208
(*c*) with deficiency	667,752
Total	2,219,525
Grand Total	16,953,146

The so-called disposable surplus (this is, according to the explanation in the Government Actuary's Report: 'where a surplus is found on valuation the valuer shall certify as disposable only such part of it as in his opinion may be reasonably expended within the period of the duration of the scheme of additional benefits following the valuation'. It has to be distinguished carefully from 'aggregate net surplus') was approximately the same at the Third and Fourth Valuations (the Third Valuation ended in 1929, the Fourth in 1934). But it should be remembered, before the conclusion is drawn, that the position of Approved Societies had not deteriorated between the two dates,[5] that while

1 Cf. for a detailed description in Wilson and Levy, *Industrial Assurance*, chapter on 'Business-getting'. 2 See above, p. 236.
3 See *Government Actuary's Report, loc. cit.* p. 7. 4 Cf. *ib.* p. 26.
5 Such impression is given in the *Annual Report of the Ministry of Health*, 1935–36, p. 182.

the Third Valuation covered 11,588,144 members, the Fourth covered 14,733,621 members of societies with a disposable surplus. It must be noted that, in the Fourth Valuation, there were no fewer than 5,000,000 women so covered against 2,100,000 in the Third; thus in consequence the sickness frequency was greater, since the relation of the sickness claims of women to the actuarial standard of claims is known to show an almost continuous increase.[1] In the case of 6,435 societies and branches, comprising 15,473,186 members, surpluses (though not altogether disposable) were disclosed amounting to £2·42 per member, equality of assets and liabilities was found in 228 societies, while deficits were found in 292 societies amounting to £1. 0*s*. 11*d*. per member. Of the latter societies 44 deficit cases related to societies and 248 to branches.[2] The Fifth Valuation was not completed when our investigation was begun. It is not, however, expected that the results of the valuation as to disposable surpluses will differ materially from those of the last valuation. Of 994 reports, for instance, which were made known during 1938–39, the valuer was able to declare a surplus in 803 cases covering 584,000 members; a small surplus was disclosed in 91 reports covering 54,000 members of which, however, no part could be released for additional benefits; 40 reports with 35,000 members showed equality of assets and liabilities; and in 60 reports with 28,000 members deficiencies were revealed.[3] One can say roughly that, now as before, some 15 insured persons may receive no additional benefits from surpluses against 100 who do.

The Report of the Fourth Valuation recorded with apparent satisfaction that 'no less than 87 % of the insured population are in societies able to provide additional benefits out of disposable surpluses'.[4] Such percentages are euphemistic. It would be different if additional benefits were additional 'extras' supplementing an already liberal range of benefits. Actually, this is not the case. Additional benefits are not special 'favours' which may be distributed out of surpluses; on the contrary, they represent in most instances benefits that are absolutely essential to the welfare of the insured sick, because ordinary cash benefits are utterly in-

1 Cf., for many interesting details in this matter, *Report of the Departmental Actuarial Committee to the Royal Commission*; *Report* of the latter, pp. 332 sqq. and pp. 339–40.

2 Cf. *Government Actuary's Report*, pp. 18–28, 39, 54.

3 Cf. *Annual Report of the Ministry of Health*, 1938–39, pp. 139–40.

4 Cf. *loc. cit.* p. 54.

sufficient for the needs of the working-class family and ordinary medical benefits cover only the barest needs of medical treatment. It is the additional benefit that is of decisive importance to the insured person. Against this background it cannot be regarded with any complacency that 'only' 13 % or 15 % of members of Approved Societies do not receive such benefits. It is much more to the point that no fewer than 2,000,000 insured people go without these benefits, because there are no 'disposable' surpluses.

Moreover, the mere fact that some societies have disposable surpluses cannot be regarded as sufficient to rank them as satisfactory units. In some cases such surpluses may only be sufficient to cover very slight 'additional' requirements. A society may give dental benefit, but not be able to provide any sort of appliances. Another may give ophthalmic benefit, but not be in a position to pay anything for convalescent members or nursing service or hospital treatment. We have already seen that, out of some £3,500,000 spent on additional benefits, not less than £2,200,000 went into dental benefit alone. It is gravely misleading to think that, because a society pays additional benefits, the level of medical service to the insured is at once materially raised. It is certainly so in certain cases, and it may be so to only a very limited scale. Nothing is more needed than an investigation by the Ministry of Health into the real significance of the disbursement of additional benefits to the insured sick. It means very little to say that this or that society gives additional benefit and others do not. The important point is to know exactly what these benefits are, how far they satisfy the various requirements of all the sick members, in particular as regards treatment. It is quite useless, from the social point of view, to lump all societies giving additional benefits into one total and then to express satisfaction that only 13 % or 15 % obtain no such benefits. The sufficiency and effectiveness of benefits remain entirely undisclosed by statistical generalizations of this sort.

Nor is it any consolation to living members to be reminded that a 'considerable part of the surplus has to be carried forward' and that 'these reserves, with their accumulations, will eventually form a predominant element in the maintenance of additional benefits in the future, since the opportunities of accumulating new surplus will necessarily be restricted'.[1] It was one of the chief complaints about insurance clubs in former days that one generation of

1 Cf. *Government Actuary's Report*, p. 54.

members was asked to pay for another. Young persons were disinclined to pay for the benefit of older members who might later on participate in the sharing-out of the funds.[1] The issue in this case is not the same, but similar. It is not fair to the present members of approved societies, when they fall sick, to tell them that they cannot be given adequate additional benefits, as perhaps the society would desire, because funds have to be reserved to maintain the existing inadequate benefits for future generations. Instead of depriving the current generation of proper benefits in favour of those coming after them, or of those now still in good health, but liable to sickness in the future, such institutions should rather be regarded as incapable of fulfilling their obligations and removed. It was certainly not the purpose of the framers of the law to have millions of insured persons left without additional benefits. Nor was it in their mind to bestow upon a large section of the insured additional benefits insufficient in range and unsatisfactory in both quantity and quality. Their expectations would certainly suffer a shock if they were to learn that many societies pride themselves on belonging to the munificent class of insurance carriers that give dental benefit, or provide help in the obtaining of appliances or artificial limbs. An analysis of the causes of these financial shortcomings which restrict the insurance benefits of millions, and of the financial disparities between the insurance carriers, is one of the most urgent necessities for understanding of the present administration of the scheme.

CHAPTER XXVI. FINANCIAL SHORTCOMINGS

'...the most important investment of all is investment in the health, intelligence and character of the people.' PROF. PIGOU, *Socialism versus Capitalism*, 1937.

THE financial position of approved societies has a general background and a specific background. Under any system of sickness insurance there will be particular conditions which contribute to the greater or lesser financial success and stability of the insurance carriers. If, for instance, as in Britain, the administration of sickness insurance is burdened with the financial responsibility of medical benefit to workers injured in their occupation, this obligation must obviously react on the financial condition of the scheme. Again, the finances of the scheme will depend to a large

1 Cf. Wilson and Levy, *Industrial Assurance*, p. 27.

extent on the legal and administrative arrangements made for the economical administration of medical benefits. These are matters related to the general background of economical administration. They do not directly relate to the question which is our concern at this stage, that is, what the particular factors are which are responsible for the financial deficiencies of approved societies. We can take for granted the general conditions of economic and financial organization which affect all insurance carriers and single units alike; and then ask why, in the case of a large number of insurance carriers, the conditions which should enable them to provide an ample and adequate supply of additional benefits do not exist.

The first possible cause that comes to mind is maladministration, either actual abuses or fraud, or inefficiency. Actually legislation and the central administration provide ample safeguards against abuse or fraud.[1] In the words of the Ministry of Health: 'it is essential that each Society should have competent officers and a Committee of Management who take an active interest in the affairs and administration of the Society. . . it is the practice of the Department to watch closely the administration of each Society in these respects and the position of every Society is periodically brought under review. . . where any serious weakness is found in the administration of the Society, interviews are arranged between officers of the Department and the Committee of Management of the Society'.[2] A great number of departments are in continuous control of the administrative affairs of approved societies (see chapter XXII, pp. 212–14) and hardly any loophole is left. The Act also contains provisions against maladministration by societies and their officers by the application of certain sections of the Friendly Societies Act, 1896. The sections applied to the Insurance Act are set forth in a schedule to the regulations, and deal with such matters as the bankruptcy of officers, the rendering of accounts by officers and various offences.[3] Deficiencies in a society's administration account may be wiped out by a levy on members. In practice, a deficiency does not arise until the savings of previous years have been wiped out.[4] So that the process of financial deterioration—the transition from a surplus to an

1 Cf. for regulations of maladministration and withdrawal of approval, section 26 of *Approved Societies' Handbook*, 1933.
2 Cf. *Annual Report*, 1935–36, pp. 187–8.
3 Cf. Foster and Taylor, *loc. cit.* pp. 123–43 and pp. 233 sqq. for further details.
4 Cf. Sir Walter Kinnear, Evidence to the Royal Commission, Q. 766.

eventual deficit—may be a slow one, and the process may remain hidden from the members, particularly as they do not take an interest in the administration.[1] It is, therefore, not only necessary for the central inspection to stop irregularities and financial deficiencies, but also that this should be done at the earliest possible date and before the actual emergency occurs. The Government Actuary's obligations as regards 'apprehended deficiencies' resulting from valuations should serve as an example.[2] Nevertheless, maladministration in the legal sense cannot possibly be said to be the cause of the financial deficiencies of the societies. It cannot be contended, nor has any evidence been adduced, that the administration of approved societies by insurance officers lags behind the general high commercial standard of the insurance business in Britain. The Report of the Royal Commission could not find any fault. Sir Walter Kinnear, for the Ministry of Health, told the Royal Commission that 'the standard of their administration' had now reached a high level, even if due consideration was paid to the fact that in many societies there were numbers of part-time men and sometimes a lack of 'highly competent' officials.[3]

The causes must be sought elsewhere, in economic and organizational factors which, quite apart from the actual standard of administration, tend to create surpluses here and deficits there in the business of National Health Insurance.[4]

The emergence of a surplus on valuation, or the absence of it, is mostly due to causes which are inherent in the very structure of National Health Insurance organization in Britain. There is a flat rate of contribution (though a different one for men and women) and a uniform scale of statutory benefits. No account can be taken of the varying risk-proneness of this or that class of worker or of this or that class of district. Contributions cannot be increased to meet higher risks beforehand. For example, a society composed mainly of chemical workers could hardly fail, in general, to show a less favourable result than a society mainly composed of rural workers. German legislation adapted itself to this feature by

1 Cf. Sir Walter Kinnear, before the Royal Commission, Q. 73: 'So far as members are concerned we find as a general rule [sic!] they do not take any interest in the matter until or unless there is a levy made upon them for an administrative deficiency.' For an example, see *H.C. Debates*, 15 July 1941, col. 514: 'if that decline continues, the society will go out of existence altogether.'

2 Cf. for 'apprehended deficiency', N.H.I. Act, section 107.

3 Cf. Evidence, QQ. 23,543 sqq.; cf. for Scotland, *ib.* Sir Walter Leishman, Q. 24,346.

4 Cf. also Royal Commission Report, p. 115.

creating the two classes of local and rural funds. Where the scale of statutory benefits is made dependent on a scale of contributions which is adjustable within certain limits the risk of financial loss to the insurance carrier is obviously lessened. The German sickness insurance law regulates the rate of contribution by reference to wage-standards, and varies cash benefits according to earnings (see above, p. 63). Apart from this, the statute of any sickness fund may grade the amount of contributions according to occupational groups of the insured if there appears to be a particularly great risk of sickness.[1] In some industries greater risks may find expression in higher wages, and thereby higher contributions, although this is by no means the rule. But, where, as under the German law, the funds must regulate contributions so as to be adequate to the statutory benefit requirements, occupational or local sickness risk can well be taken into account. In England no such flexibility exists. It may be argued that in general sickness may be considered as evenly spread over the whole population. But, while under the German and other laws workmen's compensation, so far as medical requirements go, is substantially covered by professional associations for particular trade groups, in England it is a general obligation under National Health Insurance. In countries where medical treatment for industrial injury is, at least for major injuries lasting for a long period, an obligation of workmen's compensation, one important contingency with a very varying degree of risk is removed from the sickness insurance carriers. In England, on the other hand, a society is not in a position to calculate the special risks involved for members who may be particularly exposed by their occupation, say, to silicosis dust, or to eye trouble, as in the metal industries, or to any other disease or injury related to some particular industry. The society, unless it has limited itself to certain principles of membership, takes its insurable persons wherever it can get them; it is not in a position to pay regard to the special risks arising from the occupation or location of its members. The result is that where a society happens to draw its members from occupational groups with particularly heavy sickness risks its financial status becomes more endangered than would otherwise be the case.

This is the case in mining. As Mr Tinker explained recently to the House of Commons:[2] 'Everybody knows that mining is a difficult occupation. Men fall sick more often in that occupation

1 Cf. *Reichsversicherung*, para. 384.
2 Cf. *H.C. Debates*, 15 July 1941, col. 514.

than in any other.[1] The men concerned pay the same contributions as others, but they are on the minimum benefits.' He described the financial status of a particular society which in a mining area had 'difficulty in continuing to exist' owing to the 'very unfavourable sickness experience of the members'.

The position is borne out by figures. The Government Actuary's Report on the Fourth Valuation stated that the financial status of approved societies was unfavourable with regard to Wales. 'These unfortunate results are to be attributed in great measure to occupational circumstances.'[2] The importance of selected membership cannot be overlooked. According to the Fourth Valuation, in 6,420 societies and branches showing a surplus, with a total membership of more than 15,000,000, the average number of members per unit was 2,400, while in 281 societies and branches with a deficiency and a membership of 606,000, the average number of members per society was 2,160. The reason is that, while large societies are in general more economically run, the smaller societies often consist of a more selected membership with a good health record.[3] In an interesting and detailed article on 'Future of Social Insurance', the *National Insurance Gazette* of 16 October 1941 stresses the point that (1) bad management and (2) bad membership may be the reasons for a denial of additional benefits. 'The chief trouble is membership', says the journal; but it merely mentions that certain territorial inequalities of health, such as exist in poor mining areas, are the cause.

It is quite obvious that economic and social circumstances outside the sphere of an approved society's control may suddenly shake its financial position and endanger the surpluses. Commenting upon the unfavourable status of some units, the Government Actuary's Report stated that the 'most prominent cause' was 'the heavy claims for sickness and disablement benefits and the shortage of contributions which has been experienced'.[4] The percentage ratios of actual cost to expected cost of sickness and disablement benefit, in the period under review at the Fourth Valuation, were:

	Sickness Benefit	Disablement Benefit
Men	111	153
Women	112	130

1 For many details of this: *Report of the Royal Commission on Safety in Coal Mines*, 1938.

2 Cf. *loc. cit.* p. 20.

3 Cf. *P.E.P. Report*, p. 207.

4 *Fourth Valuation Report*, p. 40.

Another factor which may suddenly fall heavily upon the societies' finance is unemployment. The marginal societies with some disposable surpluses may under circumstances of heavy unemployment be forced into a difficult position. As to this, the treatment of arrears has been of some importance; by the Act of 1932 the concession of a complete excusal of arrears due to genuine unemployment, which had been granted under the Act of 1928, was curtailed; the insured persons concerned were made liable for about 40 % of the value of the lost contributions. By the Act of 1935, new arrangements were made and the concession of 'full' excusal was restored.[1] Though legislation has tried to mitigate the effect of such arrangements on the financial status of approved societies, there can be no doubt that any special burden imposed by such provisions falls more heavily on the poorer societies.[2]

We have observed that, by a greater integration of insurance risks through the forming of local or occupational or professional groups, the financial position of societies might be improved. But, as the Report of the Royal Commission quite rightly observed, the process of 'segregation' has been carried so far 'that there are few societies which can be regarded as being in any way microcosms of the insured population as a whole'.[3] The contrast between societies has become widened inasmuch as (see above, p. 223) lately a movement towards the centralization of units has taken place. The big centralized society, when it opens its membership to all without distinction, may represent more than any small local body a microcosm of the entire insured population, although, as the Report observes, a society may be stronger 'in

1 Cf. *Government Actuary's Report*, p. 55, for details.

2 Cf. Foster and Taylor, *loc. cit.* pp. 35–6; the Act of 1928 provided recourse to the Unclaimed Stamps Account for societies which had suffered a loss of contribution through the arrear excusal; the movement for restoring this arrangement arose in 1934 among the large approved society organizations; the cost of the concession made in 1935 is met out of the Unemployment Arrears Fund whose income is derived from a State grant and a portion of each contribution paid by or on behalf of every member of an approved society. Out of this fund there is credited to every approved society a sum equal to 3½*d.* in respect of each of the total number of arrears of contributions which are left out of account on the grounds of genuine unemployment in accordance with regulations made under Section 65 of the Act. Cf. Arrears Regulations, 1937, Art. 3.

3 Cf. p. 100: '...As a consequence the Approved Society system is made up of societies resting on segregation, conscious or unconscious, of members varying in health experience and health prospects.' See also next chapter.

one part of the country than in another; even if its membership be spread over the whole country, it may not be uniformly strong as between urban and rural areas, or as between manual and non-manual workers'. But a centralized society contrasts with local or occupational funds in that it represents far more a disintegrated mass of risks, while funds founded upon an occupational or territorial basis will reflect far more the particularities of certain groups in regard to sickness risks. Centralization undoubtedly affords great advantages as regards administration, which smaller units do not possess. If the reduced chance of 'selection' is a disadvantage to the larger units, their centralized administration counterbalances this disadvantage and strengthens their position and their ability to show disposable surpluses, compared with the smaller decentralized societies. Where the administrative system leaves 'segregation' to the free play of competitive forces and dismisses the possibility of unified grouping, it is inevitable that a process of concentration, by amalgamation or otherwise, will prove economically advantageous.

The Royal Commission received ample evidence that, in 'business efficiency', the small approved society may well be at a disadvantage compared with the 'large concerns'. It must be stated that a representative of the Ministry of Health before the Royal Commission, Sir Walter Kinnear, did not wish to admit that the 'smallness of a society's membership should be taken as a test of its financial weakness'.[1] This is true; but it does not dispose of the fact that, where a small society fails, it may be due largely to the fact that its overhead charges and machinery of administration are less economical than those of larger societies. Sir Walter Kinnear himself could not dispute that 'the consolidation of separate branches into large units...had on the whole resulted in more efficient administration', and that 'the reduction of numbers of branches in branch societies and their transference into districts had on the whole resulted in a higher standard of administration'.[2] Mr T. Wood Huntley, Past Most Worthy Patriarch of the Order of the Sons of Temperance, expressed very definite views on this point.[3] 'The per capita expense is large in small units by reason of over-head charges', he declared. It has also to be borne in mind that a small society may be much harder hit by some casual misfortune. Witnesses for the Scottish Board of

1 Cf. his evidence *passim*, and in particular QQ. 23,562 sqq. Cf. also QQ. 1882 and 536.

2 Cf. Evidence, QQ. 618–19.

3 Cf. *ib.* Q. 21,405.

Health had to agree that 'if a society had only 50 members, one heavy claim would have so great an effect that if there was a small surplus . . . the Government Actuary would hesitate to divide it, but if you had 10,000 members and there was a surplus many times larger, but exactly the same in proportion, the Government Actuary would say: "Well, here are enough in numbers to justify taking that surplus as being not accidental, but a certainty", and therefore at any rate a certain part of it could be justifiably divided'.[1] The inexpensive administration achieved by some small societies should not obscure the underlying facts. Where small societies are managed cheaply, because they are essentially localized and benefit from inexpensive part-time work and cheap office accommodation, their expense ratio may be more favourable than in many a larger society, which only conforms to experience elsewhere, as for instance, the friendly collecting societies which sometimes, for these reasons, have relatively small expenses.[2] The problem of financial efficiency arises in the far more numerous cases where these small units are competing with larger units on conditions of similar economic organization. Here, without any doubt, their position is far less satisfactory.

We may say that neither general nor partial maladministration, neither fraud nor the negligent or incompetent management of approved societies, accounts for their financial deficiencies. It is not their technical administration that is to blame, but the system itself. On the contribution side, the rigidity of the flat-rates principle prevents any elasticity on the part of societies to adjust themselves to greater risks by ampler contributions; but on the expenditure side there are no general restrictions. Societies were started on a competitive basis whenever there seemed to be a prospect of financial success. The result is a number of units far in excess of actual necessities. A process of concentration began long ago, but it has not yet found expression in an elimination of the units which have no disposable surpluses to be distributed in the form of additional benefits. The Report of the Royal Commission mentioned that, in defence of existing inequalities, it was argued that the present competitive system 'enables the insured to group themselves in such a way as to secure the maximum advantage from their contributions'.[3] The Report was apparently

1 Cf. Evidence, Q. 1874, also Q. 21,407: '. . . with very small numbers there is a great danger of abnormal experience striking them and upsetting them.'
2 Cf. Wilson and Levy, *Industrial Assurance*, p. 365, note 1, for particulars.
3 Cf. *loc. cit.* p. 100.

in favour of what it called 'segregation', but it did not make it clear to its readers that the obvious disadvantage of such 'free grouping' in practice has been, and still is, that the 'grouping' may lack any economic logic. It would be different if all approved societies recognized the necessity to relate their grouping to certain definite principles of integration, such as territorial or occupational exigencies. But for this the *sine qua non* would be that such groups should enjoy a monopolist position in their 'circuit' which would involve a very different kind of control and supervision by the authorities. As it is, people living in the same street or working in the same establishment may be members of a number of different approved societies, of societies differing entirely in their disposable surpluses and the additional benefits provided. The position is just the same whether they are large centralized institutions or institutions with branches. Centralization does not essentially affect the question of inequality of surpluses. The average membership is not much bigger in societies with a surplus or a balanced account than in those which show a deficiency. The economy of centralized administration is offset to some extent by the ability of smaller units to select their members, though this does not mean that 'segregation' is equivalent to decentralized integration on a territorial and/or occupational basis. Overlapping and redundancy remain. Competition for membership is still the outstanding feature of the approved societies' system. It seems contrary to all conditions of purchase and sale that, for the same price, the same contribution, one purchaser may receive less than another. The system resembles the purchase of equities with fluctuations in price and dividend more than that of national social service which is expected to give equal benefits for equal or proportionate contributions. The ill-effects socially of these discrepancies on the insured themselves are notorious. It is these that must now be described.

CHAPTER XXVII. SOCIAL EFFECTS OF, AND RECOMMENDATIONS FOR REMOVAL OF, INEQUALITIES OF BENEFIT

'. . . faith in "automatic adjustments", and . . . general regardlessness of social detail, is an essential emblem and idol of those who sit in the top tier of the machine. I think that they are immensely rash in their regardlessness, in their vague optimism and comfortable belief that nothing really serious happens. Nine times out of ten, nothing really serious does happen—merely a little distress to individuals or to groups. But we run the risk of the tenth time . . ., if we continue to apply principles of an Economics, which was worked on the hypothesis of laissez-faire and free competition, to a society which is rapidly abandoning these hypotheses.'

LORD KEYNES, *The Economic Consequences of Mr Churchill*, 1925.

IN the foregoing chapters the circumstances have been described and analysed which have led to wide differences in the benefits, cash and medical, distributed by and under the system of approved societies. It is now necessary to describe the social effects of these differences. Admittedly, it would be unjustified to expect systems of sickness insurance to contain perfect 'equality' of benefits, that is to give to every insured person the same complete and comprehensive treatment, even such treatment as a well-to-do citizen can get. Such an ideal state of affairs would require as a first condition the existence and availability of a vast number of well-distributed and co-ordinated hospitals, and a national medical service within easy reach of everybody with no waiting lists or overburdened and overworked medical practitioners. Even in Soviet Russia no such comprehensive and complete service, with no inequalities of treatment at all, has yet been created, although the multiplicity of agencies that deal with sickness in this country—such as the Ministry of Health, the Home Office, the Ministry of Pensions, insurance companies, friendly collecting societies, assistance boards, voluntary welfare, etc.—has been avoided. The Russian system, though workers have no longer to make contributions, still rests on the insurance principle (plus public assistance); it is necessarily decentralized into occupational or territorial groups and to some extent the costs are borne by the State and local authorities. The machinery available up to now for medical treatment is by no means capable of guaranteeing to every sick or injured worker that, in his particular case, everything will be provided that in theory should be due to him and may be provided to others, a fact which is not surprising when the vastness of the country and the short life of the new principle of social

insurance in Russia are taken into account.[1] In Germany, too, where organization is easier and of a longer standing, no 'equality of benefits' can be claimed. As Dr G. F. McCleary, formerly Principal Medical Officer of the English National Health Insurance Commission and a Deputy Senior Officer to the Ministry of Health, has stated, 'the range of medical treatment . . . is probably most fully developed in Germany,[2] where the insured person . . . has provided for him under the insurance scheme the whole range of modern therapeutic measures, etc.' But even here special facilities for treatment exist in one place and not in another, according to whether the territorial sickness funds have been able to start and maintain them. If, for instance, the General Local Sickness Fund in Hamburg prides itself on having four institutions for artificial sunlight therapy to treat about 7,000 persons annually, or if the Krankenkassen of Berlin have a research institute for the benefit of their patients, where 5,000–6,000 examinations are made monthly, these progressive arrangements do not benefit insured German workers in other places.

In thiss ense 'equality' must still remain a theoretical category. But this is no excuse for the inequalities of benefit that exist under the present system of National Health Insurance in Britain. It is quite evident that inequalities of benefit have to be judged by the standard of the benefits granted. The fact that a certain medical treatment benefit of particular and costly nature cannot be made available to every insured person is one thing. It is quite another that there should be conditions of benefit in which a scanty 15*s*. or 18*s*. weekly cash payment may be supplemented by another, still quite insufficient, 3*s*., or where medical treatment benefits such as specialist treatment, hospital treatment or the provision of appliances, may be available to one insured person but not to another. It is inequality at the level of necessity that is intolerable.

The extreme inequalities of the benefits granted by the various approved societies have been strongly emphasized by many advisory bodies and authors. Before the Royal Commission on Workmen's Compensation, in 1939, Mr Bearn, giving evidence for the Ministry of Health, explained:[3] 'At the one extreme you get a society which can pay, say, five substantial cash benefits, and the whole of the treatment benefits, dental, ophthalmic, convalescent home—the whole range of the additional benefits. There are a few societies who can do the whole of that, and even

1 Cf., for more details, *The Economist*, 27 Dec. 1941, 'Social Insurance in Russia'.
2 Cf. McCleary, *loc. cit.* p. 53.
3 Cf. Evidence, Q. 1292.

in the extreme case, find they have got so much money that they can return the contributions . . . the extreme case at the other end is that they get their full statutory benefit for which they contracted in the premium and nothing more.' But within this wide gap of 'extremes' there are innumerable variations. It should be noted that the lack of uniformity in the provision of additional benefits, in particular treatment benefits, is not restricted to a lack of uniformity in the selection of benefits, but applies also to the different ways in which the same benefits are provided by different societies. It depends on many circumstances what an approved society will actually consider sufficient or not, and variations in interpretation may be very great. Moreover the Report of the Royal Commission observed that it had been stated that 'the arrangements made between societies and professional bodies are wanting in authority and uniformity and in some cases are accompanied by undesirable conditions'. But, to the regret of a minority of the Commissioners, the point was left 'where it was'.[1] The Royal Commission devoted much time to a discussion of the causes of these disparities of benefits, but unfortunately gathered little evidence about their social effects. In any new official enquiry the insured people who suffer under these inequalities should be heard, and bodies like the Charity Organization Society and other charitable institutions should be questioned about it. It would then emerge that people living in the same street, even in the same house, may find that they receive entirely different benefits.[2] Persons suffering from the same sort of illness, or disabled by the same kind of industrial accident or disease, may be given totally different prospects of restoration. One person may be treated for a slight dental inconvenience; another may die from a more serious dental trouble.[3] One person may recover quickly and efficiently from a serious illness in a convalescent home; another paying the same contribution may suffer a serious recurrence of illness because of the lack of this additional benefit. One person may obtain full benefit from an appliance provided; another might get an appliance of much less efficiency and usefulness; a third may get no appliance at all.

Qualifying periods for additional benefits might well be justified where the benefits are really 'additional' in the sense that they

1 *Royal Commission Report*, para. 81 and *Minority Report*, para. 86.

2 Cf. S. Mervyn Herbert, *loc. cit.* p. 95.

3 Cf. Royal Commission, Evidence, Q. 5373: 'lack of dental treatment might result in the death of a miner from septicaemia.'

represent an amplification of necessary cash and medical benefits. This is hardly the case in Britain, where additional benefits provide for what should be considered bare necessities. Additional cash benefits are granted only when an insured person has been four years a member of a society; the qualifying period for additional treatment benefits (8–16) is two years.[1] If additional benefits in Britain were of a specialized character and did not merely provide bare medical necessities, a relatively long qualifying period might be understandable; as things are, the length of the qualifying period causes wide and unfair disparities. In Germany, where many of the benefits which are 'additional' in British sickness insurance are statutory obligations of the Krankenkasse, even the highly specialized additional benefits which the latter may provide are not subject to any longer waiting period than 6 months.[2]

The Royal Commission, while paying no attention to the effects of disparities in individual cases, could not overlook them so far as they related to whole groups of industry and geographical areas. It remains one of the most disquieting features of the National Health Insurance that it is among the classes of insured who most need them that the chance of obtaining additional benefits, either in full or on a small scale, is most uncertain. This is because in the case of groups of workers in poor social conditions or workers specially exposed to injury by industrial accident and disease, the high frequency of illness and its severity may preclude the satisfactory financial working of approved societies that alone permits the distribution of additional benefits in cash or kind. The system of approved societies does not lend itself to any system of occupational or territorial integration—or, as the Report of the Royal Commission puts it, there are few societies which can be regarded as being in any way 'microcosms of the insured population as a whole'.[3] But there are, on the other hand, 'branches' of the insurance carriers abnormally subject to special local risks, which are independent financial units. So far then as room is left for the local administration of sickness insurance, the difference in the expectation of sickness in different local units is bound to aggravate the discrepancies in benefits. In the words of the Report of the Royal Commission those Approved Societies or branches 'which are predominantly built upon an occupational basis must inevitably reflect the health risks of the trade concerned;

1 Cf. Foster and Taylor, *loc. cit.* pp. 71 and 73.

2 Cf. *Reichsversicherung*, Buch II, Krankenversicherung, para. 208; even this short period is not applicable in certain cases.

3 Cf. *loc. cit.* p. 100.

those whose membership is predominantly centered in certain areas must be affected by the relative healthiness or unhealthiness of the districts in which the bulk of the members are to be found'. This position was mostly discussed before the Royal Commission in relation to mining districts compared with agricultural communities. Sir Arthur Worley, interrogating Sir Walter Kinnear on this point, spoke of the 'water-tight' departments which had been created, and suggested that, if miners were compared with agricultural labourers, the miners on account of their less fortunate state of health and social conditions might be 'prejudiced compared with a universal system'. Mr Lee Shaw, Secretary of the Lancashire and Cheshire Miners' Federation Approved Society, made it very clear to the Royal Commission what the effect of the disparities of benefits on the mind of the insured worker must be:[1] 'I receive numerous enquiries regarding dental and optical treatment, and arrangements for sending men away to convalescent homes, and that sort of thing, and of course I have always to turn them down.[2] Once that happens you can see there must result a state of dissatisfaction in the mind of the person concerned.'

The administrators of approved societies impressed on the Commissioners 'that in the case of the miners their benefit was small because they had a large benefit beforehand in the way of sickness benefit, and in the other case additional benefits were larger because the members had smaller sickness benefit, and that, therefore, both parties got a fair benefit out of the system of equal contributions'. But arguments such as these[3] do not alter the fact of social injustice to the insured person who happens to be in an unhealthy district or in a dangerous or unhealthy occupation. They are merely arguments in defence of actuarial necessities. The representatives of approved societies tried to point out that it had not been the intention[4] of the Act 'that all insured persons should get equal treatment'. But this defence should have carried little weight. It should be remembered that the ad-

1 Cf. Evidence, Q. 7356.

2 The society was not in a position to give additional benefits on account of the 'adverse experience' of the state of health of members.

3 Evidence, Q. 8291.

4 Cf. *ib.* A. 5358: 'The expressed intention of the Act on the floor of the House was, "Each Society shall have the benefit of its own experience". That was held out over and over again. If you read the debates you will find it was put like this: "You, the farm labourer or the domestic servant, you people that have got this better experience, form your own society and you will have the advantage of that." That was preached as the cardinal principle.'

ministrators started with the assumption that additional benefits would be granted on a large scale out of forthcoming surpluses. They actually considered the statutory benefits as a bare 'minimum' only.[1] It was even contended then that the British flat-rate system was fairer to the worker than the German percentage-of-earnings benefit because under the German system the earner of very low wages was penalized while the British worker with low earnings had the advantage of a flat-rate 'minimum'.[2] The assumption was that this would really be a minimum and that ample additional benefits would be the rule. Mr Lloyd George even contemplated at one time that a comprehensive medical service including hospital treatment and the services of specialists and consulting physicians would be at the disposal of well-defined territorial groups of insured workers. On 2 January 1913 he gave a very elaborate illustration of what he had in mind to the Advisory Committee, taking as an example the financial possibilities of a city of 100,000 insured persons and the possible creation of a salaried medical service for the same.[3] This would have led to the formation under National Health Insurance of institutions like those existing in connection with the German Krankenkassen. It would have resulted in adequate and equal medical treatment for all insured persons.

Such developments did not ensue. The cause was that territorial funds were not adopted. Instead the wish of the insurance offices to compete haphazardly was complied with. The accompanying condition was that the flat-rate system had to be adopted, as being the only possible alternative to territorial and occupational funds with contributions varying according to health risks and to financial and actuarial disparities. No doubt, inequality would remain even under such an organization, as some groups of insured would have to pay more in contribution to get the same benefits. But it may perhaps be assumed that English workers would be quite willing to pay more in contributions, together with employers, if the benefits provided were satisfactory.[4]

1 Cf. Chiozza Money, *loc. cit.* p. 66. 2 Cf. Rubinow, *loc. cit.* p. 273.
3 Cf. Brend, *loc. cit.* p. 227.
4 The role which the system of flat rates plays in preventing the adaptation of contributions and benefits to sickness risks by integral groups of occupational or territorial funds has not been considered by Simey, *Principles of Social Administration*, 1937, who, however, shares the views expressed above on the unfortunate results of the present system, see pp. 150–52. He complains that 'the segregation of good and bad risks, both geographically and as between occupations', has 'prevented the societies from becoming representative of

The disparities of benefit due to occupation or social conditions of workers in particular areas may be considered as the major example of the existing inequalities under approved society organization. There are, apart from these, other less extensive possibilities of unequal treatment. Under the system of approved societies competing all over the country, a member of one society who wishes, or is obliged, to change his society forfeits all his rights as to the qualifying period for additional benefits and must begin the waiting time again. Although he may have been a member of society 'A' for many years, if he changes over to society 'B' the latter may withhold the additional benefits until he has qualified again. Similarly, a person who becomes a member of a society or branch, after being a deposit contributor, has to wait for the appropriate periods until he is entitled to additional benefits.[1] He will not be entitled to additional treatment benefits until the beginning of the benefit year corresponding with the third year following the year in which he becomes a member of the new society; or to additional cash benefits until the beginning of the benefit year corresponding with the fifth year of membership.[2] It may so happen that a worker may have been a member of a society for ten years, and when compelled by stringent circumstances to withdraw his membership he may have to wait for years for additional benefits while his colleagues in his former society who may have been insured for a much shorter time enjoy these benefits. It may not be a great number of insured who suffer in this way—a figure of 7,000 transfers a year was given to the Royal Commission in 1924[3]—yet, the social ill-effect remains for those who have to transfer in regard to any available additional benefits. And, but for the renewed waiting period, the number of transfers might be far larger.

the population as a whole'. But he overlooks the fact that the alternative to the present system may be not a 'centralized' system, but rather a system decentralized into territorial and occupational groups to compose integrated bodies administering National Health Insurance on the basis of differing contributions for highly specialized, but statutory, benefits according to the expectation of health. Such differentiation, however, is out of the question with societies having members scattered all over the country in a haphazard way or, as it was once expressed, 'units studded all over like a cluster of nebulae', see *Royal Commission Report*, p. 96.

1 Cf. *Memorandum of the Ministry of Health to Workmen's Compensation Commission*, p. 156; also Taylor and Foster, *loc. cit.* pp. 132–3 for more details.

2 The transfer value which in such cases is transferred to the second society relates to the liability of the first society to statutory benefits only and is calculated in accordance with tables prepared by the Minister.

3 Cf. Evidence, Q. 1777.

There are two more inequalities to mention. It was stated not long ago in the House of Commons that there are societies which, although they have not passed a formal rule to this effect, do not in fact accept married women as members.[1] The point did not escape the attention of the Royal Commission. The matter was discussed at length with witnesses giving evidence for the Royal Insurance Officials' Benevolent Societies. Sir Arthur Worley observed that 'we set out with a National Scheme, so called, and then we divided it up and said it can go into societies, as I think yours might be called. Then you go a step forward and make it only a class society for your employees—you will take this in a friendly way—but you divide those into men and women, and then because the women would cost more in all probability you put them on one side, so that you get a superclass society.'[2] The witness explained the actuarial wisdom which guided the society in excluding women altogether. Women might come back into the society 'after marriage' or 'after becoming widows'. So it was deemed wiser to exclude them.[3] The other inequality to be mentioned arises from the relations between National Health Insurance and Workmen's Compensation. As the Stewart Report stated in 1938[4] the complaint is frequent that hardship is caused to workmen by the attitude of certain approved societies which, when it is suspected that a condition from which a man is suffering is due to industrial disease, refuse to issue sickness benefit, and leave him to claim on his employer. No difficulty arises in cases where the employer accepts liability without demur; but in a proportion of the cases he does not immediately accept liability. He enters an appeal against the certificate of the certifying surgeon, and pending the hearing he does not pay compensation. The workman is thus left without wages, compensation or sickness benefit under National Health Insurance, in some cases for a period of several weeks. The approved societies are authorized to grant sickness benefit in such cases, and practically all the larger ones do so when their members ask for advances. But (as

1 Cf. *H.C. Debates*, 15 July 1941, col. 503 (Mr Buchanan) and col. 532 (Mr Davies). 2 Cf. Evidence, QQ. 11,161–72.

3 It should be kept in mind that we are dealing here with inequalities arising in connection with the benefits made available by the administration of particular approved societies; this has to be distinguished from any general discrimination made by the Statute, such as when the Act of 1932 reduced the rate of disablement benefit for unmarried women and the rates of sickness and disablement benefit for married women. Cf. for further particulars Foster and Taylor, *loc. cit.* pp. 173–4. 4 Cf. *Stewart Report*, pp. 60–61.

was admitted before the Stewart Committee, though unfortunately the evidence remained unpublished) some approved societies may not be so accommodating for two reasons: either because they do not want to be put to trouble, or because it is necessary sometimes to exert pressure on workmen in order to induce them to prosecute their claims under the Workmen's Compensation Acts.[1] Such pressure would not, of course, be necessary, if industrial accident insurance in Britain were compulsory and administered out of compensation funds, in which case injured workers could not be told by small employers that if they made claims their employers might go bankrupt.[2] A third reason for approved societies not making advances may be that their financial position makes it necessary for them to avoid all risks; such risks may exist where advances have been made both by approved societies and the public assistance authorities to the same insured person, and the question arises of priority rights for repayment out of the compensation.[3]

These are the main and typical effects of discrepant administration by different approved societies. They may sometimes amount merely to inconvenience to the insured worker when he compares what he gets from his society with what the more fortunate members of other societies get. Sometimes, however, these disparities, and in particular all those relating to additional treatment benefits, mean nothing less than tragedy and injustice, and represent a further detriment to the nation's health.

The gross inequalities in the administration of benefits by approved societies were not dismissed lightly by the Royal Commission's Report. 'We are not surprised that these great disparities should have occasioned disappointment and dissatisfaction in cer-

1 As to the latter point cf. the very striking evidence of Mr Bearn, Deputy Controller of Health Insurance, Ministry of Health, before the Royal Commission on Workmen's Compensation, 31 March 1939, Q. 1489.

2 For details cf. Wilson and Levy, *Workmen's Compensation*, vol. II, 1941, pp. 300–1; cf. also as to this matter the *Memorandum of the Ministry of Health to the Workmen's Compensation Commission*, pp. 158–9: 'Payment of benefit by way of advance'. Mr Spearing gave evidence for the Association of Approved Societies; he tried to make it clear that the societies for which he spoke were regarding it as 'their essential duty' to give such advances, but the chairman, Sir Hector Hetherington, observed that the societies covering the majority of insured workers 'do not take such action', cf. Q. 1692.

3 The question was discussed before the Joint Committee on Consolidation Bills, when the National Health Insurance Acts were consolidated in 1936, but no decisive conclusion was reached; cf. Workmen's Compensation Commission, p. 159.

tain quarters, and that they should have provoked keen criticism of the present system.'[1] But the Majority Report refrained from proposing any other system, and its justification for doing so should not be overlooked by future advisory bodies which may take up the matter. The Minority Report flatly recommended that approved societies should disappear and local authorities take their place.[2] The Majority Report dealt with the arguments in favour of another system with some care. Unfortunately it did not bring out clearly the complex conditions which knit the 'system' of approved societies to the unequal structure of benefit provisions, and which make the reform of the one impossible without the reform of the other. The system of flat rates with a fixed bare minimum of statutory benefits, and the earmarking of benefits which in other countries are considered as necessarily statutory as 'additional' benefits dependent on the financial status of the societies concerned, is a direct outcome of the system of approved societies. So long as legislation leaves the administration of National Health Insurance to any number of single units competing with each other all over the country, no other result is possible from the actuarial and accounting viewpoint. What would happen if an approved society, having through 'free choice of membership' members all over the country, widely and differently spread, had to provide benefits to insured persons according to their earnings? It would not be practicable. It is only practicable where insurance is tied to definitely integrated groups, either territorial or occupational, where it is possible, by experience of the expectation of sickness, to calculate the risks and to fix contributions actuarially in order to provide the statutory benefits laid down. Where there is competitive overlapping of insurance carriers, the only possible way is to stereotype contributions, which necessitates the restriction of benefits to a bare and primitive minimum, without any possible refinement by the insurance carriers themselves. The result has been and still is to keep medical treatment of any special kind out of the National Health Insurance scheme.

The Report of the Royal Commission did not envisage a breaking with the system of 'uniform contributions'. The mistaken idea that 'uniformity' means equality was the decisive factor. By arguing that the desired equality of benefits for all insured persons implied a 'single fund' and 'that it would be administratively and

1 Cf. *loc. cit.* p. 114.

2 Cf. *ib.* pp. 311, 315 and p. 327 (7).

financially indefensible to contemplate such a fund being operated upon by independent bodies freed from the responsibility for the consequences of their actions' the Report conveniently sidestepped the main issue. It is, indeed, impossible to make all the present additional benefits, which depend on the financial status of the societies, statutory, and yet leave the system of competing and scattered approved societies as it is. The alternative, which was not considered by the Royal Commission, is to make possible the widening and equalizing of benefit provisions by substituting a system of territorial or occupational grouping, with clearly integrated risks and varying contributions, for the present system of approved societies.

Another argument of the Royal Commission was very astounding. Inequalities, argues the Report, are unfortunate.[1] But the worker has 'free choice of the society' to which he shall belong; 'and if he selects a society which proves to be relatively unsuccessful and, as a consequence, unable to provide substantial additional benefits, he is to some extent responsible for the unfortunate position in which he finds himself'. It is necessary to scrutinize this remarkable dictum somewhat more closely. It is a well-known fact that workers in general know very little about the conditions and regulations of social insurance.[2] They do not know much about the possible disparities of additional benefits. They are not in a position to investigate the financial status of approved societies. They can hardly be responsible if a society, after a period, gets into a financial situation that precludes additional payments. Even if the worker who chooses his society with some care should have his doubts, it is by no means certain that he could easily find a society that would accept him under any circumstances. It was stated before the Royal Commission that it was difficult to 'induce young miners to join a purely miners' Society where, judging by the past, he knows he will get no additional benefit'. But it was also agreed by witnesses representing approved societies that they could 'not imagine' an agricultural society admitting

1 This expression is frequently used in official utterances relating to this matter; in connection with arrears regulations the *Report of the Fourth Valuation*, p. 55, observes: 'Societies whose members have the advantage of regular employment thus assist those whose members are less fortunate in this respect.' But it should be noted that this arrangement, which was brought about by the Act of 1935, 'leaves a residual loss of substantial amount (sic!) which must necessarily retard the growth of surpluses generally', a loss which must, on its part, react upon the benefits which the 'unfortunate' have to expect.

2 Cf. Evidence, Q. 7358.

a miner to membership, or any such societies which the witnesses called 'cosmopolitan'.[1] The position then is, as Sir Arthur Worley expressed it before the Commission:[2] '. . . that he has a choice, that his choice is absolutely barred by the selfishness of existing societies, and that they will not admit him unless they think that he comes up to the A 1 standard? Is it not a choice in form and not a choice in substance?'

The witness could only reply that 'there is a pretty wide choice even to-day (sic!) in cosmopolitan societies'.[3] If it is a question not of the original selection of a society, but of leaving a society for the 'free choice' of a better one, the road is blocked by the regulations of transfer. The insured person who wishes to transfer faces the disadvantage of being entitled to no additional benefits at all for a long period of waiting, which must have the effect of a deterrent. Witnesses before the Royal Commission declared that this meant 'limitations on transfer'.[4] Moreover, the formalities of transfer are not simple; it can ordinarily take place only at fixed dates; the society may object to the transfer and the matter may be left to the decision of the Minister of Health.[5] The Minister, on his part, may be influenced by a number of considerations; he may, for instance, declare that, rather than permit individual members to transfer from a society, it would be more desirable that the whole engagements of the society be transferred to another, and pending such arrangements no person shall be allowed to terminate his membership in any way; or the Minister may think it fit to postpone the permit of transfer for a period of two years from the date on which the result of the valuation is declared.[6] The rights of the societies are well fenced by the Administration. There is no corresponding right for the insured worker to claim that he should be entitled to leave his society at once for lack of adequate additional benefits. 'There is no freedom while the insured person forfeits his right to additional benefits', declared Mr F. Kershaw, President of the National Association of Trade Union Approved Societies.[7] Yet those who signed the Majority Report spoke of the 'cold analysis' which had been applied to criticism of the disparities of benefit and that on account of 'free choice' they found them defensible.

1 Cf. Evidence, Q. 8294. 2 Cf. *ib.* Q. 8299.
3 Cf. Q. 8366; also Q. 9747 for the same difficulties.
4 Cf. QQ. 9745 sqq.
5 Cf. *National Health Insurance Memo.* 239 (1938), p. 23.
6 Cf. Foster and Taylor, *loc. cit.* p. 133. 7 Q. 22,073.

In view of this attitude towards a matter which needed, and still needs, by far the greatest attention by reformers, it is not surprising that the recommendations of the Royal Commission for improving the inequalities of benefits were evasive and half-hearted. The Majority Report's recommendations related mainly and merely to what one might call strengthening certain 'safety valves' in the financial structure of the system of approved society administration. The Report referred to the contingencies fund and the central fund, the purpose of which was to protect the members of societies in deficiency from suffering either a reduction in benefits or an increase of contributions.[1] Both these funds were constituted after 1918 as 'protective funds'; their revenue was obtained by diverting a portion of the sums retained out of the weekly contributions for the redemption of reserve values. It has also been provided that an annual payment out of moneys provided by Parliament should be made to the central fund, a subsidy which was later abolished.[2] The sums diverted from a society's contribution income for contingencies fund purposes are periodically credited to the societies' contingency fund. The fund thus formed constitutes, in effect, a reserve fund which is available for making good as far as possible—but only with this limitation—any deficiency disclosed by a valuation. So far as the contingencies fund of a society is insufficient to make good a deficiency not due to maladministration (see above, p. 244), recourse is had to the central fund, which is under the control of the National Health Insurance Joint Committee.[3] The Report of the Royal Commission proposed to extend the pooling system by a somewhat complicated method. Instead of collecting certain reserves out of the income of approved societies, it was now suggested as a 'principle' that 'the surpluses of Approved Societies should in part be pooled'. The Report took great pains to explain how this should and could be done, and even went so far as to suggest that its recommendations should be viewed under the assumption that a sum of £2,000,000 should be so made available. It was envisaged that as much as one-half of the surpluses should be brought into the pool. It was further recommended that the amount paid into the pool should be distributed among the societies at a flat rate per head of membership. The Commission was highly optimistic as to the effect of such partial pooling. The

1 Cf. *Report*, para. 255.
2 By the N.H.I. (National Economy) Order, 1931.
3 See for further particulars Foster and Taylor, *loc. cit.* pp. 9, 169–71 and 178–9.

Majority Report actually expressed the expectation that under such a system it would be possible to provide for all insured alike an extension of medical benefits, including a specialist and consulting service.

The recommendation was not adopted by legislation. It was apparently dictated by the desire to alter the system of approved societies as little as possible, and to patch up existing inequalities and injustices as well as possible. Stress was laid upon the necessary condition that the incentive to good and economic management should not be endangered by a system which would give part of the resulting surpluses to others. But a sharp reduction in such surpluses would certainly mean a blow to incentive. In fact, the proposals of the Majority Report wavered between a system which left everything to the free play of competitive societies and the chance of circumstances, and the centralization of the results of these chaotic circumstances by a pool. The other alternative—to take for granted unavoidable differences in the health condition of the people and the effect of these upon the actuarial structure of the insurance scheme, and to adapt the structure to the differences by decentralized but integrated funds, territorial, occupational, or in single large establishments—did not occur to the Commission. It would have meant the abolition of the approved societies' system. And it was probably just this that was to be avoided. The proposals of the Royal Commission, quite apart from their administrative incompleteness, would have removed a very meagre fraction of the insufficiencies and anomalies of the present system; the pooling arrangement was actually mainly devised to avoid 'deficits' from being shown by a great number of societies, and the possibility of raising the general level of benefits by these means was very doubtful.[1]

It is to be regretted that so far writers on sickness insurance have not seen fit to examine the necessity of abolishing the competitive chaos of approved societies and creating a more integrated scheme of administration.[2] Lately, attention has been distracted even more from such reforms of the administrative structure of National

1 Cf. *P.E.P. Report*, p. 221, where the pooling proposal is discussed; it is rightly observed that the Majority Report did not even include in-patient treatment in hospitals in its proposals of extension of benefits.

2 The matter has been ignored, for instance, by T. S. Simey, though he is well aware of the deficiencies of the system, cf. *Principles of Social Administration*, 1937, pp. 149–150, and even more so by W. Blackshaw, *The Community and the Social Service*, 1939, pp. 259 sqq.; neither has it been treated by W. H. and K. Margaret Wickwar, *The Social Services*, 1936, pp. 144 sqq.

Health Insurance by the putting forward of ambitious, and probably unrealisable, schemes for medical services for the nation, the financing of which is not considered from an orderly insurance angle.[1] Such schemes, if they were feasible, would not only pigeon-hole the progress of sickness insurance as a social service, but they would obstruct the necessary improvement of National Health Insurance from within. They would not only create a service separate from that of National Health Insurance, simply because the latter has proved incapable of coping with the requirements, but, at the same time, they would help to perpetuate the insufficient, incomplete and inequitable system that results from making approved societies on a competitive and chaotic basis the administrators of the scheme.

II.

CHAPTER XXVIII. INSURANCE COMMITTEES

'The absence of medical counsel in public affairs is a serious drawback, for the medical man is peculiarly fitted to take part in social legislation. Unlike the lawyer, who venerates precedent, his training teaches him to look forward and welcome progress. His experience familiarizes him with the conditions of life among the poor and gives him a knowledge of human nature. It is permissible to hope that the Insurance Act will at least have the effect of bringing to the medical profession a stronger sense of its civic duties and opportunities.' DR WILLIAM A. BREND, in the *Lancet* of 2 March 1912.

IT is the peculiarity of health insurance as of industrial accident insurance that its administration is necessarily bound up with the assistance of the medical profession. In the administration of National Health Insurance schemes—whatever the insurance carriers may be (whether territorial municipal funds, friendly societies, etc.)—it is necessary to enlist doctors, or representative bodies of doctors, for the administration of various sides of the scheme, in particular for the administration of medical benefit. This necessity may entail conflicts. This may be the case, for instance, where doctors feel that their desire to treat patients as completely and efficiently as possible does not meet with the approval of the insurance carrier or its criterion of 'economy'.[2] But these differences of interest or attitude have not prevented the setting up of separate bodies of medical men for administrative purposes in

1 Cf. D. Stark Murray, *Health for All*, 1942.

2 Cf. I.L.O., *Economical Administration*, pp. 24–5, where such conflicts are explained in detail.

most schemes. In the German system the individual practitioner who undertakes insurance work is responsible, not to the sickness fund but to the German Insurance Practitioners' Association, for the proper provision of medical care for insured persons; he is remunerated, controlled and instructed by this body.[1]

Under the British National Health Insurance legislation it is the insurance committee which represents, as an entirely distinct feature from the approved society, the collaboration of the medical profession in the sickness insurance scheme.[2] The function of an insurance committee, as the reader already knows, is to administer medical benefit. Each insurance committee prepares a list of doctors in the area who have agreed to treat insured persons under the conditions of the scheme. This is the 'Medical List' of the area and is popularly known as the 'panel'. An insurance committee is legally[3] a corporate body, established under the Act in each county and county borough; membership consists of representatives of insured persons, the local municipal authority, insurance medical practitioners, pharmacists, and the Ministry of Health.

In connection with the administration of medical benefit three further committees are set up in each *insurance* committee area. One is the panel committee of insurance medical practitioners, another is the pharmaceutical committee composed of persons who have agreed to supply drugs and appliances to insured persons. The third committee is the local medical committee which is set up at the option of the qualified medical practitioners in the county. In any area where no local committee has been recognized, it is provided that the panel committee is to be recognized instead. The main function of the local committee is to represent the views of all the medical practitioners, whether insurance doctors or not, on all general questions affecting the administration of medical benefit. In particular, this committee must be consulted by the insurance committee about arrangements made with medical practitioners for giving attendance and treatment to insured persons.[4]

1 The Association concludes collective agreements with the sickness funds. The funds are affiliated to their respective national federations, a separate federation being formed for each type of fund—local, rural, works and guild funds.

2 For the latest arrangements cf. Insurance Committees Regulations, 1937, which came into operation on 1 May 1937.

3 Cf. Henry Lesser, *The National Health Insurance Acts*, 1936–38, London, 1939, p. xxiv.

4 Cf. Foster and Taylor, *loc. cit.* p. 143; cf. also Medical Benefit Regulations, 1936, Part II.

Apart from the main and most important duty of administering medical benefit, insurance committees have to administer sickness, disablement and maternity benefit for deposit contributors; they have to make reports to the Minister of Health about the health of insured persons within the area; and they are entrusted with certain educational and enlightening duties.

The Royal Commission concerned itself with particular care with the position, duties and efficiency of the insurance committees. It did not cast any reflection upon the way they had fulfilled their duties.[1] In particular the Report emphasized that there was no evidence of failure on the part of these committees or their officers to perform their tasks adequately.[2] We can take it for granted that this observation needs no correction. The work continues with a notable degree of success and the 'zeal and thoroughness' which the Royal Commission found on evidence has remained.

When the Report of the Royal Commission suggested that the insurance committees should be abolished[3] it was for quite other reasons. The Royal Commission envisaged a unification of local effort in the general health services and, therefore, the transfer of the duties of the insurance committees to the appropriate local authorities. Through this transformation the new 'Insurance Committees' would actually be in a position to deal in a much wider and far more efficient way with the task of improving health. From a cautiously phrased passage in the Report it becomes evident that the Royal Commission could not escape the conclusion that the work of the insurance committees, which in the first and experimental stage of National Health Insurance legislation had done much to make the machinery run, had become 'of a routine character'.[4] It lacked the dynamic, constructive and progressive quality which was in the minds of those who had been responsible for setting the committees up. The evidence of Mr Alban Gordon, who had been a clerk to the Coventry Insurance Committee at the inception of the scheme and a member of the London Insurance Committee,[5] was perhaps the strongest indictment.

Q. 'You were a member of the London Insurance Committee for a considerable time?'

A. 'Yes.'

1 Cf. *Report*, para. 125.
2 Cf. *ib.* para. 374.
3 Cf. *Royal Commission Report*, p. 282.
4 See *Report*, p. 166.
5 Cf. Evidence, QQ. 7766 sqq.

Q. 'Was the work of the Committee of a routine nature?'

A. 'Yes, overwhelmingly so. Of course, in London obviously problems arise which do not arise elsewhere; but even so the work was of a routine nature.'

Q. 'As a member of the Committee were you ever informed of the health prevailing among the insured persons in your area?'

A. 'Never.'

Q. 'Had the Committee any means of judging the health conditions of the persons in your area?'

A. 'None whatever.'

Q. 'Would it be a proper summary of your view to say that the Insurance Committees have never functioned at all as Health Committees?'

A. 'Never at all, to the best of my knowledge.'

Q. 'They have never realized in any way the expectation held in regard to them in 1911?'

A. 'That is so.'[1]

In view of this criticism it appears somewhat surprising that Dr McCleary, some seven years later, did not find it necessary to refer to it, but doubted whether 'the historic importance' of the insurance committee as an organization, separate from approved societies, and working under the guidance of the medical profession in the administration of medical benefit, was fully appreciated at the inception of National Health Insurance.[2] In actual fact it was so much appreciated that expectations far wider than could be realized were originally entertained. The functions of the insurance committees are in reality mainly and merely concerned with the 'administration' of medical benefit, and their principal activities consist in the direct arrangements for medical benefit and in enquiries into complaints and into 'excessive sickness'.[3]

The Report of the Royal Commission recommended the transfer of the powers and duties of the insurance committees to the local authorities. The Minority Report endorsed that view;[4] but the signatories expressed the opinion that 'to bestow powers and duties of such importance and magnitude upon the Local Authorities without any direct financial responsibility, is a departure from

1 Cf. for similar views, QQ. 16,120, 17,100, 24,401 sqq.
2 Cf. McCleary, *loc. cit.* p. 170.
3 See also above, pp. 115 and 193.
4 Cf. *Report*, p. 315.

the principles of local government hitherto considered essential in this country', and they recommended certain modifications of the Majority's proposal. No change has taken place. But there is another aspect of the problem which clearly deserves attention. The intention of the original Act had been to create special bodies for administering medical benefit. This was obviously prompted by recognition of the fact that medical matters would require far more specialized administration than approved societies were able to provide. It is unthinkable that the approved societies with their entirely disintegrated membership should be in a position to deal properly with the different local conditions of medical and pharmaceutical service throughout the country. It was the imperfection of the system of competing approved societies again which made it necessary to provide separate machinery. The insurance committees are not the only machinery set up to relieve approved societies from the impossible task of grappling with the medical problems of National Health Insurance. A similar example is the appointment of a regional medical staff which is intended to make available to approved societies a body of referees to advise in cases of doubtful incapacity for work, and also in cases in which it may appear that a second medical opinion might contribute to the restoration of the patient's working capacity;[1] and this arrangement contrasts very favourably with Workmen's Compensation, where the injured worker is left in cases which are not decided by the Courts between the verdict of the employers' doctor, on the one side, and of his own (if he is in a position to afford it), who may be in entire disagreement, on the other.[2]

It is natural that those disappointed with the effects of National Health Insurance on the progress and improvement of the nation's health should be critical of the activities of the insurance committees. It is doubtful whether such criticism is really justified. It may be agreed that more work could have been done by insurance committees in health propaganda, as suggested to them by Section 96 (1) (*b*) of the Act. But, as the Report of the Royal Commission observed, such work would more appropriately fall within the province of the local health authority. But this is not the important point. The promotion of better health, and of

1 The staff of this machinery includes whole-time and part-time officers; for their work, England is divided into four divisions, each of which is in charge of a Divisional Medical Officer.

2 The Court of Appeal case Redpath, Brown and Co. *v.* Hayes, *Times Law Report* of 11 Feb. 1942 and the letter of the author to *The Times*, 14 Feb. 1942 and to the *B.M.J.* 18 July 1942.

curative treatment in particular, is not chiefly concerned with propaganda work. One would expect of a body directly concerned with the administration of medical benefit that, from its experience, suggestions and experiments in organization, actual improvements in the administration of medical treatment would result. It is the complete absence of this process that constitutes the major charge against the work of insurance committees; and the Royal Commission did not enquire into the causes of this imperfection. We may try to give some of the reasons. It must, first, be remembered how the insurance committees are composed. They consist of representatives of insured persons who form three-fifths of the members; representatives of the local authority which appoints one-fifth of the members; two members are appointed by the local medical committee; one member is a medical practitioner appointed by the authority and representatives by the Minister of Health. The two sub-committees, the local medical committee and the panel committee, are overwhelmingly made up of doctors. There cannot be the slightest doubt that this structure has offered little or no encouragement to the dynamic and progressive improvement of the medical services rendered under National Health Insurance. Doctors have other more pressing duties to perform than to elaborate schemes of health improvement; their daily work does not allow them leisure for 'unpaid' services that require constant zeal, attention, investigation and the drafting of elaborate schemes. Sir William Glyn-Jones, who had been Chairman of the Middlesex Insurance Committee, told the Royal Commission[1] of his own experience: 'Probably the average practitioner—I say it with great respect—and the average pharmacist does not worry himself very much about the machinery [of Insurance Committees], provided the terms and conditions are all right for him personally.' Doctors are not there to elaborate big, new administrative schemes, even if only in the local sphere. This should be the task of experienced administrators, who may make use of the medical and medico-social knowledge of doctors in general and of the doctors in their districts in particular. If a local doctor did set out to better the administration or medico-technical arrangements in which he works he would probably do so at the expense of his daily duties as a practitioner. It is a very different matter if the leaders of the profession draft, from time to time, schemes for medical improvement, including the

1 Cf. Evidence, Q. 24,406.

improvement of administration, from the high pedestal of thei life-long experience, knowledge and authority.

Such activities cannot be expected from the ordinary membei of insurance committees; and it is unfortunately the experienc that the interest of medical members in the affairs of these com mittees is slight. It was reported to the Royal Commission tha out of a membership of 36, not more than 15 members attende meetings on the average.[1] A larger membership of insurance com mittees was sometimes asked for 'because with the smalle numbers' there were not enough people to fill the sub-committee and 'keep the thing going'.[2] It was, with some justification, cor tended that 'numbers' of members were not necessary for progres 'Sometimes, if there is only one such individual, he can inspir enthusiasm in those about him', observed Mr H. Lesser. Th may be so. But even if such inspiration should here and ther emanate from a member, then one must further ask, Are th opportunities to follow him in his enthusiasm offered to th committee?

The fundamental condition for all improvements in medica treatment—apart from research and propaganda—is the availa bility of funds to provide the necessary institutions to carry ou the recommendations made by the medical profession, insuranc committees, panel committees or local medical committees. Witl out such resources the recommendations must remain on pape The recommendations, for instance, of the two reports of th Delevingne Committee on the Rehabilitation of Injured People, a they related to the better treatment of fractures, were compreher sive, clear and medically unassailable. Yet, nothing happene in the years that followed on any appreciable scale; the mod fracture clinics remained few; and, if it had not been for the wa and the increased interest in rehabilitation, physio-therapy an similar treatment, even the scanty measures now taken woul perhaps not be attempted. Under the present financial organiza tion and administration of National Health Insurance the questio which confronts any recommendation for improved medical treat ment is always the same: where are the funds to come from If the insurance committees were once expected to become th 'Watch-Dogs of Public Health',[3] any endeavour by them to in

1 Cf. Evidence, Q. 12,261.

2 Cf. Evidence, Q. 13,554; cf. also Q. 22,947 (Mr Henry Lesser), where 'meeting' of two members is mentioned, deploring the want of interest.

3 Cf. Chiozza Money, *loc. cit.* p. 125.

fluence the progress of applied medicine through the machinery of National Health Insurance has been discouraged by the financial and other limitations imposed by legislation.

Insurance committees administering medical benefit have no funds of their own to invest in institutions necessary for the improvement of health. They receive merely the sums necessary to provide statutory medical benefit under the National Health Insurance Act, 1936.[1] The total maximum sum per annum which is to be available for medical benefit is fixed; and so is the proportion of that sum which is allocated to meet the administrative expenses of insurance committees and the central Department. The picture is as follows[2]:

Insurance committee administration	6*d.* per insured person
Expenses of the Minister	3*d.* per insured person
Available for medical benefit	12*s.* per insured person

This system may appear simple and uncomplicated. But the insurance committees are given no chance to devote special funds to the improvement of health institutions. If a doctor is 'inspired' by the wish to improve the machinery of medical treatment, he certainly cannot look to the insurance committee for that purpose. He will have to look for financial assistance either to a public authority, or to some private individuals and voluntary efforts.[3] It is very questionable whether national progress can be secured by these means. It is quite evident, on the other hand, that where, as under the German system of sickness insurance, the municipal hospitals work hand in hand with the requirements of the sickness funds, a very definite scheme and machinery of

1 Section 118 (2). 2 Cf. also Lesser, *loc. cit.* p. 172.

3 Such was the case with the foundation of the well-known Miners' Rehabilitation Centre (Midland Counties) at Berry Hill Hall. The doctor who deserves the credit of having inspired this institution was Dr E. A. Nicoll, Surgeon-in-charge of the Fracture Clinic in Mansfield General Hospital. Colliery owners gave the money for the institution and about 100,000 men may profit from it. On the other hand, as the author was informed, miners contribute indirectly to the administrative expenses and the running of the centre, as there exists a profit-sharing wage agreement with the collieries by which a substantial part of the profits, after the covering of costs, are distributed among the miners. As the effect of this arrangement is that any reduced profits means a corresponding pressure on profit-distribution to miners, the costs of rehabilitation are to some extent borne by the miners—even it is assumed that the centre will greatly reduce the costs which the collieries concerned would otherwise incur by industrial accidents. See, for particulars, *News Letter* circulated by the Central Council for the Care of Cripples, October 1940, pp. 4 sqq. and *British Medical Journal*, 5 April 1941, pp. 501 sqq.

institutional treatment, with chemical, pathological, bacteriological and serological branches, can be set up and financially maintained; and all doctors in a district, including the specialists, can show their close interest in these institutions because they make use of them both as private and insurance doctors. Dr G. F. McCleary, the former Principal Medical Officer of the National Health Insurance Commission, rightly states that 'the extensive range of the medical services provided by the German scheme brings the insurance societies into close range with the great body of the medical profession in Germany'.[1] Drs Goldman and Grotjahn estimated in the twenties that about 30,000 German doctors, or about 80 % of the whole profession, were employed by the sickness funds.

It is the duty of the insurance committees to administer medical benefit. But this benefit only comprises the most rudimentary requirements of medical treatment. Treatment by specialists is not included, nor hospital treatment, nor anything in the way of special cures such as physio-therapy, X-ray diagnosis and treatment, after-care, etc. So far as provision for any of these things is at all available under National Health Insurance it comes under the additional medical treatment benefits which are not administered by the insurance committees. But it is precisely from these specialized spheres that progress in the socialization of medicine should come. It is in these spheres that the principal need and opportunity for medical research are to be found. By barring insurance committees from this wide and promising field of specialization legislation took away the great stimulus that might have been active among panel practitioners. It is not without significance that, where it has been deemed necessary to take certain medical benefits out of the ordinary framework of National Health Insurance administration and entrust them to special bodies, those bodies have at once undertaken some of the constructive work which the critics have found absent in the insurance committees. Such has been the case with dental benefit, where the Dental Benefit Regulations for 1938 enable the Dental Benefit Council (see p. 155 above for the activities of this body) to draft and, on approval of the Minister of Health, to put into operation schemes for providing one or more experimental (sic!) clinics for the dental treatment of persons entitled to dental benefit.[2] The Dental Benefit Council is not a body outside the National Health

1 Cf. McCleary, *loc. cit.* pp. 53–4.

2 Cf. Dental Benefit Regulations (S.R. and O. 1938, No. 1466), 16 (1).

Insurance scheme. It is constitutionally and financially directly linked up with the approved societies as the carriers of National Health Insurance.[1] But this is an additional benefit which it has been found necessary to treat as a 'specialist' treatment benefit; as the sums involved are a very large percentage of the entire sum spent on additional treatment benefits, it was possible not only to set up a special organization for administration, but it was also possible to entrust this particular body with important tasks relating to the further progress of dental medicine and its socialization. For other benefits no such opportunity exists.

Two conclusions cannot be avoided. Much of the criticism of the insurance committees should not be addressed to their members, but to the system as such. It is the fault of the legislator if he expects results from legislative or administrative measures which do not contain the fundamental conditions necessary to secure such results. The recommendation of the Royal Commission to transfer the powers and duties of insurance committees to committees of the appropriate local authorities may have been justified. But it missed the main point of the criticism of insurance committees. Local authority committees would be in precisely the same position as regards constructive improvements as the insurance committees are, so long as the funds available were just enough to cover a minimum of medical benefits; all the requirements of improved treatment would remain outside the scope of the committees, however constituted. And it is merely ingenuous to free National Health Insurance, as in the treatment of tuberculosis, from the logical responsibilities borne by all other known schemes, by shifting its duties to local authorities. If the existing organization of the scheme makes necessary the restriction of medical benefits to a bare minimum and the exclusion of higher benefits from the duties of the insurance committees that administer ordinary medical benefits, this deficiency in organization and administration can only be remedied by an entire and fundamental reform of the system. With territorial or similarly integrated funds the administration of all National Health Insurance benefits could well be housed under a single roof. This would not exclude special organizations of panel doctors and other members to attend to specific medical problems. But the creation and extension of the medical services would remain a duty and object of the fund itself, the administrators of which would have to decide whether the means available should be utilized for such a purpose. A new

1 See Dental Benefit Regulations, Part II, 5 (*c*) and 13 (1) and (2).

flexible system of contributions might then become necessary—a point with which we shall have to deal at a later stage. Here we conclude our observations on insurance committees by expressing the belief that a mere transfer of their duties to local authorities would not increase the opportunities for the dynamic administration of medical benefits.

III

CHAPTER XXIX. THE RELATION BETWEEN NATIONAL HEALTH INSURANCE AND OTHER STATUTORY SOCIAL INSURANCE SCHEMES

> 'When two authorities are up,
> Neither supreme, how soon confusion
> May enter 'twixt the gap of both and take
> The one by the other.' SHAKESPEARE, *Coriolanus*, Act III, sc. 1.

WE have referred to some of the inter-relations between National Health Insurance and other statutory social insurance schemes.[1] How far do such relations affect the administration of National Health Insurance? There are three social contingencies which border closely on the contingency of sickness and the insurance need created by it. They are unemployment, old age and industrial injury. All three enter the picture of National Health Insurance, though in rather different ways. Unemployment may mean that the worker hitherto insured against sickness may lose the right and title to cover by reasons which are obviously outside his control. Old age is another instance of unemployment; and the question again arises how a worker of a certain age, hitherto insured against sickness, can get along when his benefits under National Health Insurance cease. Industrial disability by accident and disease is just another social form of sickness; but its redress by insurance has developed on lines separate from National Health Insurance.

In the case of unemployment insurance and pensions in relation to sickness insurance, the law has drawn a very clear line of

1 Cf. pp. 34–6, 41, 50–51, 64–6, 259–60.

demarcation. This is not so in the case of Workmen's Compensation.[1] The problem of how to indemnify the worker insured under National Health Insurance against the effects of unemployment, while not undermining the financial position and actuarial basis of the insurance carriers, has been a constant preoccupation of social insurance legislation in this country. The list of the measures enacted for this purpose is longer than the list of any other amendments to National Health Insurance.[2] In this respect, at least, the recommendation of the Royal Commission has made decided progress, and insured workers if unemployed are in a decidedly better position to-day when they fall sick than they were while the Commission was sitting.[3] The statutory arrangements for a 'free insurance period' and the excusing of arrears are one of the very few items of real progress during the history of thirty years of National Health Insurance contributions. Arrears are not now counted

(*a*) for any period of incapacity for work of which the member gave notice to his society within the time allowed, or

(*b*) in the case of a woman for the period of two weeks before and four weeks after her confinement, or

(*c*) for complete weeks during which an employed contributor proves within the time allowed that he was available for but unable to obtain employment.[4]

The method of administration is not complicated. The normal way of obtaining evidence of genuine unemployment is for the member (even if he is not insured for Unemployment Insurance purposes) to register for work at an Employment Exchange or other Local Office of the Ministry of Labour, and to present his Health and Pensions contribution card there weekly, when the card will be impressed with a special stamp for each week during the whole of which genuine unemployment is proved. The cost of this arrangement is borne by the Unemployment Arrears Fund, whose income is derived from a state grant and a portion of each contribution paid by or on behalf of every member of an approved society. The legal and actuarial arrangements in this matter are certainly not uncomplicated, and, as Lesser observes, 'cases may

1 See pp. 50–51. 2 Cf., for a full list of these, Lesser, *loc. cit.* pp. 43–6.
3 The *Report*, p. 27, urged 'that some arrangement to excuse arrears in respect of genuine and, as far as possible, official certified unemployment should be part of the permanent scheme'.
4 Cf. also N.H.I. Act, 1936, section 65 (2) and (3).

arise' in regard to the legal interpretation of the same, but there is no evidence yet that any administrative conflicts have arisen.[1]

When a national system of contributory pensions was introduced in 1925 by the passing of the Widows', Orphans' and Old Age Contributory Pensions Act (15 and 16 Geo. 5, c. 70; we shall refer to this legislation as C.P.), convenience of operation and economy in administration led the Government to 'interlock' it with health insurance.[2] The main reason for choosing that, rather than unemployment insurance, was that a large field (roughly $3\frac{1}{2}$ millions) would be covered, for, at the time, agricultural workers, domestic servants, and out-workers, though qualified for health benefits, were not covered by the Unemployment Insurance Act. All persons insured under the National Health Insurance Act became, automatically, insured under the Contributory Pensions Act. The established system for collecting and accounting for contributions under the National Health Insurance Act, and the records of individual contributions necessarily maintained by the approved societies for the purposes of National Health Insurance, sufficed for pensions purposes. The stamp system was retained as it existed for National Health Insurance; and the only difference to the public was the increased value of the stamps, which now represented the amount of the combined weekly contribution due under both Acts. The effect of interlocking is, as Wilson and Mackay express it, that 'the administration of pensions insurance is virtually "lost" in health insurance up to the point at which title to pension arrives and insurance ceases'. The Contributory Pensions Act did not repeal or supersede the older, non-contributive, Old Age Pensions Act. These remain in full operation alongside the newer scheme. The original contributions applied

1 The National Health Insurance etc. Bill, 1941, necessitated a rearrangement of the Unemployment Arrears Fund. With a view to strengthening the financial position of the Fund to enable it to meet post-war demands upon it, which may be heavy, the Health Insurance portion of the income from the contributions paid by the employers of men aged over 65 and women aged over 60, which were before credited to the Central Fund, are now credited to the Unemployment Arrears Fund. The strong financial position of the Central Fund enables it to dispense with this source of income, and the Unemployment Arrears Fund will benefit to the extent of about £500,000 a year on the present level of receipts, adjusted for the proposed increase in the rates of distribution (cf. National Health Insurance etc. Act, 1941, section 7, and *Report by the Government Actuary on the Financial Provisions of Part I of the Bill*, 1941, pp. 7–8).

2 We follow here the very instructive description of C.P. legislation in Sir Arnold Wilson and G. S. Mackay, *Old Age Pensions*, Oxford, 1941, pp. 93 sqq., 124 sqq., 186 sqq. and *passim*.

only to the cost of old age pensions between the ages of 65 and 70. When the latter age is reached the pensions are regarded as under older Acts, though without restriction as to means, residence and nationality, and the whole cost of them is transferred to the Exchequer. In the first ten years of the new arrangements, the number of beneficiaries in Great Britain under the Old Age Pensions Acts, 1908–24 decreased from 1,031,575 to 662,508, while the number of beneficiaries under the Contributory Pensions Acts, 1925–29 increased from 166,132 to 1,020,718,[1] owing to the increasing number of unconditional old age pensions granted to persons over 70 who were previously pensioners under the contributory scheme. The great advantage which accrued to insured persons from the passing of the Contributory Pensions Act was that the qualifying age was reduced (with abolishment of restrictions as regards means and property) from 70 to 65. The effect on National Health Insurance was that the contributions applicable to National Health Insurance could now be reduced accordingly. The Widows', Orphans' and Old Age Contributory Pensions Act of 1937 introduced for the first time a class of voluntary contributors towards pensions who have no rights under National Health Insurance. This 'breaking' of the interlocking necessitated fresh definitions, but did not affect in any way the great body of employed contributors, whose position remains unchanged. The new arrangement under the 1937 Act was merely that, from January 1938, persons who, on cessation of combined compulsory insurance, desire to continue as voluntary contributors, are allowed at their own option to choose the form of insurance best suited to their needs, and to be voluntary contributors for health insurance or for pensions, or for both.

As a whole it may be said that the administration of Contributory Pensions has not created any administrative conflicts or friction with other insurance administrations, such as that of National Health Insurance. The main problems here have not been of an administrative nature, and even so careful and critical investigators as Sir Arnold Wilson and Mr Mackay could observe in 1941 that the administration of Contributory Pensions 'had attracted remarkably little criticism' during its fourteen years of operation.[2] The main problems remain the scale and amount of the pensions to be granted and the contributory financial burden involved.

Thus, the administrative inter-relations between National Health

1 Cf. P.E.P., *The British Social Services*, June 1937, p. 131.
2 Cf. Wilson and Mackay, *loc. cit.* p. 217.

Insurance, on the one hand, and Unemployment Insurance Contributory Pensions Insurance, on the other, have shown no spectacular conflicts. Unemployment and age are social facts that can be definitely ascertained and the chance of mis-statement by fraud or error is restricted. Difficulties in finance may be overcome by wise actuarial computation. The position as regards the inter-relations between National Health Insurance and Workmen's Compensation is unfortunately very different.

Although sickness due to industrial injury, by accident or industrial disease, is logically and technically hardly distinguishable from ordinary ill-health, legislation in almost all countries has separated health insurance from industrial accident insurance; and most countries include in compensation for industrial injury the obligation to restore the normal working capacity of the worker, as far as possible. British Workmen's Compensation does not do so; it merely tries to indemnify the injured worker for loss of earnings by cash compensation, and the more important part of the matter, medical restoration, is left to National Health Insurance.

It should, however, be noted that in countries such as Germany or the U.S.A. for instance, where medical treatment is an obligation under industrial accident insurance, the latter will not necessarily have to make full arrangements for the medical treatment of the injured by its own medical service. It has been wisely recognized that in the great majority of lighter injuries it would be uneconomical to have two medical administrations, one exercised by the sickness funds, the other by those under industrial accident insurance. This is the reason why under the German law very definite arrangements exist between the sickness fund and the industrial accident funds. The sickness fund must provide curative treatment for the first 26 weeks, provided that the industrial accident insurance fund (Berufsgenossenschaft) does not choose to take over the treatment sooner, or at once—which it will do if the case is a serious one requiring special medical treatment.[1] The sickness fund, moreover, bears all the expenses incurred for treatment and even cash benefits for the first 45 days after the accident, so far as the cost of the treatment given does not exceed that of the ordinary medical benefit of sickness insurance.[2] It is interesting to note that, even under a system which

1 This coincides with the diagnostic arrangements made by the Berufsgenossenschaft, see above, p. 139.

2 Cf. Wilson and Levy, *Workmen's Compensation*, vol. II, 1941, p. 215 and *passim*, and also Royal Commission on Workmen's Compensation, Paper No. 17 B, pp. 727–8 of Evidence (International Labour Office).

so distinctly separates industrial accident insurance from National Health Insurance, there is a definite administrative connection between them. This system in Germany has led to little administrative friction because, as in the case of National Health Insurance and unemployment and pension insurance in Britain, the relationship is largely between official bodies or departments. The relationship between a communal sickness insurance fund and a semi-official mutual indemnity association (Berufsgenossenschaft), though their separate financial interests may come into play, are not likely to be influenced by the motive of 'profit' or by the desire to avoid liability by shifting it to the other body. In the U.S.A. administrative conditions are not so satisfactory. The medical service, when entrusted as an obligation to industrial accident insurance carriers, has sometimes led to undesirable commercialization when the latter, as may be the case, discharge their duties by making arrangements with private institutions.[1]

In Britain, National Health Insurance and Workmen's Compensation, on the surface, bear no relation to each other. Workmen's Compensation, it appears, provides the cash benefit, National Health Insurance the medical benefit, both by means of separate administrative bodies. Actually, a very disquieting interrelation does exist, and this inter-relation is crucially influenced by the fact that private interests are affected. National Health Insurance is administered by approved societies, which are associations of private persons, while Workmen's Compensation is administered either by the employer himself, so far as he is insured, or by mutual indemnity associations of employers or insurance companies. Here then a quite different situation arises; it must be the interest of the insured party to watch carefully over its interests and to see that its burden remains as small as possible. The desire to shift the responsibility to the other party, if possible, is intensified, and finds constant encouragement in the vagueness of the compensation law.

Any satisfactory relationship between sickness insurance and industrial accident insurance should, first of all, be based upon a very definite interpretation of industrial injury. If the definition of 'industrial accident' or injury by accident and disease is unduly wide, it is obviously to the disadvantage of the administrators of sickness insurance. The British Workmen's Compensation law unfortunately has widened the scope of dispute in this connection

1 This is the complaint of Walter F. Dodd, *Administration of Workmen's Compensation*, New York, 1936, pp. 445, 447, 452–6 and 494–5.

by making the term 'industrial accident' dependent upon the proof that the injury was received 'in the course and out of employment'.[1] In other countries the term is simplified by the fact that every accident which happens to workers employed in the insured 'establishments'—including accidents on the way to and from work—is regarded as an industrial accident. There is, for instance, not much dispute under the German law of workmen's compensation as to whether sickness or industrial injury is involved, much to the advantage of the administration of the two sickness funds. Sir Ralph Meredith, the famous originator of the 'Ontario' system of Workmen's Compensation, was so impressed by what he saw of the legal complications in England that he drafted his own scheme of Compensation Boards with the special purpose of avoiding 'the nuisance of litigation'.[2] One of the last words which a great social worker in Britain, for many years Secretary of the Charity Organization Society, the Rev. J. C. Pringle, wrote before his death in 1938 was that the constant attempt (again shown by the Stewart Report of that year) to secure reforms of the medical referee system and improvements in the legal procedure under Workmen's Compensation appeared to be presumptive evidence that workmen did not get 'an absolutely fair trial'. The case worker, Mr Pringle observed, 'deprecates the whole idea of a trial, and deplores the fact that legislatures have made industrial accidents the occasion of anything of the kind'.[3] The approved society will probably hold the same view, for if the injured worker fails to succeed with his claim under Workmen's Compensation, 'unfair' as this may appear to him (and there are a good many hard cases year by year where judges regret not to be able to decide in his favour), he has to rely upon his sickness benefit under National Health Insurance. It is therefore of greatest interest to the approved society to see that proceedings to enforce claims are taken. In common with trade unions and clubs, it is a common practice for approved societies to assist members in this. Moreover, section 53 of the Act entitles approved societies to take proceedings for compensation or damages where an insured person unreasonably refuses or neglects to enforce his claim.[4] Apart from proceedings which societies may

1 Cf., for details as they relate to this matter, Wilson and Levy, vol. II of *Workmen's Compensation*, 1941, all the pages quoted in the Index under 'Arising etc.'
2 Cf. U.S. Department of Labour, *Monthly Labour Review*, June 1938, reprint, p. 4.
3 Cf. *Charity Organization Quarterly*, July 1938, p. 156.
4 Cf., for details, Lesser, *loc. cit.* pp. 100–1 and Foster and Taylor, *loc. cit.* pp. 87–9.

decide to take in the name and on behalf of their members under this section, they may make arrangements for members to obtain the services of a solicitor and agree to defray legal costs in whole or in part. Any reasonable expenses in that respect are regarded as a proper charge to the administration account of an approved society.[1] Several of the larger societies have, in fact, special departments with a legal staff to which compensation cases are usually referred, whilst many others have arrangements whereby legal advice and assistance are available if required in connection with such cases. Life assurance offices pride themselves that their approved societies have large departments to deal with Workmen's Compensation matters and 'protect' the 'interests' of those insured under National Health Insurance, while actually this work is in the direct financial interest of the approved societies and their parent bodies.[2] Societies may also provide the fee for examination by the certifying surgeon (in the case of the ordinary industrial diseases) or by the Medical Board (in the case of silicosis and asbestosis). Of 499 centralized societies which were asked in 1938 by a questionnaire to state what arrangements were made for the assistance of members in whose cases action relating to compensation for industrial injury (by approach to the employer or the insurance company) had not led to a satisfactory settlement, 104 had taken legal action on members' behalf, either through the society's solicitor or under arrangement with another solicitor; 68 had referred to Legal Departments of Associations (e.g. the National Association of Trade Union Approved Societies, etc.) for advice or any legal action which might be deemed appropriate; 31 had informed members that legal action would be taken by the society on their behalf if they so desired; and 16 societies replied that legal action had been taken by trade unions in cases where the member concerned is also a member of a trade union. With the rest of the societies either no occasion had arisen or no action was taken.[3] This gives an indication of the importance of the matter. It is a rather disquieting feature of the administration of social insurance services that occasion for such 'inter-administrative' conflicts is constantly latent. They would certainly not exist

1 Cf. *Memorandum of the Ministry of Health to the Royal Commission on Workmen's Compensation*, 30 March 1939, Evidence, p. 160.

2 Cf. *Report on the 81st Annual Meeting of the Royal London Mutual Insurance Society*, which handled 66,000 Workmen's Compensation cases in 1941–42; cf. *The Times*, 28 April 1942.

3 Cf. *Memorandum of Ministry of Health to the Royal Commission on Workmen's Compensation, loc. cit.* p. 160.

if both schemes were in the hands of State departments or of semi-official organizations, such as the Compensation Board in Ontario, where, in the words of Mr Marshall Dawson,[1] 'there is no motive for its representatives to be unfair to the claimants'.

The matter is made still worse by the frequent unwillingness of the injured worker to claim at all under Workmen's Compensation. The Royal Commission on Workmen's Compensation was informed by the representative of the Ministry of Health that cases had been brought to the knowledge of the Department, by approved societies and otherwise, where an insured person, through fear of losing his employment, not only refused to claim compensation himself, but was also reluctant that action should be taken by his approved society.[2] 'I have had both men and women sitting in my chair who have explained to me almost pitifully that they much prefer not to make their claim for compensation. . . . I remember very distinctly the case of a young man, a member of my society; a director of the firm made it clear to me that the man would lose his job if he claimed compensation. The man preferred to go without his three or four weeks compensation rather than lose his job', Mr T. A. E. Spearing, the Honorary Secretary of the Association of Approved Societies, told the Royal Commission.[3] Such cases, of course, relate mostly to injuries of a lighter nature. In cases of grave incapacity the worker does not show the same reluctance to claim compensation, as he expects to lose his employment anyhow. It should be remembered that, according to estimates made by a previous committee on Workmen's Compensation, no fewer than 250,000 employers, mostly smaller ones, are to be reckoned as un-insured and therefore possibly inclined to dismiss a worker if he claims compensation.[4] The introduction of compulsory industrial accident assurance would certainly be in the interests of the administration of National Health Insurance simply because (since 1928) approved societies have to grant sickness benefit when compensation claims are irrecoverable. Perhaps it may also be assumed that, if the cash benefits under National Health Insurance were not so meagre as they are and so disproportionate to those under Workmen's Compensation (see p. 64 above), the incentive to injured workers to try to get under

1 Cf. Marshall Dawson, 'Ontario Procedure in Settlement of Workmen's Compensation Claims', *Monthly Labour Review*, Jan. 1936, reprint, p. 3.
2 Cf. Royal Commission on Workmen's Compensation, Evidence, p. 158 and Q. 1489.
3 Cf. Evidence, QQ. 1710–13.
4 Cf. Wilson and Levy, *loc. cit.* vol. I, p. 161.

National Health Insurance what they should get under Workmen's Compensation would be still greater.[1]

An even more serious and complicated situation arises where the injured worker gets less in compensation than he should get. The approved society has a very definite interest that he should get as full compensation as possible, for when, under the special provisions of sections 51–54 of the National Health Insurance Act (which relate to compensation payments or damages under the Workmen's Compensation Acts, the Employers' Liability Act, 1880, the Common Law or the various injuries in War (Compensation) Acts), the weekly value of the compensation or damages is less than the sickness benefit otherwise payable, the difference between the two amounts has to be paid by the society. It is therefore in the interest of the approved societies that benefit claims linked up with compensation claims should be fully scrutinized. It is the lump sum settlement that has given most trouble and inconvenience to the approved societies.[2] It is a fact, proved by innumerable experiences and observations from all quarters, that these settlements, which should represent some sort of capitalized 'weekly payment', always involve the risk that the injured worker will not get the compensation sum he is entitled to. They are, first of all, a matter of bargaining between the injured person, who may be partially or fully, temporarily or permanently disabled, and the much stronger employers or insurance offices. True, the administrative machinery to deal with these agreements has been improved and the greatest injustices which may result from such 'bargains' have been diminished by the regulation that only registered agreements have any legal validity, and that County Registrars may reject such agreements as unfair to the injured person. Actually, however, this machinery has not been efficient enough to stop the evil of inadequate and unfair settlements.[3] The financial interests of approved societies are immediately involved. The award of compensation closely affects the funds of societies; and following a recommendation by the Holman Gregory Committee, section 12 (4) of the Workmen's Compensation Act 1923 (now section 23 (6) of the 1925 Act) was introduced, under which it is provided that the Approved Society is entitled to

1 I have treated in some detail the point of the fear of the injured worker to lose his employment in *Back to Work?* 1941, Fabian Research Series, No. 56, p. 10 and *passim.*

2 Cf. Wilson and Levy, *loc. cit.* vol. II, chapters on Lump Sum agreements.

3 For this cf. Wilson and Levy, *loc. cit.* vol. II, pp. 151–63, where the point is dealt with in detail.

receive due notice of any agreement proposed to be made for the settlement of a member's claim for compensation by payment of a lump sum. The society, to which the County Court Registrar is required to send a copy of the Memorandum of Agreement, is entitled to lodge objection and to appear as an interested party in any subsequent proceedings. Again, complicated administrative measures are involved. They relate to the evaluation of the lump sums. The Ministry of Health, fortunately, has suggested for the guidance of the societies general principles which may be followed 'although they are not applicable in every case'.[1] Where the incapacity is permanent, it is laid down in section 13 of the Workmen's Compensation Act that where weekly payments of compensation have continued for not less than six months, the lump sum payable is to be determined by taking the cost of purchasing the annuity through the Post Office of an amount equivalent to three-fourths of the annual value of the weekly compensation. But this regulation applies in cases of permanent incapacity only and 'shall not be construed as preventing agreements being made for the redemption of a weekly payment by a lump sum'.[2] The International Labour Office has recommended that where compensation is paid in a lump sum the sum should be not less than the capitalized value of the periodical payment.[3] Cases of special hardship to the insured and of unexpected obligations to the approved society may also happen where an injured person has accepted a lump sum settlement (which always means the final liquidation of the matter) on the understanding that the incapacity would last a certain period, while actually the incapacity may last much longer.[4]

Sickness benefit may be paid by the approved society while

1 Cf. *Memorandum of the Ministry of Health, loc. cit.* p. 161. 2 Cf. section 13 (*a*).
3 Cf. Recommendation No. 22, *The Minimum Scale of Workmen's Compensation,* in International Labour Organization, 1936, p. 128.
4 The following figures illustrate the importance of lump sum settlements: in 1938 there were according to the incomplete figures of the Home Office (which relate to 8,000,000 employed in seven groups of industry only, while the Acts cover some 17,000,000 to 18,000,000) 18,303 cases of disablement by accident and 1,637 by disease where lump sum payments were made. The great majority of these cases were settlements after previous weekly payments. Yet, there were 1,963 such cases of disablement by accident without previous weekly payments. Statistics as regards litigation do not give details of what the litigation was about. There were 29,732 cases in which memoranda of agreements and informal arbitrations were registered in the courts. This did not compare favourably with the ten years average of 1928–37, which had been 26,520. The Registrar (see above) refused to record the memorandum at first presented in 1,118 cases, but subsequently recorded it without reference to the Judge after the original amount had been increased (cf. *Workmen's Compensation Statistics,* 1940, Cmd. 6203, pp. 5, 14 and 23).

the injured worker is awaiting a decision as regards his claim for compensation. Approved societies are not under any obligation to pay; for the inconveniences or distress of the insured member is due to the uncertainty and the delay caused by workmen's compensation disputes. Section 52 simply confirms that 'nothing . . . shall prevent the society or committee from paying benefit to an insured person by way of advance pending the settlement of his claim for compensation or damages, and any advance so made shall, without prejudice to any other method of recovery, be recoverable by deductions from, or suspension of, any benefits which may subsequently be payable to the insured person'.[1] In general, it may be assumed that approved societies make it a practice to advance benefits to members in such cases.[2] Yet it appears that the payment of these advances is by no means certain. There are also some definite exceptions: where a member has been awarded compensation and the payments have not been made, by bankruptcy of the employer, a society cannot pay benefit by way of advance pending the ascertainment of the lump sum.[3] If an insured person's approved society makes an advance of benefit to a member under section 52 of the Act, and the Public Assistance Authority also grants him relief, the question may arise whether the rights of the society or of the authority are to prevail; this position actually has led to much departmental discussion, but the Joint Committee on Consolidation Bills found, in 1936, that though there were 'several possible solutions', none of them recommended itself as to be adopted in a Consolidation Bill. The Ministry of Health and the Department of Health for Scotland express the opinion that such claims ought to rank according to the date on which they are given.[4] But the view was expressed before the Royal Commission on Workmen's Compensation that the position of approved societies in this respect was 'unsatisfactory' and 'that they have a case for saying that they should come first in order of priority'.[5] Similar inconveniences are caused to approved societies where lump sum payments are agreed or awarded in respect of a minor; these have to be paid into Court, and the money is to be paid out only at the discretion of the Judge.[6]

1 Note that all references to insurance committees in such respect apply to their administration of sickness and disablement benefit of insured persons who are not members of societies.

2 Mr Spearing assured the Royal Commission on Workmen's Compensation that the Association (see also p. 260) 'encourages its Societies [122 societies with an aggregate membership of 1 million] to take all necessary steps to that end'. Cf. Evidence, Q. 1692; cf. also Lesser, *loc. cit.* p. 99: 'in practice it is usual'.

3 See C.A. in Lewis Merthyr Consolidated Collieries (No. 2) 1929.

4 Royal Commission on Workmen's Compensation, Evidence, p. 159.

5 Cf. *ib.* QQ. 1611–12.

6 Cf. *ib.* p. 159.

All these difficulties have the effect of discouraging approved societies from making such advances. They are yet another example of the unsatisfactory relationship between health insurance and industrial accident insurance in this country. It is not surprising that the Memorandum of the approved societies submitted to the Royal Commission on Workmen's Compensation criticized lump sum settlements and urged their abolition; and that it recommended the setting-up of an independent statutory authority, a Workmen's Compensation Board (with an appeal to a Compensation Tribunal), in order to avoid the present legal and medical uncertainties which contain the constant danger of litigation and of costs and outlay by the approved societies.[1] It is a most disconcerting feature in a so-called 'national' statutory social service to see a hunting ground for legal disputes among administrations which should be able to co-ordinate their efforts, free from commercial motives. Mr James Snoxhill, Fellow of the Chartered Insurance Institute, observes that 'every Society should be in a position to have the services of a reputable solicitor', and that 'the society official who is well versed in the subject may save his society hundreds of pounds in unnecessary legal expenses and may at the same time secure handsome settlements for the members'.[2] He is right when he says that unnecessary legal proceedings cost the societies sums which are not to be lightly indulged 'out of the Society's slender administration allowance'.[3] But it should be added and emphasized that all these risks and costs might be saved if the inter-relation between the two statutory services were not dictated by the fact that private insurance offices (companies and mutual indemnity associations of employers) naturally try, as far as possible, to avoid claims and are therefore quite prepared to risk litigation, employing for that purpose the kind of professional medical witnesses of whom Dr Brend wrote 'that they have a sound knowledge of their work and at the same time are highly skilled in presenting a particular aspect of a case which may exercise much influence on a law court'.[4]

1 Cf. paras. 8–22 of the Memorandum of the Association.

2 Cf. James Snoxhill, *Notes on Approved Society Organization*, N.D. p. 45.

3 There have been from time to time complaints that approved societies—probably those of a less stable financial position—tried to avoid the payment of costs where law suits of their members were not successful; so before the Royal Commission on National Health Insurance, see QQ. 10,432–34; similarly Mr McIntyre giving evidence for the Bentham Committee before the Royal Commission on Workmen's Compensation in 1939, see Evidence, QQ. 5301–10, where the matter was intensively discussed.

4 Cf. Dr Brend, *Traumatic Mental Disorders in Courts of Law*, 1938, p. 93.

IV. THE ECONOMIC SIDE OF ADMINISTRATION

CHAPTER XXX. THE EXPENSE RATIO

'It is one of the penalties of our piece-meal and half-conscious reforms that, whilst multiplying all this social machinery, we have failed to provide the means of co-ordination of its several parts.'

SIDNEY and BEATRICE WEBB in *The Prevention of Destitution*, 1911, p. 205

THE test of the economic and financial efficiency of social insurance institutions rests to a great extent on the costs which their administration involves. The effects of a high or low expense ratio are very far-reaching. A high expense ratio may devour a good deal of the financial assistance which the State is prepared to provide and through this become an unwelcome burden on the taxpayer; and it means a constant pressure on the sums which would otherwise be available for benefit distribution. Yet, the expense ratio may not be altogether dependent upon the actual efficiency of administration; it may be due as much to costs inherent in the methods of organization and administration adopted for the insurance service. A social insurance service may be excellently organized so far as its administrative technique is concerned, yet it may rest upon a costly system of organization and administration in principle and show a high expense ratio for that reason. This is the situation in British social insurance, statutory or voluntary. It must be said to the credit of all branches of insurance in this country that their efficiency has never been doubted as far as commercial routine, the efficiency of staff, and soundness of finance are concerned. The high costs of administration result from the system, not from the administrative machinery at the disposal of the system. So we have the astounding fact that in industrial assurance, according to the latest available figures, out of a yearly premium income of £69,235,000 not less than £22,909,000 went into management expenses (including bonus or other distribution of profits to staff); in other words 30 % of the premium income went into expenses.[1] The cause of this is not inefficiency, but the expensiveness of a system which collects its premiums by door-to-door visits in pennies and shillings through

1 Cf. *Industrial Assurance, Report of the Industrial Assurance Commissioner*, London, 1940, p. 3.

an army of some 70,000 agents and canvassers. Another example is Workmen's Compensation. The administration of this great service is certainly not in any way impaired by deficient methods; for many years the proportion which the total amount paid or set aside—reserves—in respect of claims bears to premiums has been arranged between the most important organization of the trade, The Accidents Offices Association, and the Home Office to be not less than 60 %—the so-called 'loss ratio'. This means that 'at least' 60 % of the premiums must return to the insured, in form of benefits or reserves, which indicates the high scale of the expense ratio.[1] Actually, in 1938 out of £6,384,706 of the income of companies from premiums in connection with employers' liability insurance in Great Britain and Northern Ireland, £3,875,007 were expended in payment of compensation or damages (including legal and medical expenses in connection with the settlement of claims).

Here, too, the expense ratio is very alarming.[2] With Mutual Indemnity Associations the expense ratio is lower, but not 'low'. Exact figures are not available.

The costs of administering National Health Insurance are fortunately not of this surprisingly high order. In 1938,[3] out of the receipts by contributions, Exchequer grant, interest, etc. and transfer from the Unemployment Arrears Fund amounting to £37,616,000 the sum of £5,024,000 was paid in administration, the major amount, £3,670,000, being the expenses of approved societies, while £423,000 was the cost of administration of insurance committees and £931,000 that of administration by the central departments. Here the 'expense ratio' is not more than some 13 %. If the sum transferred to the Central Fund is included, the ratio would be between 14 and 15 %. The figures, however, do not look so satisfactory if we relate the cost of administration to the benefits granted; that is, if we eliminate those sums which have to be retained for actuarial purposes, although these can also be regarded as a benefit to the insured from a financial viewpoint. In that case, the net cost of administration of £5,024,000 would have to face payments for benefits amounting to £28,784,000 (all these figures relate to England only), which

1 During the war the loss ratio was increased to 70% on account of the higher premium income.

2 Cf. Home Office, *Workmen's Compensation Statistics*, 1940, p. 7 and for full details Wilson and Levy, *Workmen's Compensation*, vol. II, pp. 318 sqq.

3 Cf. *Annual Report of the Ministry of Health*, 1939, pp. 271–2.

would mean that the administration cost some 17 % of the sums granted in benefits.

It is the usual way of measuring the cost of administration by showing it as a proportion of the premium income. Yet, this method, as has been recognized by the International Labour Office in other cases,[1] is not quite satisfactory where different methods of insurance administration prevail. It is a better way to compare costs of administration with the actual benefits granted, or, in other words, to find out what it costs proportionally in various countries to provide for the benefits. The figures published by the International Labour Office in 1936 for many countries relate to 1933, but give an approximate indication of the prevailing differences:[2]

Country	I. Expenditure in Benefits		II. Cost of Administration		III. % (approx.)
Irish Free State	£	802,637	£	163,596	20
Great Britain and Northern Ireland	£	33,496,000	£	5,808,000	17*
Austria	Sch.	70,842,000	Sch.	12,970,000	16
Japan	Yen	23,764,000	Yen	3,089,182	13
Germany	RM.	1,036,000,000	RM.	127,861,000	12
Sweden	Kr.	27,505,000	Kr.	3,010,918	10
Switzerland	Sw.Fr.	70,389,493	Sw.Fr.	7,087,859	10
France	Fr.	1,211,398,000	Fr.	89,709,000	7

* According to the *Beveridge Report*, p. 285, the cost of administration as a percentage of benefits was 17·4 in 1939.

The figures are not strictly comparable, but the table does give a rough indication of the relatively high cost of sickness insurance administration in Britain. International comparisons of this kind have been criticized by British insurance offices as being deceptive. Before the Royal Commission on Workmen's Compensation the Accident Offices Association contended that the low expense ratio of Workmen's Compensation in other countries—for instance, in Ontario with 9 % against that of 28·7 % which was the Association's figure for Britain—was due to the fact that the benefits in such countries might be much larger than in this country; if, the Association argued, in such countries the benefits had been

1 *Supplementary Memorandum of the I.L.O. to the Royal Commission on Workmen's Compensation*, Paper 17 A, Evidence, p. 725.

2 The selection of these countries is not arbitrary; in many countries sickness insurance is merged with another social insurance service which makes strict comparisons impossible. There are other considerations which prevent a strict comparison; and in this table only such figures have been selected where comparison seems to be reasonably well justified.

the same as in this country the total amount expended in claims would have been less with no corresponding reduction in expenses.[1] The argument, however, is not convincing when applied to industrial accident insurance, or to international comparisons of sickness insurance costs. It certainly does not explain very marked differences in relative costs; even the Accident Offices Association was not able by its subtle calculation on the basis of British benefits to raise the Ontario level above 16·2 %,[2] which still compared unfavourably enough with the Association's figure of nearly 30 %. But there is in Britain a much more important reason for not accepting the Association's argument. It can by no means be assumed that higher benefits simply represent a relative smaller overhead expense ratio compared with the total amounts of benefits granted. The term 'Higher benefits' does not merely imply a higher scale of 'cash' benefits; it implies a qualitatively different and much more elaborate service altogether. If, under National Health Insurance, medical benefits of the specialized type included in foreign schemes were brought in, no doubt the expense ratio would be far higher than it is. 'The administration cost of non-cash or treatment benefits is fairly high,' Sir Walter Kinnear told the Royal Commission, 'but there is not much extra labour involved in the administration of additional cash benefits'.[3] This being the case, it is interesting to note that, while in 1933 in Great Britain and Northern Ireland some £19,000,000 were spent in cash benefits (sickness, disablement and maternity) and only £10,000,000 in medical benefit, in Switzerland—with its low expense ratio—the reverse happened: Frs. 26,000,000 were spent in cash benefits, while not less than Frs. 43,000,000 went into benefits in kind.[4] In countries where treatment benefit plays an important part, where ordinary treatment benefit has long since been superseded by specialized medical, surgical and pharmaceutical provisions, where sanatorium and hospital treatment is included as a statutory obligation, where even research plays its part in administration, administration costs—whatever the beneficial effect of such medical expenditure on the incidence and duration of sickness might be—certainly increase progressively and not proportionally, when compared with the expenditure on

1 Cf. Evidence, 29 Feb. 1940, p. 834, 142 (*b*) and 143–7.

2 This calculation was repeated in a letter to *The Times* of 23 July 1942 by Mr A. E. Sansom.

3 Cf. Evidence, Q. 769; he also mentioned the special administrative allowance granted to societies for non-cash or treatment benefit.

4 Cf. I.L.O., *loc. cit.* vol. I, p. 361 and vol. II, p. 432.

cash benefits. Such an increase in the cost of administration would certainly overweigh by far the relative relief to overhead charges on cash benefits when the latter are increased. In making comparisons it is, therefore, imperative, not simply to compare the amounts spent in benefits in various countries, but also to take into account the nature of the services provided in their varying costs of administration. By any such test the administrative costs under National Health Insurance in Britain must appear not only absolutely high, but still higher relatively when compared with those of foreign schemes, for National Health Insurance in Britain does not touch even the fringe of the medical and pharmaceutical services which involve the highest cost.

There is another factor which places the high British expense ratio in a still more unfavourable light compared with other countries. National Health Insurance draws very substantial assistance from services of a voluntary and charitable nature. If it had to stand on its own feet, it would be still more expensive both absolutely and relatively. Instead of being burdened with high administrative costs, as would be the case if the administration of hospitals were its charge, as for instance in Germany, National Health Insurance makes considerable use of the voluntary hospitals. National Health Insurance is able to take advantage of the British Hospitals Contributory Schemes with their annual collection of £3,000,000, of which some £2,400,000 annually go to hospitals.[1] Four million contributors to these schemes enable the hospitals to offer their medical and administrative services, such as they are. National Health Insurance administration, even if it pays for these services, benefits through such contributions as well as through the charitable subscriptions to hospitals. It is thus enabled to save administrative costs of hospitalization. For surgical appliances, Approved Societies can use the excellent services of the Royal Surgical Aid Society, which again exists in the main by annual subscriptions, donations and collections.[2] The society has developed into an authority on the supply of surgical appliances, and National Health Insurance benefits greatly by the fact that this body is sustained by voluntary charitable efforts; and that it built up an efficient and economical system of providing appliances. The same applies to nursing; The Queen's Institute of District Nursing has arrangements with Approved Societies to include

1 Cf. *Memorandum of the British Hospitals Association to the Royal Commission on Workmen's Compensation*, April 1940, p. 8 (reprint).
2 Cf. *Report for* 1939, p. 29.

nursing services among additional benefits; the total income of the associations affiliated to the Institute comes to some 84 % from sources other than patients' payments.[1] The administration of National Health Insurance again profits substantially. In countries where no such voluntary organizations exist legislation encourages sickness insurance institutions to employ their own nursing staff in areas where it is insufficient.[2] But the cases in which approved societies employ nurses of their own are rare.[3] It is of course far more expedient to make arrangements with the District Nursing Associations, either to provide nursing under the additional benefit scheme, or else under section 70 of the Act (formerly section 26 of the National Health Insurance Act, which was much debated by the Royal Commission), by which an Approved Society is entitled to make donations to charitable institutions of prescribed nature.[4]

Thus compulsory National Health Insurance is bolstered up by charity and voluntary effort.[5] There must be grave doubts about the propriety of a system, once called the 'parallel-bars' by the Webbs, whereby national sickness insurance benefits indirectly by monies given in a charitable way with the object, not of relieving sickness insurance administrations of a burden, or to lessen their expenditure, but to help the 'unknown beneficiary' according to his most urgent need. A gift sent to a charitable society is intended to help some person in utmost need and unable to get help otherwise or elsewhere, certainly not to diminish the cost at which statutory bodies administering sickness insurance can discharge their obligations. But National Health Insurance administration would be very much more costly if this aid were not forthcoming. The British expense ratio, compared with countries where more costly benefits are given and there is no 'parallel' assistance to be exploited, is still less favourable than the actual figures would indicate.

It is not irrelevant to consider the systems of administration which show so much more economical results than the British system. In Austria the scheme is administered by territorial in-

1 Cf. *P.E.P. Report*, p. 177.

2 The German code, cf. para. 185 of the *Krankenversicherung Gesetz*.

3 Cf. Royal Commission, Evidence, QQ. 19440–41.

4 See Lesser, *loc. cit.* p. 159 and section 226 of National Health Insurance Act, 1936.

5 Cf. Evidence, Q. 19,455, where it was stated that workers were paying subscriptions at a penny per week or more, which of course did 'not really cover the cost of nursing'.

surance funds, works funds, guild funds, and miners' benefit societies; the system is almost the same as in Germany with its three main funds, the territorial, the occupational and the 'substitute' funds—the occupational funds being again divided into works funds, guild funds, miners' and seamen's funds.[1] In neither country is the sickness insurance system connected with any private interests; nor is it one of competing and overlapping local agencies. It is in the main a municipal system, decentralized and integrated regionally. In Japan health insurance is administered by industrial undertakings employing 500 workers or more, which are under the obligation to set up autonomous health insurance funds if the competent Minister so orders. Undertakings employing from 300 to 500 workers may do so, and smaller enterprises may combine to form funds with at least 300 members; workers not belonging to such autonomous funds are insured with one of the fifty prefectural health insurance offices. There is a central administration under the Bureau of Social Affairs under the Ministry of the Interior. Here again is the principle of decentralized integration.

In Sweden, whose social services deserve high praise, sickness funds are divided into two groups (since 1931), local and central. A local sickness fund is as a rule competent for the area or commune or a number of neighbouring communes, and has at least 100 members. A central sickness fund competent for one or more provinces or one or more towns is administered by a provincial council. Insured persons domiciled in the area belong to that fund. The central funds have two classes of members: the members of the local funds within the area of the central fund; and the direct members, that is, persons domiciled in localities within the central fund area but without a local fund. The central sickness funds also provide benefits for insured persons who have exhausted their rights to benefit from their respective local funds. The sickness scheme is supervised by the State. The scheme, it should be remembered, is voluntary, but State-subsidized. The central funds are regarded as the very backbone of Swedish sickness fund organization.[2] The membership increased in 1936 to 1,010,000, which represents about one-third of the occupied population. To this has been added the number of those who are insured in sickness benefit societies not in receipt of State support, who number some 260,000.[3] We have here a system which, though

1 See p. 229.
2 Cf. for this *Social Work and Legislation in Sweden*, Stockholm, 1938, pp. 132–3.
3 Cf. *ib.* p. 133.

on a voluntary basis, is one of strictly territorial and semi-State administration.

In Switzerland sickness insurance under the Federal Sickness and Accident Insurance Act is administered solely by recognized funds, which may be private funds organized as associations or as co-operative societies; funds set up by institutions and public bodies; or public funds set up by decision of the cantonal or communal authorities for any given group of persons. Insurance is not necessarily compulsory. Yet, in the most important industrial cantons it is so, in Basel town, Appenzell, Berne, Lucerne, Zürich, Geneva, Schaffhausen, St Gall, etc. The State (Confederation) grants subsidies to recognized funds, and here lies, as was early recognized by writers such as Rubinow,[1] an important point. The system is not altogether on a territorial basis; yet it provides the basis for territorial organization on a voluntary principle, and as the State contributes to the funds—not merely paying the costs of central administration—there is a considerable degree of supervision and control over the activities of recognized societies.

The Irish Free State has a scheme administered by a single mutual benefit society of which all insured persons are members. The society was established in 1933. It took over the assets and liabilities of all the existing approved societies and is managed by a committee consisting of nine persons elected by the insured, their employers' representatives appointed by the Minister of Local Government and Public Health, and three trustees similarly appointed.[2]

In France compulsory sickness insurance dates from an Act of 5 April 1928. The risks of sickness, maternity, invalidity and death are assigned

(*a*) to departmental or inter-departmental funds, covering, in addition to persons who wish to be insured with them, persons who do not select any other organization;

(*b*) to funds set up either by mutual aid associations or federations of such associations or by trade unions or trade union federations, or by independent associations of insured persons;

1 Cf. Rubinow, *loc. cit.* pp. 241–2.

2 It should be noted that no medical benefit is granted: this, of course, means a corresponding reduction in the expense ratio, as medical benefit is more costly in administration than sickness benefit; but additional benefits, including some treatment benefits, are granted. It may be assumed that the expense ratio would be higher, if the same benefits were granted as in Britain, but it must be remembered that the high expense ratio of 20% relates to a period when approved societies were still the administrators.

(*c*) to employers' institutions which have been authorized to insure, as insurance institutions, against assessment risks.

The management of the sickness fund—as of the other social service funds—is vested in a board of management consisting of at least eighteen members, not fewer than half being insured persons, six being representatives of employers and the remainder doctors recommended by medical associations. Here, we have a mixed system of public and semi-public administration. The system contrasts with that which Rubinow found in 1913 and which he did not want to dignify by the name of a national subsidized system of sickness insurance. In Alsace-Lorraine there existed, before its conquest by Germany in 1940, a system very similar to that in Germany, that is, a system of territorial and works funds; as with Workmen's Compensation the German legislation prevailing before 1918 had been retained. The expense ratio is highly satisfactory; in 1933 some 77,000,000 frs. were paid in cash benefits and 90,000,000 frs. in medical benefits, comprising elaborate treatment benefits; yet the administrative expenditure was only 11,000,000 frs., approximately 6 %.

International comparisons in this matter must be dealt with most cautiously. Granted this, it is surely not accidental that the expense ratio of sickness insurance is so much lower in countries which have a system of decentralized but integrated territorial funds under central control than it is in Britain. This is the case in spite of the greater and much more complicated medical benefits granted, which reinforces the conclusion that the cause of the high expense ratio must be sought in the system of organization and administration of National Health Insurance. One would not be so bold as to contend that, as a matter of principle, insurance administration by public or semi-public authorities should be cheaper than that of the private insurance society. It is easy to imagine that the approved societies, as they are constructed in this country, would show very different expenses of administration if they did not cater for contributors in a competitive way. When Mr J. Redman Ormerod, in his fight against State insurance, declares that 'the defects in National insurance... consist in the flat rate of contribution charged',[1] he forgets entirely that this method owes its existence to the fact that any number of administrative bodies may compete locally and that the flat rate was necessitated by what the Report of the Royal

1 Cf. Ormerod, *National Insurance, Its Inherent Defect*, p. 26, 1930.

Commission rightly called the 'segregation' of risks,[1] on account of the disintegration of the societies' sphere of activity. The problem is far more one of administration than of State versus private insurance.

In 1927 the International Labour Office stressed the fact that 'wherever voluntary insurance has made any progress, open funds, established on a territorial basis, are growing more rapidly than other types'. It pointed to developments in Switzerland, Belgium, Finland and France, and stated that 'this movement in favour of territorial institutions is not peculiar to European countries', citing developments in Australia and New Zealand where 'the societies are definitely territorial'.[2] Ten years later the International Labour Office again urged the expediency of territorial funds, making it clear at the same time that these should not be confounded with public administration.[3] The International Labour Office made a 'clear-cut' distinction between the management of insurance institutions, which on the principle of self-government should be in the hands of those directly interested in the operation of insurance institutions, and their supervision, which is entrusted to the public authority.[4] Article 6 of the Draft Convention (No. 24) concerning sickness insurance for workers in industry and commerce and for domestic servants has embodied this principle. Special arrangements were, however, recommended where in sparsely populated districts the territorial or local system would not have been applicable, and special services might be instituted directly by the State.[5]

The point, then, is that institutions of a territorial, or otherwise, integrated scope, would probably show a lower expense ratio than the present British figure. We gave an illustration of the sort of items which make up the high expense ratio when we mentioned the costs incurred by societies competing for new members.[6] We have already seen in detail how the inauguration of insurance committees was an attempt to mitigate the disadvantages of the 'disintegration of societies' by setting up a concentrated unified and uniform administration in one sector at least of National

1 Cf. *Report*, pp. 100 and 115: '...the Approved Society system is made up of Societies resting on a segregation, conscious or unconscious, of members of varying health experience and health prospects'.

2 Cf. I.L.O., *Voluntary Sickness Insurance*, Geneva, 1927, p. xxvii.

3 Cf. I.L.O., *The International Labour Organization and Social Insurance*, Geneva, 1936, p. 54, where the 'undoubted advantages of territorial funds, particularly as regards the rational organization of medical aid' are noted, together with 'simplicity in operation and control'.

4 Cf. also I.L.O., *Approaches to Social Security*, 1942, p. 6.

5 Cf. *ib.* pp. 58–9.

6 Cf. p. 239.

Health Insurance, that of medical benefits. But in a country where cash benefits, in spite of their low rate, play the outstanding part in the financial administration of health insurance the high level of the expense ratio is not much alleviated by this arrangement alone. We have also seen that the tendency is to centralize dispersed units. But this, again, does not mean more than rationalizing the administrative machinery of single approved societies; it does not mean that the competitive situation between societies thereby disappears. And it is the 'segregation' of membership due to this situation which mainly causes the higher costs.

There can be no doubt that the multiplicity and competitive position of approved societies involve a great many expenses which could be saved if integrated funds covering a definite insurance unit or group were in existence. A much greater amount of actual work is needed, which cannot be eliminated by machinery. Salaries may be taken to absorb 70 % of the administrative expenses.[1] Next come printing, stationery, postages, rents, rates, taxes and insurance and travelling expenses. Before the Royal Commission, the societies definitely denied that administrative economies could be effected;[2] and the Royal Commission omitted to investigate the general organizational imperfections of the system of competing and disintegrated approved societies which results in the overlapping and duplication for which the member has to pay in the high expense ratio.

One of the expensive items in the cost bill of National Health Insurance is the work of the agents. The system of administering certain National Health Insurance services by agents would not exist if there were no industrial assurance. Taking the figure given to the Royal Commission of a payment of 10½*d.* per insurance card per half year to the agents employed in National Health Insurance[3] one might say that roughly the sum spent in this connection may be estimated as being some 1·7 million pounds to 1·8 million pounds a year.[4] What this means may be best illustrated by the fact that it represents about a fifth of the sum

1 Cf. Royal Commission, Evidence, Q. 3772, also QQ. 3946 and 5632; cf. also Snoxhill, *Notes on Approved Society Organization,* p. 62.

2 Cf. Evidence, QQ. 6251, 7186, 7393: 'I cannot see where any reduction could be brought about without impairing the efficiency of administration.' Also QQ. 7497–8.

3 Cf. Evidence of the Scottish Miners' Approved Society, Q. 6689.

4 With the Prudential the make up of the average weekly remuneration of all agents in 1938–39 was £5. 13*s.* 4*d.*, of which 11*s.* 11*d.* came from approved society service. Cf. *Beveridge Report,* p. 251.

paid in sickness benefit, about a sixth of the sum paid in medical benefit and much more than the sum paid in maternity benefit.

It is much more than the total of all sums allocated in a year to ophthalmic benefit, convalescent homes, medical and surgical appliances and hospitals under the additional benefit schemes. It is indeed a dearly paid service.[1] The question was very bluntly put to some representatives before the Royal Commission whether 'the work entrusted to agents' represented 'greater costs than would be incurred if that work were done from the head office of the Society'. The answer was definitely evasive.[2] It was argued that 'having regard to the services rendered' the service was 'cheaper than any other service'. This may be so; and the agents are certainly not in an enviable position. It must be also conceded that the big insurance offices do their best to reduce the costs of the agents' work by the elaboration of more economic systems of administration, such as the block system, which by a unification of the agents' 'rounds' tries to prevent overlapping.[3] But it is certainly not the rationalization of the service as it stands that matters, but the expediency of the system itself as a whole. It is monstrous over-expenditure that every approved society and every sickness insurance unit should have agents of its own in every locality, large or small, whatever the size of the unit's membership. The work involved consists, so far as the 'state business' is concerned, in collecting and distributing the insurance cards, receiving claims for benefits and paying benefit claims. The agent may also act as a sick visitor. He has to deal with a number of technical matters to which one would expect the insured person or his relatives to attend, such as changes of address, marriages or deaths. There may be an enormous amount of unnecessary calls simply for lack of proper organization; it was stated before the Royal Commission, for instance, as regards the collection of cards, that on his first round the agent may not receive more than 60–70 % of the cards that he should have collected; it takes him sometimes 'four, five, six or seven visits before he can get the total number in'.[4] Apparently those responsible for these and other

1 The costliness of the home service cannot be better illustrated than by the elaborate enumeration of items of such service by the approved societies themselves. See 'Memorandum of the Industrial Assurance Approved Societies to the Beveridge Committee', in *Insurance Mail*, 23 Sept. 1942, p. 754.

2 Cf. Q. 4443.

3 Cf. for the agent's hard life, Wilson and Levy, *Industrial Assurance*, pp. 241–2, 252–3 and *passim*; for 'block system', *ib.* pp. 291–2, 273–7 and *passim*.

4 Cf. Royal Commission, Evidence, Q. 4425.

matters rely upon the services of the agent—who has 'to make himself as agreeable as possible',[1] as one witness said, to secure as many members as possible (for this as for the other purposes which are his business). Here again is that dangerous dual capacity in which the agent acts, and is strongly expected to act—that is, his function as an administrator of certain statutory arrangements, and his commercial task to canvass for private life assurance, an even possibly other kinds of private insurance, on which his income primarily depends.[2] There is no reason why, as in countries with territorial or municipal funds, the insured persons or the works concerned should not attend to the matters which are in Britain entrusted to a special staff of home service agents. The system of 'Melde-' and 'Zahlstellen', which in Germany even provides in certain cases the machinery for an area wider than the merely local one, would dispense with the work of agents entirely.[3] The work now left to agents could be dealt with by the insured themselves by direct access to those local bodies or offices which would supply the cards, make the necessary payments, and supply information; and all this could easily be done by personal visits by the insured or by someone empowered by him (members of the family), and through the post. The system is simple and relatively very inexpensive. Its introduction in England has been prevented merely by the fact that, on the one hand, the interconnection between approved societies and insurance offices has given an undue, though commercially understandable, preference for the agency system, while, on the other hand, the disintegrated nature of the scattered sickness insurance units acts as an impediment to any unified and locally centralized method of dealing with the clerical work involved.

1 Cf. *ib.* Q. 4436.

2 An instructive summary of the agent's various prospects of activity is found in 'Aquila', *Insurance Agency Works*, N.D. (1941). Also 'Memorandum submitted to the Beveridge Committee by the National Conference of Industrial Assurance Societies', in *Beveridge Report*, Memoranda from Organizations, pp. 51–3.

3 Cf. *Reichsversicherungsordnung*, Buch II, paras. 319, 322, 345.

CHAPTER XXXI. ECONOMY THROUGH CONTROL

'Oh, powerful bacillus,
With wonder how you fill us,
Every day!
While medical detectives
With powerful objectives
Watch your play.'

WILLIAM TOD HELMUTH, *Ode to Bacillus.*

THE problem of avoiding the uneconomic exploitation of sickness insurance has existed from its very beginning. As early as 1898 the Munich Medical Association asked one of its members, Dr Ludwig Dresdner, to make an elaborate investigation into certain economies necessary in prescribing. In 1924 an international committee of representatives of sickness insurance funds and medical associations drew up the first guiding principles for economical prescribing which have been modified in various ways since that date, but have remained the same in their fundamental conceptions. The International Medical Association drafted certain principles for the economical administration of sickness insurance in 1928, which were adopted in 1935. The latest contribution is the Report of the International Labour Office in 1938 on the Economical Administration of Health Insurance Benefits, which we have frequently quoted. There are certain principles which can be applied wherever national sickness insurance is in existence.

There are two main problems in the economical administration of health insurance. One is 'excessive sickness', the other 'excessive treatment'. It is quite natural that on the part of the health insurance administrators, whether of central departments or individual funds, there is always suspicion that insurance benefits may be unwisely or unnecessarily exploited. This is especially the case when claims under sickness and disablement insurance show a rising tendency. Such, for instance, was the case in Britain between 1921–27, with the result that the attention of the Ministry of Health was aroused and a Memorandum was issued on the matter in 1931.[1] The background was the following increase in the benefits which in that period had been provided:

	Sickness Benefit increase (%)	Disablement Benefit increase (%)
Men	41	85
Unmarried women	60	98
Married women	106	159

1 Cf. Ministry of Health, *Memorandum on Certification of Incapacity for Work*, 1931.

These were very remarkable increases. The Minister stated that 'the observed increase in claims has been due, in the main, to an increase in the number of persons who received sickness and disablement benefit though not incapable of work'. It was explained that the phrase 'not incapable of work' should not be understood to imply that 'such persons or any large number of them were malingerers. They may have thought themselves more ill than they were, or at any rate have hoped that their illness, such as it was, might be regarded by the doctor as sufficient to justify a certificate of incapacity. Patients cannot be held responsible for the estimates of their own incapacity, except in the rare cases in which they seek to deceive.'[1]

The Ministry rightly adopted the view that malingering as such was an exceptional matter. In this it agreed with the view which has long been held by the medical profession in this country.[2] The suspicion of malingering, however, has been very much alive in regard to the administration of German health insurance. In particular a treatise written by Dr Liek in 1927 accused the scheme of fostering valetudinarianism,[3] and his and other writers' observations have not escaped the attention of authoritative English writers, such as McCleary.[4] An insured person, it has been contended, will consult his insurance doctor for trivial ailments for which he would never think of seeking medical advice if he had to pay a fee as a private patient. He attaches an importance to such ailments out of all proportion to their real significance. He broods over symptoms, becomes obsessed with ideas of disease, overwhelms his doctor with unnecessary calls upon his time. It is from this angle that insurance institutions appear called upon to check what is described as 'excessive sickness'. To this may be added the very apt remarks of the International Labour Office:[5] '. . . the psycho-physical situation of the average insured person is quite different from that of a person in a more favourable economic position. The special occupational, economic and social conditions in which they live constantly menace the health of

1 Cf. also Dr D. C. Norris, 'Malingering', in *British Encyclopaedia of Medical Practice*, 1938, p. 356.

2 Cf. Dr Brend, *Traumatic Mental Disorders in the Courts of Law*, 1938, p. 47; Dr Norris, *Some Medical Problems in Accident Insurance*, reprint, 1937, p. 19; *ib.* as cited in footnote above; the *Holman Gregory Report* had come to the same conclusion, cf. pp. 43–4.

3 Cf. Dr Erwin Liek, *Die Schäden der Sozialversicherung*, München, 1927.

4 Cf. McCleary, *loc. cit.* pp. 161–3 and 155.

5 Cf. *Economical Administration*, p. 5.

insured persons, and a comparatively slight illness may lead to unfitness for employment and consequent poverty. For that reason many insured persons react to threatened or existing illness in quite a different way from persons who live in satisfactory hygienic conditions and secure material circumstances. They generally consider only the symptoms of their disease without realizing its nature, and are therefore liable to worry about the whole future. They demand from the insurance schemes very intensive assistance, effective medical treatment and drugs, and at the same time protection against the possible consequences of their illness.'

This kind of psychological observation should be contrasted with such sweeping and ill-advised statements as 'that there are hundreds of thousands of men and women who have become so demoralized by their acts of deception and of exploitation of National Health Insurance funds, and so incapacitated by prolonged illness, as to be unemployable in an economic sense'.[1] It is an argument frequently heard by persons who abhor the idea of comprehensive national insurance schemes. The old-fashioned idea of the magic of 'self-help' is applied to public health; it is suggested that there is an enormous amount of ill-health which is merely auto-suggestion, and that more energy and self-determination are the only means necessary for 'cure'. Nobody will deny that here and there this is true, and that a certain tendency to imagine ailments may sometimes be encouraged by the expectation of treatment for which one has paid a premium. On the other hand, there is a good deal of evidence for the view that sick people are in many cases far too reluctant to seek proper medical advice and treatment at the proper time.[2] It is precisely the purpose of National Health Insurance—and of sickness insurance in all countries—to counteract such behaviour. There can be hardly any doubt that where, under an insurance system, illness is detected and treated at the right time, the nation's health is improved—though superficially the amount of 'illness' is increased. In view of the dangers of hidden and neglected illness, it is exactly this increase of recorded cases of sickness that is the aim of national insurance. It would defeat the very ends of this social service if it were assumed that this recorded increase is wrongly due to insurance and unnecessary treatment, and to adduce certain exceptional neurotic cases as evidence for this

1 Cf. Ormerod, p. 17.

2 Cf. above, pp. 205–7, also John Newsom, *Out of the Pit*, 1936, pp. 46 and 115.

assumption. One cannot try to promote treatment-mindedness[1] and at the same time condemn health insurance as a means of stimulating a desire to be treated.

Moreover, the position of the British worker under National Health Insurance is not such as to promote eagerness to go on the sick list. It may be that some categories of insured persons, such as domestic servants or certain workers in offices, may be inclined to indulge in 'excessive' illness. It is, however, questionable whether these cases are in any way important compared with the positive effect of insurance, which is that most people will tend to seek medical attention earlier. There may also be exceptional circumstances which induce people to malinger.[2] It is sometimes contended that high cash benefits may have the effect of increasing illness and expenditure to the administration.[3] But it must be kept in mind that low cash benefits have the inevitable effect of worsening the patient's condition and lessening the prospects of a quick and easy recovery. 'Is there not the other side to be considered, namely, that where you have the bread-winner sick and there is not an income to provide him with the necessaries he requires both for his family and his individual requirements that also would have a tendency to prolong sickness?' Prof. Gray asked a witness this before the Royal Commission.[4] The same applies to the sick worker, who is said 'not to care to go back to work',[5] a problem which worries the approved societies more than that of the 'malingerer'. Here also the danger of too early a return to work[6] always exists, and may produce the 'hospital-repeater',[7] just as costly to the sickness fund as the reluctance of some workers to return to work as early as possible, perhaps even more costly.

In Britain, this complicated problem must be viewed against the background of the actual scale of cash benefits. A weekly 15*s*. in peace-time, or 18*s*. a week in war-time, is certainly not a temptation to remain sick and idle. It is true, as Mr Smyth told the Commission on Workmen's Compensation, that 'one may want to go to a football match . . . or something like that', but he could really see no advantage for the workman receiving, say, £3 a

1 Cf. also Aleck Bourne, *Health of the Future*, 1942, p. 23.

2 Cf. for instance, Q. 18,408 of the Royal Commission, where it was mentioned that a worker wanted to join his wife at a spa, and was said to have intended to do so by getting a panel doctor's certificate.

3 Cf. *ib.* Q. 5304.

4 Cf. *ib.* A. and Q. 5406.

5 Cf. *ib.* Q. 5436.

6 See above, p. 206.

7 For an interesting discussion of the point, see *Lancet*, 13 Jan. 1940, p. 91.

week, in fining himself by claiming to be sick and receiving National Health Insurance benefit.[1] Yet while there is little reason to believe that unfair claiming, whether intentional or half-conscious, is responsible for much unnecessary expenditure under National Health Insurance, it cannot, of course, be disputed that certain measures to guard against this danger are justified. The Regional Medical Staff of the Ministry of Health perform certain services in connection with National Health Insurance for which payment is made out of insurance funds. They advise, for instance, in cases of doubt as to the insured person's incapacity, or inspect the medical records of insurance practitioners.[2] Their purpose is to give approved societies administering sickness benefit the opportunity to obtain an authoritative second medical opinion in cases where they are not satisfied, on the basis of the medical certificate submitted to them, that the insured person is incapable of work. In the German system the same kind of arrangement exists in the appointment of medical referees—Vertrauensaerzte; some funds even request all applicants for sickness benefit to see the referee (if well enough to visit him) and in such cases pay benefits only to applicants who are certified by the referee to be incapable of work.[3] In Britain the appointment of Regional Medical Officers to act in this capacity was first made in 1920 (though there had been provision for obtaining a second medical opinion under the administration of sickness insurance by friendly societies), mainly on the recommendations of a Departmental Committee which had received a large amount of evidence, both from approved societies and doctors, in favour of the establishment of a system of medical referees.[4] In 1938 the total number of cases referred for advice as to incapacity under the Regional Medical Scheme was 421,667 (420,012 from approved societies and 1,655 from doctors).

1 Cf. Royal Commission on Workmen's Compensation, Evidence, 20 June 1940, Q. 12,430. 2 Cf. Lesser, *loc. cit.* p. xxv, for more details.

3 There has been a growing tendency in Germany to relieve the insurance practitioner from the burden of certification; the argument is that such a procedure would eliminate the danger of insurance practitioners being tempted to give certificates for the benefit of their reputation or to refrain from doing so by fear that they may lose popularity. The tendency is, however, opposed by German panel practitioners who contend—not without justification—that the doctor who treats the sick person is best able to judge his condition, degree of illness and working capacity; cf. also McCleary, *loc. cit.* pp. 137–8. Cf. for an employers' complaint about medical certificates 'granted too easily', *The Times* of 17 Sept. 1942, p. 8, letter by Mr R. B. Templeton.

4 Cf. *Report of the Departmental Committee on Sickness Benefit Claims under the National Health Insurance Act*, Cd. 7687, 1916.

Of these 65 % related to men and 35 % to women—an interesting fact if contrasted with the generalization sometimes heard[1] that women tend to malinger more than men. Actually the proportion of doubtful cases on this basis corresponds pretty well to the numerical proportion of women and girls in the total insured, viz. 6,100,000. The number reported to have received a final certificate before the date fixed for examination was 166,899 and 83,769 others did not attend for examination. Of the persons examined 164,759 were reported incapable and only 56,080 as capable of work; 218 references were received from the Unemployment Assistance Board with regard to cases where there was a conflict of evidence on the question of capacity for work or doubt as to the reasonableness of a claim for extra nourishment.[2] From the figures as annually given, it seems clear that there is no reason to suggest a very large number of cases of suspicion or to justify suspicion of malingering or a disposition to valetudinarianism. The question is not easy to settle. Dr McCleary aptly points out that 'the interpretation of the phrase "incapable of work" is difficult; and that should it be taken literally, apart from the completely paralysed and the unconscious, it would be difficult for anyone to establish a claim for sick benefit'.[3] On the other hand, here as in other cases, what appears on the surface may not disclose the actual state of affairs. There may be many cases, where sickness is not genuine, which may never be investigated at all.[4] Before the Royal Commission, sufficient evidence was given to show that the provision of a regional medical staff has certainly had the effect of preventing malingering. Sir Walter Kinnear definitely agreed that as a result of administrative action by Regional Medical Officers 'over-generous certification is not a substantial financial danger',[5] a statement which was corroborated by Sir James Leishman of the Scottish Board of Health.[6]

The danger of over-expenditure by excessive illness is further

1 Cf. Q. 12,430, Royal Commission on Workmen's Compensation, Mr Smyth: 'I know that, that has been the criticism of women in Health Insurance for a good many years.'

2 Cf. *Annual Report*, 1939, pp. 151–2; it should be noted that most societies have in their rules a provision to expel a member who refuses examination by a Regional Medical Officer, but he may be certified by his doctor as being unfit to attend. But there are many quite natural reasons for non-attendance, cf. Royal Commission, Evidence, QQ. 5220 and 6712–14.

3 Cf. McCleary, *loc. cit.* p. 130.

4 Cf. Royal Commission, Evidence, QQ. 5437–8.

5 Cf. *ib.* Q. 275.

6 QQ. 1617–18.

lessened by the insurance carriers themselves, through the system of sick visitors. Under almost all sickness insurance schemes, sickness funds have established a staff of visitors who periodically visit those who are unfit for work, in order to see that they are following the instructions of the insurance practitioner about going out and about prescriptions. Many of these visitors were formerly nurses, and have in addition been specially trained in social matters, and they can be very helpful to practitioners in many matters of social medicine.[1] There is in Britain no express arrangement for sick visitation under the Act; but its existence is recognized, and an approved society is allowed to make rules for the visiting of sick persons.[2] 'The maintenance of an efficient system of sickness visitation is an essential part of the administration of a properly conducted Society', emphasizes the *Approved Societies' Handbook*.[3] It is further stressed that the free use of the services of Regional Medical Officers by a society cannot be in any way regarded as a substitute for proper 'sickness control', and that the two methods should be regarded as complementary. The task of the sick visitor is strictly circumscribed. He or she should certainly not act as a medical adviser, and should not in any way interfere with anything within the doctor's province; he should especially refrain from criticism of the treatment given. The societies, on their part, should observe—and mostly do observe—the following requirements: the sick visitor should be properly qualified; he or she should be employed as whole-time; visits should be made at irregular intervals and at varying times of the day; they should be made before the first payment of benefit is due; a written report ought to be furnished by the sick visitor. Women may only be visited by women.[4] It is suggested to sick visitors that persons who are not employed on full-time work—women cleaners, charwomen, domestics—should be watched particularly, as it may be more profitable and convenient for them 'to be on the sick fund than to be at work'.[5]

Again, the ill-effects of the disintegration of approved societies and of the segregation of their risks enters the picture. Complaints are heard that not every society can afford to pay a salaried visitor in every district where it has members. A useful expedient would be for a number of societies, each with a few

1 Cf. *Economical Administration*, p. 70.
2 Cf. Foster and Taylor, *loc. cit.* pp. 137 and 251.
3 Cf. *loc. cit.* p. 113, paras. 424–8. 4 Cf. section 64 (1) (*c*).
5 Cf. Snoxhill, *loc. cit.* p. 27.

members in a particular district, to start a co-operative scheme. One scheme, it is said,[1] has functioned 'fairly successfully' for some years. This is a meagre result. It can well be imagined that there is reluctance on the part of societies to employ staff who may have contacts with a number of societies in matters which are sometimes of a rather confidential nature. Here the approved societies again show their affinity with purely private and competing firms. With integrated funds, territorial or otherwise, this problem would hardly arise. Better economy and more control would be the result.

The second problem in economical administration is that of excessive treatment, and of excessive prescribing in particular. We have already dealt with the matter as viewed from the patient's angle, that is, under the heading of medical benefits.[2] The doctor, in many cases, is between two stools. He may feel that a certain treatment is necessary but refrain from it because of the cost, fearing the controlling authorities may object. On the other hand, he is well aware that parsimony may be interpreted as ill-will by the patients and damage his popularity. As the International Labour Office quite rightly observes, many doctors will resolutely reject what they consider to be unnecessary interference, as 'of course, the well-being of his patient and not the principle of economy' is the 'paramount consideration of the doctor'.[3] The International Labour Office further states, against the background of its wide investigations:[4] 'A frequent answer of doctors to the demand of the insurance institutions for the constant application of the principle of economy is that sickness and sick persons cannot be compared with or treated as material goods, to which the principle of economy is normally applied; the practice of medicine is essentially an art; the patient's confidence in the doctor is of the highest importance for success; where immaterial factors play a preponderant part, the principle of economy is quite inapplicable.'

In Britain the conditions under which insurance doctors work can hardly be said to foster any effort on their part to exert themselves unduly in the treatment of their patients. As we have seen, the conditions of payment are so unsatisfactory that the contrary is far more likely to be the case. Matters might be different if the capitation fee system of remuneration were to be replaced by fees based on attendance or treatment. The latter

1 Cf. Snoxhill, *loc. cit.* p. 28.
2 See above, pp. 191–4.
3 Cf. *Economical Administration*, pp. 24–5.
4 Cf. *ib.* p. 27.

system may entail a greater danger of 'excessive treatment'. But it is surely not very satisfactory to think that it is only the inadequate payment given to insurance that acts as a brake on 'over-treatment'. If the present system of remuneration has no more to be said in its defence it should be dropped forthwith. It should be noted that, in the Manchester and Salford scheme of payment according to attendances,[1] a system of checks on excessive treatment was evolved, and the Royal Commission was satisfied that they were sufficient to check the tendency to over-attendance.[2] There can be no doubt that under any system of attendance fees the necessary checks to excessive treatment can be evolved, particularly where there exist strong collective medical bodies of control. In general, the cases brought to notice as regards excessive treatment do not appear to suggest that any appreciable economy could be secured by their reduction. There may be some abuse of certification. Here and there certificates may be issued in a somewhat negligent way and not strictly according to the regulations.[3] Before the Royal Commission the approved societies were inclined to make complaints about 'lax certification'; but it was categorically denied by the representative of the Insurance Department of the Ministry that the extent of over-generous certification was a 'financial danger'.[4] Any improvement in the doctor's working conditions—a reduction of his pressure of work, of his panel list or of his unavoidable hurry in many instances—and a better chance to transfer some of his clerical work to assistants might well be enough to remove such dangers as there are of lax or negligent certification.

There remains the factor of 'excessive prescribing'.[5] There can be no doubt that checks on too generous prescribing must play an important role from the viewpoint of the approved societies' finances. The procedure for the investigation of excessive prescribing in Britain is highly elaborate. In England the pricing bureaux ascertain the price of every ingredient in every prescription issued by insurance practitioners. This they do primarily to

1 See above, pp. 124–6.

2 Cf. Evidence, QQ. 14,829–40; Q. 14,830: 'We were told in evidence that these checks had been so scientifically applied as to nullify any tendency there would be to over-attendance?' A. 'Quite so.' Also QQ. 15,202–3.

3 Cf. for two such cases, *Annual Report of the Ministry of Health*, 1939, p. 146.

4 Cf. for complaints, QQ. 11,423 sqq. and 11,760; for the view of the Ministry, Q. 275; cf. also as to this problem the very able article on 'Medical Certification' by A. Kefalas in *B.M.J.* of 25 April 1942, pp. 531–3.

5 Cf. *Economical Administration*, pp. 91–3.

enable the insurance committee concerned to pay the accounts of the insurance chemists; but at the same time they compile certain statistics, submitted quarterly to the Ministry of Health, which indicate possible cases of excessive prescribing. In Scotland, there is a central checking bureau which enters on each prescription the price of each ingredient, the dispensing fee, if any, and the total cost.[1] Investigation may be followed by procedure against the practitioner.[2] The strictness of the procedure is much resented and criticized by practitioners. There is little reason to assume that it is inadequate. No such contention was made by Dr McCleary, who gave much attention to the subject and who could speak from experience.[3] In some countries sickness funds levy a small contribution from the insured for each prescription or the actual cost, if less than this amount. It can hardly be assumed that such payments have any more effect than to act as a check on the prescribing of trivial medicines.

The question of the nature of the medicine which may or may not be prescribed by the practitioner is certainly important. In England and Wales a National Formulary has been worked out by the British Medical Association and a Memorandum on Prescribing and Tariff for Drugs, Appliances and Dispensing Charges by the Department of Health for Scotland. In the former the fact is stressed that 'experience has shown that considerable saving can be effected in certain directions without sacrificing efficacy'.[4] 'Blunderbuss' prescribing is particularly discouraged by the Formulary. In both publications, attention is paid to the expediency of prescribing no proprietary preparations if it can be avoided.[5] Examples are given to show that proprietary medicines may be far more expensive with no more medical effect than plain prescriptions; the doctor may prescribe Paraff. Moll. Flav. at 1*d.* an ounce and not Vaseline at 2*d.* per ounce. There are innumerable instances. It cannot be denied that the modern drug industry has improved the stock of medicaments to a tremendous extent by

1 In Scotland all doctors who themselves supply medicines have elected to be paid on a capitation basis, so that the question of control does not arise in their case, cf. *Economical Administration*, p. 238.

2 Cf. above, pp. 191–3.

3 Cf. McCleary, *loc. cit* pp. 126 sqq.: 'It is the general experience of health insurance schemes that the cost of drugs and appliances tends to increase, and one of the most difficult tasks of insurance administration is to keep the cost within reasonable bounds. The responsibility for the increase cannot wholly be laid upon the doctors.'

4 Cf. *National Formulary*, p. 7.

5 Cf. *ib.* pp. 8–9; *Memorandum*, p. 9.

adding new chemical substances, by providing entirely new drugs and by improving their method of presentation. But under the cover of these great advances a wealth of inferior products have appeared which are simply imitations or casual mixtures. 'These', writes the International Labour Office,[1] 'would be of little importance in practice if they were not distributed so widely and in such a way that it is difficult to recognize them and assess their real value in time.' Every drug factory sends daily to doctors numerous samples of attractively packed products; they are lavishly advertised in the medical journals. The prices of these products are certainly not low—whatever their merits may be—and retail trade associations strive at preventing by elaborate action any competition among retailers which would reduce prices below the level of the fixed schedule.[2] It is certain that there is here a very important field of possible economy on the part of doctors. The National Formulary stresses the fact that 'proprietary preparations should not be prescribed unless the practitioner has satisfied himself that the therapeutic object aimed at cannot be attained by the use of non-proprietary remedies'. Efficient substitutes, it is declared, are usually available, and the panel doctor who has failed to give such substitute a trial 'may in the event of any enquiry into prescribing have difficulty in justifying his action in prescribing the more costly preparation'.[3]

These, then, are the checks which have been placed upon the practitioner for the prevention of excessive treatment and excessive or uneconomic prescribing. It should not be assumed that they have been without the desired effect. Complaints about extravagance and recklessness in treatment and prescribing have not been at all prevalent; far more complaints have been made in the other direction. This being so, it cannot be assumed that much could be saved by strengthening still further the safeguards against laxity of economical administration in these respects.

But there is another point which cannot be left undiscussed. When the Insurance Act was originally passed few sections attracted more attention[4] than the one designed to establish machinery whereby financial liability might be fixed on a local authority or an employer held to have been guilty of default leading to unsatisfactory health conditions and consequent exces-

1 Cf. *Economical Administration*, pp. 90–91.
2 Cf. Hermann Levy, *Retail Trade Associations*, 1942, p. 139 and *passim*.
3 Cf. *National Formulary*, pp. 8–9.
4 Cf. *Royal Commission Report*, p. 259.

sive payments of sickness and disablement benefit.[1] Section 183 of the Act (section 107 of the former statute) lays down the procedure to be followed where an approved society or insurance committee alleges that excessive expenditure on sickness or disablement benefit is attributable to some default on the part of the local authority or an employer. The section provides two things. First, there is machinery for instituting an investigation to determine whether the society's allegation of unsatisfactory conditions is well-founded; such conditions may be found in the nature of the employment of the insured person, in bad housing and lack of sanitation or in insufficient or contaminated water-supply, or in a neglect on the part of any authority or person to observe the requirements of the Factory Acts or any provisions relating to the health of workers in industrial, manufacturing or mining establishments, etc. Secondly, the section enacts that where such allegations have been proved correct, and where by such unsatisfactory and illegal conditions excessive expenditure has been caused, a penalty may be imposed requiring the culprits to pay to the society the estimated amount of the 'extra' (excess) expenditure.[2] Reading these regulations one would assume that here a very powerful measure of control of excessive sickness was created, as approved societies and insurance committees might be expected to avail themselves very fully of the right to act as 'watch-dog' in their very own interests. Actually, the section has proved surprisingly disappointing in practice. No change in experience has occurred since the Royal Commission reported on this matter with keen regret. As was explained to the Commission by officers of the Ministry of Health, no case has ever occurred in which any society had recovered any moneys under the section.[3] The section is at best a useful pointer; for practical purposes it has remained inoperative.

The reasons for this failure are highly illuminating, as they relate partly to the fundamental deficiencies of the administrative machinery of National Health Insurance. 'As Approved Societies are seldom based on a geographical basis', observed the Report of the Royal Commission,[4] 'it is very difficult, if not impossible, to establish from their records the sickness experience among insured persons in a particular locality.' If there had been 'one

1 Chiozza Money, *loc. cit.* p. 125, called attention to section 63, which gave such powers to Insurance Committees, as one of 'the most interesting and important new provisions' of the Act; see also *ib.* p. 273.

2 Cf. for the interpretation of 'extra expenditure', Lesser, *loc. cit.* p. 276.

3 Cf. Evidence, QQ. 1491–8. 4 Cf. p. 259.

national society', it was explained to the Commission, it would be a more or less simple matter to get the necessary information from all the people in any locality. Actually the application of the section was dependent on there being comprehensive local statistics.[1] These were lacking as a result of the 'segregation' of the insurance funds. It was explained to the Commission that the insurance committees were powerless to act in this matter; they could only act on behalf of persons for whose benefits they were responsible—that is, either of deposit contributors or of members of the Army and Navy Fund.[2] That this was the position appears to be another proof of the imperfection of a system which divides responsibility between the approved societies and the insurance committees without any attempt to secure co-ordination in important issues. Obviously the situation would be very different if there were an integrated body to administer both sickness and medical benefit in well-defined areas or occupational units.[3] Apart from this difficulty there is the other one, stressed by the Commission, that it would not be possible to disentangle the proportion of 'excessive sickness' which could properly be attributed to any particular cause from among the many causes that might be operative, and so to enforce the penalty contemplated in the section.[4] It would, for instance, be impossible, it was argued before the Commission, to state how far 'excessive sickness' in a block of slum buildings was due to the conditions under which the people were living and how far it was due to irregular employment. 'You cannot isolate one or two of the number of factors all contributing in varying degree to produce your total result.' The Royal Commission thus became convinced that the section as it stood (and still stands) was 'incapable of effective application' and that the penal provisions directed against the local authority or the employer were useless. It hinted at the desirability of the bodies responsible for the local administration of medical benefit to insured persons being given power to institute enquiries into the cases of excessive sickness brought to their notice, with access for this purpose to the medical records collected under the National Health Insurance scheme.

1 Cf. *ib.* Q. 1496: Sir Alfred Watson: 'You cannot get the excess of sickness until you have ascertained the expected quantity of sickness, of which a factor is numbers and ages.'

2 Cf. *ib.* Q. 1470.

3 Cf. *ib.*: 'If the people living in that district are insured in 100 different societies which have no interest whatever to co-operate to provide the necessary information, you are never going to get the data upon which it would be possible to proceed under Section 63.'

4 Cf. *Report*, p. 260.

Thus one of the liveliest hopes of the originators of National Health Insurance, that their scheme would not only serve as an insurance against sickness but also, through the medium of control by the insurance agencies, as a means of discovering and remedying conditions of unjustifiable official or private neglect and carelessness, was entirely frustrated. The story is just the same as that of the inability of the insurance committees to promote general health improvement.[1] The reasons are not as mechanical as the explanations given to the Royal Commission suggest. It is imaginable that even approved societies might be interested to collaborate on a common basis with insurance committees, provided they were really interested in improving health and thereby reducing sickness; even under a system of segregation some sort of pooling of statistical information might have been possible. But, as things are, the duties of approved societies are entirely distinct from those of insurance committees, while the competitive position of the various approved societies precludes any interest in disclosing their particular 'business experiences'. The management of approved societies gives no opportunity for members to take part and push forward the aims they might entertain for the prevention of excessive sickness in their particular districts.[2] Any local community of interest is debarred from the present system of health administration by the 'segregation' and undemocratic machinery of approved societies; and the central agencies of the insurance carriers themselves have little interest in contributing to the improvement of health conditions as a business proposition.

The conclusion is unmistakable. While economy in administration is well safeguarded so far as the effectiveness of control over excessive treatment and prescribing is concerned, any incentive by the insurance agencies to diminish ill-health by enquiring into the causes of excessive sickness for which public authorities and employers might be made responsible is entirely absent; and this deficiency is directly a result of the present system of administration. Not much further progress in economy can, or should, be expected from controlling and restrictive measures imposed on patients and doctors; but a great improvement in the economical side of National Health Insurance administration might be obtained from measures linking it up with the general improvement of public health.

1 See pp. 270–71. 2 Cf. *Minority Report, Royal Commission Report*, pp. 302–3.

V.

CHAPTER XXXII. THE TERRITORIAL SYSTEM

'We may be optimistic or pessimistic in regard to the effects of industrial and mechanical progress of mankind. We may be uncertain whether progress is an inevitable law of nature or a movement in opposition to natural laws. But in the sphere of public health we need entertain no doubts concerning the beneficial effects of progress.'

'On the State of Public Health', *Annual Report of the Chief Medical Officer of the Ministry of Health*, 1938.

IT may be appropriate to add, as a concluding chapter to the part of our enquiry that deals with administration, some final observations on the system of administration which we have, on many occasions, seen to be the opposite of the present British system. We hardly need explain to our readers what the territorial system of sickness insurance administration is; we have already contrasted its structure so often with the system of approved societies.[1] Its main features are the better balancing of risks by the setting-up of local funds and concentrating the administration on the experience of their sickness expectation. Insurance can then be based upon a well-defined integrated grouping. The same principle may be also realized by other than strictly local organizations—through works funds, for instance. The system of approved societies leads to inequalities of benefit and a high expense ratio through high costs of administration. Furthermore, it is incapable of influencing progress in public health. Yet the Report of the Royal Commission refused to consider in any detail the adoption of the system of territorial funds. A year before the Report was published the International Labour Office made an exhaustive enquiry into sickness insurance, and the steady progress of territorial funds all over the world was recorded.[2] The International Labour Office distinguished between 'open' and 'closed' funds, the former admitting all persons who satisfy the conditions of age, health and income prescribed by the law or the rules of the funds, the other recruiting their members from persons working in one and the same undertaking or engaged in the same occupation, or belonging to the same political party or the same religion (works funds, trade funds, political, denominational funds). The International Labour Office found on enquiry that

1 Cf. above the whole of chapter XXIV, also pp. 248–9.

2 Cf. I.L.O., *Voluntary Sickness Insurance*, Geneva, 1927, pp. xxvi–xxvii.

'open' funds on a territorial basis were by far the more numerous, even where no compulsory sickness insurance was in existence.[1] Denmark had 1,584 territorial funds as compared with 60 trade funds. In Sweden there were 964 territorial funds as compared with 312 trade funds. In Switzerland the difference in number between territorial funds and the trade, political or denominational funds was less striking, but the first group had 835,000 members, and the second group only 218,000. Territorial funds, the International Labour Office Report stated, were making progress in Belgium, Finland and France. The movement in favour of territorial institutions was not peculiar to European countries. In Germany this tendency was to some extent due to the existence of local funds, remnants of the guilds.[2] The opinion of the International Labour Office as already evolved at the time when the Royal Commission was sitting had not altered ten years later when they again surveyed the whole field of social insurances against an international background. It 'could not omit a reference to the undoubted advantages of territorial funds, particularly as regards the rational organization of medical aid'.[3]

Yet the Report of the Royal Commission did not pay the least attention to the international development of sickness insurance administration on a territorial basis. This omission led to the erroneous belief that there was only one alternative to the existing system of administration by approved societies, namely centralized State administration with a common fund. 'We feel', the Report emphasized, 'that if a centralized system were adopted it would compel the dissolution of Approved Societies, since the reduction of the Societies to mere paying agencies would involve the separation of administration and financial responsibility, a result which could not in our opinion be defended. . . we feel that it is to the advantage of the public that this great Scheme should be administered by the representatives of the insured themselves.'[4]

1 For the same as regards other systems see I.L.O., *Compulsory Sickness Insurance*, 1927, under 'Insurance Institutions' and *passim*.

2 Also in Switzerland, where in 1914 the communal compulsory sickness fund of the town of Lucerne was organized on the lines of the workers' sickness fund, the activities of which date back to the year 1650, when it was created by the Brotherhood of Bachelor Journeymen, cf. *Voluntary Sickness Insurance*, p. 394.

3 Cf. *International Labour Organization*, Geneva, 1936, p. 54. Recommendation No. 29 concerning the general principles of sickness insurance contains the paragraph: 'A good organization of medical benefit and, in particular, the efficient provision and utilization of medical equipment embodying the results of scientific progress, can be most easily secured. . . by concentrating action on a territorial basis.'

4 Cf. *Report*, pp. 101–2.

Actually, the existence of decentralized territorial funds does not exclude the existence of a state organization as an insurance carrier[1] for certain purposes. But the German system,[2] while differing essentially from the system of approved societies, leaves self-administration to the local and occupational institutions. The International Labour Office has made it clear that such 'self-government by the persons concerned' is imperative, though it has also stressed the fact that territorial funds under the supervision of the public authority is, in their opinion, the best method. It is between funds of this kind and the scattered and unco-ordinated multiplicity of British approved societies that the contrast lies, not between approved societies and centralized administration.

In Britain medical treatment under National Health Insurance is still limited to the lowest possible scale. The difficulties of providing more elaborate medical treatment, with specialist and hospital treatment in particular, under a system of funds having their members scattered all over the country would have become far more obvious to the administrators of National Health Insurance if such benefits had been the statutory obligation of approved societies. But this acid test was never made; and the tendency was to shift the burden of more specialized services to other agencies just at the point where the lack of a territorial system of administration should have been most felt. These agencies were and are worked mainly on a territorial basis, though they may be open to persons non-resident or not permanently resident in the areas. They are the hospitals, for instance, and the district nursing associations. In a letter which the author received from a quarter closely connected with the latter service it was said: '. . . approved societies are providing nursing at the least possible cost to themselves and another arrangement [i.e. than that to administer nursing benefit through the District Nursing Associations] would not be to their advantage. One reason for this is that a nurse can attend within a reasonable area all types of patients whether insured or not. In this way much overlapping and overhead charges can be avoided.'

While the system of approved societies definitely rejects the idea of territorial organization, it recognizes the administrative advantages of the territorialization of the services that it would

1 This is the case in Sweden, where local sickness funds and central sickness funds exist, the latter having, apart from other obligations, to deal with persons who do not belong to a local fund; cf. *Social Work and Legislation in Sweden*, Stockholm, 1938, pp. 122–3.

2 See pp. 231–2 above.

have to render at a far higher cost if these voluntary local services, operating singly in each area, did not exist. If innumerable nursing societies existed, competing with each other in all areas, and if by this overlapping the cost to the approved societies rose above the present low rate of 1*s.* per visit, the approved societies would be the first to protest against so wasteful a system of administration. Even those who are still opposed to National Insurance in principle and who favour 'the company-society and the voluntary principle' seem satisfied that some local integration is desirable.[1] Here and there, even in Britain, examples may be found where integrated funds have shown economical administration and highly satisfactory results. Such was reported from a medical aid society—a form of insurance association, which we would not recommend as worthy of general application.[2] At Tredegar, it was reported, all workers pay the National Health levy of 1*s.* 8*d.* a week, and all members pay an extra 6*d.* to the fund of the medical aid society. With this sum the committee manages to run a very complete medical service, and to attract first-rate doctors to the district by the offer of a fair pay; the surgeon of the local hospital is paid £1,900 per annum.[3] There is no reason to doubt that integrated approved societies with a definite number of local members could achieve the same results.

The opposition to a change in the system which has prevented a unified grouping of risks on a territorial basis comes mainly from the approved societies themselves. This is not unnatural in view of the benefits which the sponsors of the system of approved societies, the insurance offices, derive from their existence. But this factor alone does not explain this resistance to the introduction of an integrated territorial system. Approved societies in this

1 Cf. Ormerod, *loc. cit.* p. 18: 'The only way of exercising effective supervision is to decentralize the National Insurance schemes, and to do so to such an extent that you will have in every township a representative committee or tribunal, not elected by insured persons(!?) but appointed by the executives of the several approved societies, possibly with a Labour Exchange Official to act ex-officio, such tribunal to have plenary powers, save that . . . the insured person shall have a right of appeal to a superior court.'

2 Medical aid societies generally give no free choice of doctors. They are strongly opposed by the British Medical Association. New so-called 'Approved Institutions' can no longer be created. In 1936 there were 118,902 persons in England and 33,704 in Wales receiving National Health Insurance through these or similar institutions, cf. *P.E.P. Report*, pp. 150–51; see also criticism of medical aid societies by McCleary, *loc. cit.* p. 79.

3 Cf. *The Tribune: Health at our Price*, 18 June 1937; for similar experiences cf. Dr L. T. Hilliard in *Medicine To-day and To-morrow*, March 1941, p. 13.

country are linked with aims other than purely that of social insurance. Those who have built up the societies are afraid of losing their contacts with these aims if a system of integration is introduced. Not long ago, for instance, Catholic circles expressed the apprehension of Roman Catholic approved societies 'that their own autonomy would be endangered' if sweeping co-ordination schemes were envisaged by the Government after the war.[1] The competitive struggle for members was emphasized in this case by the fact that the Chief of a local Special Constabulary, who at the same time was the senior trustee of the approved society, was urging a great recruitment of members now that compulsory insurance brings in the large numbers of black-coat workers with salaries up to £420. There is sometimes an ideological 'vested interest' fighting for the retention of a system whatever its defects in a national sense may be. Before the Royal Commission representatives of approved societies tried to bring home the point—always of some attraction to British administrators—that the disintegrated and competitive approved society was a promoter of a healthy individualism. For this reason they rejected the idea of pooling interests or of any territorial integration. 'If whatever results you produce are all to go into a pool nobody will be interested', declared one witness; 'a man when he is working hard for a society is working for himself.'[2] Not only is such 'self-interest' on the part of those who run the society in many cases an incentive to administer its affairs in a far more rigid commercial way than a public local authority would, but 'working for himself' means that he remains personally interested in the retention of a body which gives him pay whatever the arguments as to the public utility of such a type of organization may be. Mr Alban Gordon told the Royal Commission that 'in the case of a territorial society you have plenty of such guarantees—not only civic pride, but also the close scrutiny which would be exercised by the local electors'.[3] While stressing the fact that he was himself a member of a friendly society and until recently a member of the Executive of the National Conference of Friendly Societies, the witness remarked that in his opinion 'what is popularly called the friendly society spirit to-day is growing to be a definite hindrance in National Insurance administration'. We noticed the growing lack of democratic control in the approved societies. It is

1 Cf. *The Catholic Herald*, 9 Jan. 1942: 'Approved Societies, their Independence Threatened?'

2 Cf. Evidence, QQ. 11,778–81. 3 Cf. QQ. 7502–5.

irrelevant to hold up the associative spirit of the approved societies as an incentive to social progress, while declaring that local authority administration is dead machinery without individual effort and efficiency. German experience, as recorded by Dr McCleary, in the progressive methods of medical treatment and hospitalization by communal funds, hardly justifies any assumption of inertia on the part of local sickness funds.[1]

In the background there is another set of facts which is rarely mentioned and which has never been satisfactorily scrutinized. The 'flat rate' is the actuarial basis of the British system. It is quite evident that any system of integration—in contrast to the system of competitive canvassing for membership or of arbitrary segregation of members[2]—must be based upon a well-defined and reliable complex of risks graded locally or by occupations. Two towns may each have 150,000 insurable persons with very different risks of sickness. Such differentiation in risk even increases the complications of insurance where the benefits to be granted are wider in scope and value than in Britain. Dr Hädenkamp, for instance, emphasizes that the risk may vary according to the wage and earnings prevalent in the district, or according to the number of family members (where dependants are covered); there may be districts with a large percentage of young unmarried workers; there may be districts, and occupations, with greater or lesser occupational risks, a part of which is borne by the sickness funds; there may be some districts with better health for many reasons and others with very bad health where slums or any unfavourable conditions exist; all such circumstances influence the differentiation of risks locally or by occupational groups[3] and are constantly under discussion where territorial, or other integrated, funds exist.[4] As with such funds there is the obligation to accept every person who is legally entitled to insurance, no selective choice is possible. It is therefore necessary to determine the contributions on an actuarial basis according to the benefits payable. A system of flat rates is impossible. A system of flexible contributions according to the varying expectations of sickness has to be arranged. As we have described, in Germany this is arranged by wage-classes.

The British system of 'flat-rate' contributions was not chosen,

1 Cf. McCleary, *loc. cit.* p. 53.

2 Cf. p. 248 above.

3 Cf. Dr Karl Hädenkamp, *Die Neuordnung der Deutschen Sozialversicherung*, München, 1937, p. 20 and *passim*.

4 The point was well recognized by Sir Arthur Worley, when interrogating Mr Alban Gordon, see Q. 7500.

as may appear on the surface, for its simplicity; it was actually the result of an administrative organization which did not permit any other system. It is not simple, but primitive. It was only feasible provided that benefits under National Health Insurance were so curtailed that, actuarially, a society operating in various districts with quite different conditions of risk could manage to grant them in return for a flat-rate contribution. If any elaborate statutory benefits had been in existence, if specialist treatment, for instance, or treatment for tuberculosis had been included in National Health Insurance, obviously the fixing of a flat-rate contribution would have been actuarially impossible. An impossible condition would arise financially, in that risks of the most varying nature would have to be accepted for the same 'premium'. A man living in a district prone to dust disease or in an urban quarter breeding tuberculosis, or occupied in a dangerous trade, could not be granted the same elaborate benefits for the same premium as a normal person would have had to pay simply by applying to become a member of a certain approved society. No such system is possible. With industrial accident insurance, offices are in a position to regulate premiums according to some experience rate, which is adapted to the well-defined risks of the establishments and altered from time to time accordingly.[1] Where flat rates exist elsewhere, as in fire insurance, particular risks are excluded or subject to higher premium. A rigid system of flat rates was maintained to enable the approved societies to take everybody in, apart from certain narrow limits, and this was only possible by levelling down the statutory benefits to cover only the average basic incidence of sickness within the expectation of every insured person—the lowest common factor. Refinement of the benefits or specialization of treatment was ill-adapted to this system. The necessity of levelling down statutory benefits and allowing higher ones only after valuation surpluses was carried so far as to exclude even dental and ophthalmic benefit and hospitalization from the statutory categories. The tendency develops to shift the burden of medical assistance to other bodies in order to avoid extended responsibilities, as in the case of tuberculosis treatment.

These intrinsic reasons for the flat-rate system, arising out of

1 Cf. Evidence of the Accident Offices Association before the Royal Commission on Workmen's Compensation, 1 March 1940. *Memorandum*, paras. 80 sqq.: 'The relative hazards between different classes are compared and an adjustment for one class may involve the consideration of allied classes.'

the self-interest of competitive approved societies, have never been fully recognized in public discussion. Defenders of the present system of non-territorial funds refer to the fact that under National Health Insurance the same flat rate provides the same benefit for all.[1] They claim credit to the system for giving free choice to the insurable person to select 'his' society. '. . . the system has secured the largest possible measure of freedom for all the interests concerned', declared Mr Bearn, head of the Insurance Department of the Ministry, not long ago in addressing the Association of Approved Societies.[2] But it is a freedom dearly bought by the worker. It means that the insured man has to content himself with the lowest imaginable set of statutory benefits. Local monopolies would not be resented if they gave better and more ample service. Mr Hackforth before the Royal Commission suggested that 'the approved societies' scheme with its additional benefits to some extent mitigates possible injustice in the fact of requiring a flat-rate contribution'.[3] But the meagre and incomplete nature of these additional benefits contradicts such complacency, while systems with territorial or other integrated funds and flexible contribution scales have shown a highly satisfactory and constantly progressive development precisely in the matters of higher and specialized benefits. For this purpose, however, insurance must comprise all insurable persons in the integrated sphere. The good risks must be sought as a balance against the bad ones, and the average risk obtained must determine the contribution. It is certainly not feasible to integrate the insurance service on a flat-rate basis according to a selection of particular bad risks; where this has been attempted by approved societies it has been at the cost of cutting away surpluses and additional benefits.[4] The advantage of a territorial system faced by an average of good and bad health with the possibility of adjusting contributions where there happens to be a sickness experience beyond or above the ordinary level can hardly be over-estimated. The absence of integrated systems of sickness insurance has necessitated in Britain an exceptional posi-

1 Cf. Mr Bearn's reply to Mr Hackforth as to the 'justification of the flat-rate contribution', Evidence before the Royal Commission on Workmen's Compensation, Q. 1169.

2 Cf. *The National Insurance Gazette*, 16 Oct. 1941, p. 502.

3 Cf. Q. 1172.

4 Cf. Workmen's Compensation Commission, Mr Bearn: 'You would find that some Societies who deal with particular occupation groups with heavy sickness experience either have no surpluses or even in some cases a deficiency.' Cf. Q. 1166.

tion relating to the actuarial reserves. In the two years 1939–40, about 4 % of the total receipts of National Health Insurance were transferred to the Central Fund and other reserve funds;[1] under other systems this amount sometimes represents not more than 0·5 %.[2] Under almost all sickness insurance systems, the so-called 'assessment system' aims at maintaining a current equilibrium between income and outgo by the adjustment of contributions or, occasionally, of benefits. The system requires the maintenance merely of a contingency reserve to moderate the fluctuation of the contribution rate. In contrast to this, the 'accumulation system' is used wherever an insurance scheme provides for benefits the cost of which is calculated to increase year by year over a long period, and it is desired to meet the cost by a contribution which remains level throughout the period. In Britain the accumulation system has apparently been the outcome of the former mutual-aid movement as carried on by small local societies that could operate only on an empirical basis, providing benefits of limited duration and balancing their accounts from year to year. But, as the International Labour Office has recently affirmed, 'the number of days of sickness per member varies but little in a large fund'.[3] In other countries with an integrated system of sickness insurance, however, even in a small fund a reserve equal to one year's expenditure may prove ample to safeguard security. The International Labour Office contrasts the former British system under sickness clubs with that of other countries with 'more refined methods of keeping income and outgo in equilibrium'. But, actually, in Britain[4] the system of long-term reserves against a risk arising with progression of age, instead of holding accumulated assets of a relatively small amount, was kept alive in 1911, and has remained so. British insurance interests are likely to criticize the assessment system as the hallmark of financial insecurity. So it may be if social administration lies in the hands of disintegrated private bodies which, each for itself, must minutely balance its future liabilities and current fluctuations and guard against any vicissitudes by strict actuarial calculation. With social insurance in the hands of public or semi-public bodies, such dangers may be well faced by accumulating

1 Cf. *Summary Report by the Ministry of Health*, 1942, p. 51.
2 Cf. for instance, I.L.O., *International Survey*, col. I, p. 319.
3 I.L.O., *Approaches to Social Security*, 1942, p. 76; also Mr Lucien Féraud's review of the matter in I.L.O. *Study*, Series M (Social Insurance), No. 17.
4 Cf. also *Beveridge Report, Memorandum by the Government Actuary*, pp. 177–84.

a one-year reserve and adjusting it from year to year; this was the system which Sir William Meredith introduced with his Ontario plan of Workmen's Compensation, and which has since found much approval in the neighbouring U.S.A.[1]

There remains the objection that it may appear unjust to the insured person that, under the territorial or otherwise integrated system, those with a bad sickness rate should pay so much more for the same benefits as those with a better one. This 'injustice' cannot be disputed. It has, however, to be considered that no insurance system whatever can be expected to reduce inequalities which are inherent in the structure and differentiations of society. The worker in a dangerous occupation, or one most liable to disease, incurs a risk which no legislation whatsoever can abolish. If insurance asks higher contributions from him or from persons living in an unhealthy district, it does so with the purpose of alleviating the ill-effects of such social conditions on the individual. He and the employer have to pay for it, the latter fully participating in the higher costs of insurance. If for such higher contributions the insured person is sure to get highly efficient benefits, not as an additional possibility, but as a statutory right, he should actually feel better off than if he paid a general flat rate in common with others but remained deprived of just the benefits that a person with a bad sickness expectation should have available. It is rather to high benefits and satisfactory cure that the insured person should look.

Reform of the approved society system has been discussed of late in most divergent quarters. In each case the wasteful effect of overlapping has been the starting-point. But none has definitely proposed to institute a better integration of the administration by creating co-ordinated, self-contained territorial or occupational units. A criticism came recently from a source which cannot be suspected of being biased against approved societies, *The National Insurance Gazette*.[2] The journal praised the competitive system in connection with the unequal rates of benefits, for if there were no

1 *Final Report on Laws relating to the Liability of Employers*, Toronto, 1913, p. 6 on 'current cost plan', and lately U.S. Department of Labour, *Methods of Financing Workmen's Compensation Administration and Funds*, Washington, 1936 (reprint from *Monthly Labor Review*). At the end of 1941 investments and cash balances of N.H.I. were in England, £132 million; under the assessment system a sum approximately equal to the annual benefit payments, i.e. about £30 million, would have been sufficient.

2 Cf. 'The Future of Social Insurance', *The National Insurance Gazette*, 16 Oct. 1941, pp. 496 sqq.

'officials' of an approved society 'straining or vigorously exerting themselves' the 'advantage of competition' would be lost. Apparently the writer did not believe that a system of territorial funds might achieve the same efficiency by communal and democratic control. But the writer was not able to dispute the calamity of having 'Have' and 'Have Not' societies, and he attributed the cause to factors within as well as beyond the powers of certain approved societies. Such critics generally suggest that the financially weak societies should go out of business. The recommendation is not without a background; it may well be in the interest of certain approved societies—the bigger ones in particular—that this should happen; it would mean a reduction of competition and a strengthening of their power. But such concentration would not do away with segregation, though it might lessen it. It has nothing to do with decentralizing the administration on an integrated basis. Concentration, on the contrary, might mean greater centralization on a stereotyped pattern which would leave out of consideration the necessity of dealing differently with differing risks. Maybe, such concentration and the disappearance of some competition (for instance by agents) would reduce the expenditure of some societies and thus enable a greater distribution of additional benefits. But the process would be a slow one, and the increase of benefits hardly appreciable.

It is evident that such a development would be preferred by many societies and insurance offices to another sometimes proposed, that of pooling resources with a view to equalizing the deficit of the least efficient approved societies. It was proposed by Mr Alban Gordon before the Royal Commission as a so-called 'equalization fund'.[1] Actually Mr Gordon, whose experience as an administrator in the matter of approved societies demands great respect, suggested the institution of territorial funds with county or county-borough units on the lines we have already described; he recommended the winding-up of the existing approved societies, the 'Local Territorial Society absorbing the functions of all Approved Societies in the area'.[2] The Commission was not eager to discuss this project as, indeed, it would have shattered the very foundations on which National Health Insurance rested, and still rests. For the purpose of mitigating the unavoidable financial inequalities of the administrations it proposed an equalization fund. We have already referred to the existence of the Central Fund and Societies' Contingencies Fund.

1 Cf. Evidence, Q. 7500. 2 Cf. *ib.* QQ. 7451–2.

The Central Fund received a State subsidy until 1931, which was abolished by the National Health Insurance (National Economy) Order. But provisions exist for the pooling of the contingencies funds of small societies.[1] Such attempts, which might well be retained or even extended (as was envisaged by Mr Gordon) under a territorial system, should not lead to the assumption that a pooling of all income of the funds would be advisable for the sake of creating equality. Such arrangements—in Germany sometimes suggested under the name of 'Einheitskasse'—would have no other effect than to reduce the feeling of responsibility on the part of the local or occupational units; 'simplification' would not mean progress in this case, for progress must always be bound up in sickness insurance with a greater differentiation of benefits according to particular needs, local or otherwise. An arrangement to be distinguished from such a fund is the 'Gemeinlast', a fund lately added to the sickness insurance legislation in Germany to equalize some very flagrant financial discrepancies between the funds and their effects on contributions and benefits.[2] Even under a system of flexible contributions additional benefits may be granted—for there will always be room for them even if the statutory benefits are much higher than in Britain. All this, however, differs widely from the idea of pooling all resources, which should be regarded as entirely unrealistic.

Another attempt to abolish the system of approved societies comes from a very different quarter. It comes from doctors. Their interest is very reasonably in the improvement of the medical services and is centred on the introduction of a State or a National Medical Service or both, the first being a system of State doctors, the latter a nation-wide provision of medical attention. If such aims are realized it is thought that, to use the last published words of an eminent authority on the subject of social medicine, the late Sir Henry Brackenbury, M.D., LL.D., that 'all additional medical benefits might be removed from the purview of approved societies', or that even 'the abolition of many or all (*sic*) of those societies or a modification of their character' might be envisaged.[3] Political Economic Planning suggests that 'perhaps the most fundamental objection to the extension of medical services by extending the

1 Cf. Foster and Fraser, *loc. cit.* pp. 170 and 194.
2 Cf. Haedenkamp, *loc. cit.* pp. 14 and 20.
3 Cf. *British Medical Journal*, Sir Henry Brackenbury, 'A National Medical Service and Conditions of Medical Practice after the War', 24 Jan. 1942, Supplement.

system of National Health Insurance is that it might hinder a proper overhauling and integration of all the medical services', and it quotes to support this view the Majority Report of the Royal Commission, which quite openly claimed that a wider scope of the health services would make it more difficult to retain the insurance principle,[1] and that the ultimate solution should be a clean divorce of the medical services from the insurance system.

Socialist circles come to the same conclusion. It is not quite illogical to claim that a 'socialized medical service' should be 'free to all', and that socialists should cite the British Medical Association's view that hospital provision is not possible in an insurance service.[2] The antagonism between the British Medical Association and National Health Insurance becomes apparent when the former writes:[3] 'The Insurance Act was a break-away from the policy underlying most of the developments in the associations between government and the health of the people.' The old contention voiced by doctors in 1911 that the Insurance Act, as far as medical benefit goes, would not improve, but rather impede the progress of the application and socialization of medicine by imposing a third party between medicine and the public health services is here repeated.[4] The hopes of an intensive influence by National Health Insurance legislation on the medical services of the nation were not fulfilled. The Act remained sterile in that respect, and it may be argued that by remaining so it retarded progress by the vain hopes it evoked. But it is doubtful whether the conclusion to be drawn from this is that the provision of medical services should be withdrawn from National Health Insurance administration. Persons like the writer in the *National Insurance Gazette* already welcome such a possibility.[5] The 'Have-nots' among the societies, it is argued here, would see many of their complaints removed if, for instance, dental and ophthalmic benefits were to disappear entirely from the National Health Insurance scheme. They would. They could then devote their unsatisfactory financial and actuarial resources even more than to-day to the most primitive benefits; they would see their competitive power increased without any help on their part. The benefit provisions of National

1 Cf. *P.E.P. Report*, p. 212 and *N.H.I. Report of Royal Commission*, pp. 65–6.

2 Cf. *Medicine To-morrow*, A précis of articles, N.D., reprint, p. 7.

3 Cf. *A General Medical Service*, p. 41.

4 Cf. Dr Brend, in *Lancet* of 2 March 1912, 'The Insurance Act and Public Health': 'The Insurance Act affords the latest instance, and one on a large scale, of the unsatisfactory way in which matters demanding medical knowledge have been dealt with by the State.'

5 Cf. *loc. cit.* p. 502.

Health Insurance would be even further levelled down. The expense ratio would be relieved from a most inconvenient item—the administration of medical benefits. It is a rather queer suggestion of progress to relieve inefficient administrative units by reducing their obligations.

In other countries the divorce between health insurance and public health services has not been contemplated. Where approved societies of the British type do not exist, but communal territorial funds, progress, as Dr McCleary and Sir Arthur Newsholme have testified, has gone forward and sickness funds are regarded as great improvers of public health. 'Sickness insurance schemes', emphasizes the International Labour Office,[1] '. . . endeavour to raise the standard of health of the insured population and thus improve the general risk they have to meet. The insurance schemes in advanced countries have adopted a variety of measures for this purpose.' It is further stated that the purpose of this systematic preventive work is 'to change a steadily increasing proportion of the population into healthy risks, to restrict therapeutic measures to their natural minimum. . . and to make the sickness insurance scheme a means of safeguarding the health and working-power of the economically weaker sections of the population.' In the face of this experience they are ill-advised who exclaim that there is no way for sickness insurance institutions to become constructively and practically instrumental to the progress of national health. If such has not been the case in Britain, it is not National Health Insurance, but the administrative system imposed upon National Health Insurance legislation by particularly interested bodies that has to be blamed. Can we wait for improvement till a National Medical Service or even a State Medical Service arrives to do what approved societies have not been able to do? We have tried to explain in this chapter where, as far as the administrative machinery is concerned, the solution lies. But administration is never more than a means to reach a certain goal. It is never an end in itself. The reform of National Health Insurance is not one of administration alone. Far more is another type of administrative machinery needed to serve at least the most urgent requirements of the scheme, which we have discussed in our chapters dealing with the scope of and benefits under the present legislation. It is from this angle that we now approach the final stage of this investigation.

1 Cf. *Economical Administration*, p. 21.

PART VII. *CONCLUSIONS AND RECOMMENDATIONS*

CHAPTER XXXIII. THE FAILURE OF NATIONAL HEALTH INSURANCE

'As the life which men live well here on earth is ordained as a means to that blessed life which we hope for in heaven, so, too, whatever particular goods are procured by man's agency, whether wealth, or profits, or health, or eloquence, or learning, are ordained as a means to the end of the common good.'

ST THOMAS AQUINAS, *De Regimine Principum*, ed. Toronto, St Michael's College, 1935, p. 104.

THIRTY years have elapsed since National Health Insurance came into force (on 15 July 1912), a time sufficient to test its value and merits. We do not wish to minimize the latter. Any experiment dealing with millions of people must meet peculiar difficulties in a country which, in many ways, prides itself on the individualism and self-reliance of its people. In spite of the opposition, which by no means died away after the introduction of the Act, National Health Insurance has proved of great value to the working classes of Britain. It has extended its scope from 15,000,000 (of whom 5,000,000 were already members of friendly societies) to almost 22,000,000 in the United Kingdom before the present war,[1] and from the viewpoint of central administration there have been no major frictions or conflicts of an administrative nature during all these thirty years. Failures or irregularities by approved societies have been exceptional. The failures of National Health Insurance are not failures of administration within the prescribed framework. On the other hand, there is no reason to acclaim National Health Insurance, as Lord Addison did[2] on its 25th birthday, as 'a marvellous achievement'. This enquiry has given chapter and verse for the deficiencies and backwardness of English legislation when compared with achievements in other countries.

It is quite misleading simply to adduce the smooth working of the existing law as a proof of the excellence of the system and its worth to the working-class population. We have shown, for instance, how erroneous it is to enumerate the relatively few cases of official complaints as a proof of the efficiency of the panel-doctor

1 Estimate of the *Insurance Mail* of 23 Sept. 1942, on the basis of figures given in the House of Commons on 29 July 1941, which are the latest available.
2 Cf. *Sunday Times*, 25 July 1937.

system, because only the most serious complaints ever reach the surface.[1] Here as elsewhere in National Health Insurance 'the defects are in the present system, not of it', as the Medical Planning Commission has aptly observed.[2] We do not intend to devote our concluding remarks to a recapitulation of the deficiencies in National Health Insurance which we have set out in earlier chapters. It is the point of principle and system that matters most.

While the extension of the scope of National Health Insurance during the last decades seems to be a hopeful sign of progress—though the exclusion of benefits for dependants remains a fundamental deficiency—the quantity and quality of the benefits granted must be the starting-point of any comprehensive and critical analysis. The amount of cash benefit and the scope of treatment benefit will have limitations in any sickness insurance law. One nation may feel more generous in these respects than another. Prosperity and depression and all the exigencies of finance will play their part. The economic conditions of the working population themselves, who have to insure for these benefits and partly pay for them, must be a factor. Even so, we must state the conclusion that the gross deficiencies of benefits in Britain are largely due to the fact that the system of administration adopted at the outset necessitated, as a fundamental condition, a system of flat-rate payments. In contrast to cash benefits related to earnings flat-rate payments must in any circumstances be unsatisfactory. There are also equal contributions—except that, unjustly, there are differential rates of both contributions and benefits for men and women. The result is that for the doubtful benefit of a very doubtful 'equality' of contributions, a standard cash benefit has been established at a low level which must be regarded as socially injurious to all working people who in time of health are accustomed to much higher income levels—and these are the majority. Cash benefits in Britain have remained ridiculously inadequate. The attempt to improve the situation by giving flat-rate benefits based upon certain subsistence criteria is a dubious one; for all such criteria are of a disputable nature.[3] It is far more intelligent

1 Cf. above, pp. 115–21.

2 Cf. B.M.A. Medical Planning Commission, *Draft Interim Report*, 1942, p. 19.

3 Cf. the 'human-needs family budget' as suggested by *P.E.P. Planning*, 14 July 1942, pp. 7–8; even more theoretical is the suggestion made by the Social Security Committee of the Fabian Society, in *Social Security*, 1942. Here it is proposed to retain the flat-rate system—even with a distinction between men and women on the basis of the cost of primary needs, which again are based upon the adult male diet as it was once estimated by the British Medical Association. This estimate was a diet based on anticipated require-

to guarantee to the sick person a certain percentage of his earnings and to leave it to him to adapt his life in the case of ill-health to such reduced earnings, which conforms to the multiplicity of circumstances which characterize the individual working-class budget. But, as we have tried to make clear, this method cannot under present circumstances be adopted by approved societies (cf. p. 322). It would involve an integrated, well-defined risk expectation, covered by flexible contributions according to the risks assessed. While approved societies compete with one another in every district and within industrial establishments, they are utterly unable to plan contributions and cash benefits actuarially except on a flat-rate system. That the flat rate has remained so disquietingly low is partly a sequel to this state of affairs (see pp. 66–7); it is also partly due to a financial position which, in view of the already high cost of administration, demands the restriction of sickness and disablement benefits. In consequence, a most disturbing situation has arisen. So far from being sufficiently protected by National Health Insurance the sick person is expected, just when protection is most needed, to rely on his own savings, on his employers' charity, on assistance by voluntary social services, or, in the last resort, on public assistance. Moreover, a most undesirable discrepancy between sickness and unemployment benefits has been the result.

The development of medical benefit has been no less disappointing. The additions that have been made here and there, in the case of certain services and some rich societies, still leave a wide vacuum in the most important fields. Important services have been removed from National Health Insurance or have not found their way to it. Such is the case with the treatment of tuberculosis; such is the case with nursing, which is administered by a great voluntary social service. The National Health Insurance machinery has done nothing to administer the supply of appliances or artificial limbs. Maternity has remained a non-treatment benefit. The general tendency has been to divorce treatment from sickness insurance, while in other countries medical

ments of protein, fat and carbohydrate, and of total calories adequate to support health and working capacity, but was very remote from the actual conditions governing the habitual diet of the people. The table, given on p. 28 of the Fabian publication, shows at once the utter impossibility of applying such standards to social legislation—it is assumed that an adult male worker should consume not more than 1 lb. of meat or 1¾ pt. of milk or ¼ lb. of fish per week! Cf. also the apt criticism of this sort of theoretical and phantasmagoric suggestions as to subsistence standards in *Economist*, No. 7, p. 569.

treatment, cure and rehabilitation have become more and more the keynote of the sickness insurance policy. Treatment by specialists is excluded. Hospital treatment is outside the activities of the National Health Insurance administration and is mainly regarded as a means of removing the patients from the panel doctors' domain or to the care of non-National Health Insurance agencies. Approved societies are not autonomous in medical matters. Medical decisions are administered by insurance committees—yet another instance of the disruption of a medico-social economic organization which, under another system, might well have been lodged under one roof.

Medical benefits are as insufficient as cash benefits. But social inequality is in this case an additional disadvantage to the insured. Only the barest cost of treatment and medicine is provided, as a matter of principle, in normal benefits. Payment for any more elaborate means of treatment, even ophthalmic and dental benefit, not to speak of such modern treatment as physio-therapy or psycho-therapy, is left to the uncertainty of the so-called additional benefits. It might be well for those who still pretend that England has set an example to the world in this service to study the detailed list of medical treatment services which other countries provide for the insured sick. It is a tragedy that the reform of treatment for workers injured by accident and industrial disease was post-poned after the last war because of the expected improvement in the medical treatment service under National Health Insurance which never happened. Home nursing, reconvalescence and follow-up treatment are among the most deficient sections of National Health Insurance; and the position would be almost hopeless for the insured if there were not municipal hospitals and institutions, the voluntary social services, including hospitals and voluntary savings organizations and, recently, rehabilitation and training centres, to fill at least part of the gap. Such a state of disintegration and uncertainty was never the idea behind the 'National' Health Insurance scheme. We have seen how the socialization of medicine, in spite of the great technical progress of medicine, has remained, particularly as far as the treatment of minor ailments is concerned, a privilege of the well-to-do. Where the insured working class is entitled to participate in medical progress such participation is neither general nor complete; it depends on the financial position of the approved societies. Inevitably, therefore, there is grievous inequality in the per-missible benefits which are actually available. From this springs

the flagrant injustice that precisely those poorest of the working class who require particular assistance in time of sickness receive the smallest number of such benefits and what they receive is imperfect. We have seen that the so-called freedom of choice remains a fallacy when applied to the choice of society by the worker. He is seldom in a position to decide whether his choice is justified by the assets of the society. When ordinary benefits are so low, these additional benefits, when available, should be statutory instead of merely permissive. They are essential to any basic minimum of treatment.

The service of sickness insurance to the patient cannot be judged by the amount of benefit alone, in cash or in kind; it is closely related to the kind of service that doctors are able and willing to give. In this book, we have given much attention to this side of National Health Insurance.[1] Our conclusion is that the unsatisfactory payment of doctors has greatly restricted the interest that the ordinary panel doctor can be expected to take in any single patient. Here, as in the case of approved societies, 'free choice' remains an important element in service. There is no reason to suppose that a State doctor practising for a certain number of insured would be the ideal solution.[2] Selection of the doctor by the patient is a part of the necessary confidence that the sick man must have in his treatment. But free choice, either of society or of doctor, is hampered in the British system by the undue complication and difficulty of transferring from one to another.[3]

The International Labour Office[4] has stressed 'the maintenance of a healthy and vigorous labour supply' as a purpose of sickness insurance and has emphasized that 'this development is only attainable by applying provident measures to obviate or make good any loss of the workers' productive efficiency'. This high aim has not been secured by National Health Insurance in Britain. It would be complacent and largely irrelevant to compare the present state of the insured population with that before 1912. The idea of National Health Insurance when it was started was certainly at that time that, by measures other than the mere administration of benefits, the general state of the nation's health would be directly improved as a result of insurance legislation. This hope has not fructified. Approved societies have nowhere shown a desire to originate and pursue a constructive and dynamic

1 Cf. chapters XIII and XIV.

2 As Dr Stark Murray recommends, *Health for All*, 1942.

3 Cf. Howard E. Collier, in *B.M.J.* of 14 Nov. 1942: 'Let us keep the real point clearly before us. It is the "right to change", not the "right to choose".'

4 Cf. Recommendation No. 29, of 27 May 1927.

policy of health improvement. The insurance committees have done nothing in this direction either.[1] Approved societies were not able to promote measures of sickness prevention or improved treatment because their competitive and disintegrated system of administration made such attempts impracticable. A society with hundreds of members here, a dozen there, and perhaps thousands elsewhere, is not in a position to arrange for hygienic or clinical improvements for the benefit of its scattered members. The insurance committees failed, not so much because of the lethargy of their members as through external difficulties (see p. 275). The positive elements of any dynamic and constructive development were lacking in the scheme and in its administrators; and by its insufficiencies the scheme itself did nothing to remove the principal hindrances to an improvement in the health situation.

Under a comprehensive and effective scheme of health insurance the insured population must become more health-minded. We have made it clear that less sickness on the surface does not necessarily mean an improvement in medical treatment. It may mean people are negligent in dealing with their health till it is too late. We have seen that the Ministry of Health preaches hospital-mindedness. But National Health Insurance is unfortunately not concerned with the improvement of the hospital situation, which is particularly regrettable in the case of tuberculosis. It has not tried to reduce the long waiting-lists. It has not sought the close connection between panel doctor and institutions, the absence of which is so regrettable.[2] As long as the 'bottle-of-medicine' treatment by general practitioners continues, as long as insufficient dental benefit accounts for the gross mal-treatment of teeth, as long as the long waiting-list of hospitals precludes early treatment in less serious cases, as long as practitioners are driven by insufficient and unfair remuneration, overwork and pressure of time to exercise less care than otherwise they might do, progressive sickness prevention must remain wishful thinking, under National Health Insurance. The existing conditions of cash benefits and treatment have caused insured persons to neglect their health and, to some extent, to resort to dangerous self-medication by 'secret remedies'. National Health Insurance has certainly failed to be the engine for the socialization of medical progress that at one time was its expected development.

These are the main failures of National Health Insurance as

1 Cf. chapter XXVIII.

2 Cf. B.M.A. Medical Planning Commission, *loc. cit.* p. 9 and *passim*; cf. also B.M.A., *Report of Committee on Industrial Health in Factories*, 1942, pp. 19–22.

they relate to its benefits, and they are largely due to the system of approved societies and insurance committees which have not been able to develop to the full even the modest additional treatment benefits allowed, or to develop a satisfactory system of remuneration to doctors or a constructive policy of health improvement. But the matter does not rest here. Good and bad systems of sickness insurance are not distinct from each other only by the amount of benefits or the medical treatment provided. The administrative framework of National Health Insurance is not in itself desirable. Great stress was laid by its founders on democratic control. It was this democratic control in approved societies that was expected to offset the danger of bringing into the scheme elements which were, so far as they were not related to trade unions or purely associative bodies, the offspring of private insurance companies and the friendly collecting societies which in their commercial structure do not differ from private companies. With departments of vested interests as administrators, control by members had obviously to be the pivot of the scheme. This is not to say that the societies are in any way mal-administered. But it does mean that they are administered neither by official bodies nor by the members themselves. It matters very little that, as trade journals sometimes retort,[1] National Health Insurance is under the supervision of the Ministry of Health, because the functions of the Ministry[2] are limited to supervision and guidance. They are not concerned with the practical and factual administration of sickness insurance, which is the point that matters.

The second requirement for impartial administration was that it should be detached from other business interests. The dangers of allowing agents dealing in the vast business of industrial assurance to be mixed up with the administration of a statutory social service were not overlooked at the inception of National Health Insurance; but these warnings were dismissed. The interlocking of industrial assurance and National Health Insurance remains undesirable and a blot on the service. It is argued that the services of the industrial assurance agents are kept quite separate from their services under the National Health Insurance scheme. This is true as a matter of separate accountancy. But it does not follow in the least that private business does not derive undue benefit, in an indirect way, from National Health Insurance business.[3] The position is not very different from that of holding

1 Cf. for instance the *Insurance Mail*, 30 Sept. 1942, p. 471.
2 Cf. Foster and Taylor, p. 9.
3 Cf. above, pp. 219–21.

companies in industry or trade, which derive benefit from other companies without any formal fusion or amalgamation. In a book especially devoted to guide the insurance agent it is said that 'quite a number of experienced agents canvass primarily for National Health members, in order to open the way for introducing other and more profitable business'.[1] This should settle the matter. It explains why insurance interests have always been most anxious to see that the burial benefits should not be included as a statutory benefit in National Health Insurance. If our postmen when bringing letters to our homes were to canvass at the same time for the sale of grocery goods or motor cars nobody would deny the existence of a most undesirable mixture of public service and private gain.

We have dealt at length with one of the most conspicuous and most unsatisfactory features of the system of administration by approved societies: the inequalities of benefit. We have analysed the effect of such inequalities on the unfortunate insured who suffers from them and from the angle of administrative organization. We have tried to make it clear that the 'disintegrated' overlapping machinery of approved societies, by making it impossible to base actuarial calculations on an integrated risk and a well-defined, though locally or otherwise differentiated, expectation of sickness, accounts for this unequal system (cf. pp. 324–5). In most countries the available range of benefits—including high-grade benefits—has to be provided by unequal contributions differing with the different sickness experience of different districts or different occupations. These differences and the differentiation made necessary by them spring from general social inequalities and cannot be removed by sickness insurance. Such differentiation is certainly less inequitable than the inequalities of benefit under approved societies' administration, which are the outcome of a system of segregation and disintegration[2] that is artificial and avoidable.

This same system involves indisputably high costs of administration, which are expressed in a high expense ratio. By international comparison the high amount of the English expense ratio is manifest. The contrast appears still more unfavourable if it is taken into account that the services provided by many sickness insurance schemes are much more elaborate than in Britain; such services

1 Albert E. Sharpe and Charles Taylor, *Industrial Insurance Salesmanship, in Theory and Practice*, London: Pitman, 1936, pp. 176–7.
2 See for definition above, p. 298, footnote 1.

concentrate on expensive treatment requirements, which are costly to administer, so that the British expense ratio shows even more at a disadvantage.[1]

This led us to the necessity of entering the very complex field of expenses analysis. Obviously the insurance 'industry' suffers from the same sort of overlapping as many other trades do. There is no difference between overlapping milk rounds, the constant increase of whose services has necessitated steadily increasing retail margins and prices, and the position of the approved societies. Overhead charges could be vastly reduced, if dozens of agencies were not catering for the custom of insurables in the same districts, indeed in the same streets or establishments. Again the relationship of National Health Insurance to Workmen's Compensation leads to a great amount of expenditure which, under another system, would be avoidable.[2] It is unfortunate that one service based upon statutory non-profit-making agencies such as the approved societies should have to interlock with industrial accident insurance administered by private companies or mutual indemnity associations of employers. The injured worker has no medical benefit under industrial accident insurance but has to rely on his sickness insurance. The bodies administering National Health Insurance have to wrestle with private interests in doubtful cases; they are involved in the scrutiny of lump-sum settlements and in such matters as whether the ailment of the insured is their obligation or that of the interests administering industrial accident insurance. This state of affairs necessitates large expenditure by approved societies on legal opinion and litigation.[3]

We have discussed at some length also how far those frequently criticized features of sickness insurance, excessive treatment and excessive prescribing, may contribute to the enhanced cost of National Health Insurance administration. Safeguards against both of these dangers have been fully developed by legislation and neither the central department nor the approved societies and insurance committees can be reproached for not having given constant attention to the matter. There is no reason to assume that malingering plays any important part. Nor is there any ground for assuming that doctors are anxious to overstep their duties as to certification and prescribing. On the other hand, the

1 The point is constantly overlooked in comparisons made by insurance institutions; cf. also for similar views as theirs the letter by A. E. Sansom, 'Workers' Insurance', in *The Times* of 23 July 1942.

2 Cf. above, ch. XXIX.

3 Cf. above, p. 288.

benefits granted under British National Health Insurance are far too low to make 'sickness' an attraction. Excessive prescribing may be fostered on the part of the doctor, but there is little evidence of it. The substitution of expensive branded patent medicines by non-proprietary prescriptions might have an economical effect on costs.

The panel doctors, because of their unsatisfactory and discouraging conditions of work and remuneration, have been unable to effect improvements in these medical questions or, more widely, to make any appreciable contribution to raising sickness insurance to its proper status as a great and progressive social service.[1] But much more decisive factors have stood in the way of the true socialization of medicine by social insurance. Summarized, these potent obstacles are:

(1) The inadequate range of statutory benefits, cash and medical alike, which has crippled the capacity of sickness insurance to secure better health by prophylactic action and curative treatment. In this respect higher cash benefits are just as desirable as more specialized and comprehensive treatment. To be healthy and health-minded the working population must be fully protected against distress in times of sickness; this National Health Insurance has not achieved. A treatment-minded working population must be sure of prompt, efficient and specialized treatment; National Health Insurance has not secured this fundamental condition either.

(2) The inability of approved societies, through lack of finance and other limiting circumstances, to make use of and exploit fully the opportunities provided by the range of additional treatment benefits. One of the reasons for their failure is the heavy cost of their competitive methods, their excessive overhead charges and the high actuarial reserves necessitated by the very fact of this competitive disintegration.

(3) The exclusion of medical benefits from industrial accident insurance. Had medical treatment and restoration to health been an obligation on employers under Workmen's Compensation things might have taken a very different course. Either the carriers of industrial accident insurance would have been under the obligation to provide the necessary facilities for such treatment, or else National Health Insurance itself would have been obliged to provide them as agents of the employers' liabilities. As it was, these facilities have been nobody's business. Reforms in Workmen's

1 Cf. above, pp. 127 and 269.

Compensation waited on an improvement in the medical services which never came. It was left to sporadic and fortuitous efforts to provide the first steps towards specialized treatment and rehabilitation. Progress has been made only in scattered and isolated instances; it tended to deal only with fractures, and was far from nation-wide in scope.[1] The extension of the employment of medical officers in factories, in which the Industrial Welfare Society has since long taken a particular interest, and other private medical schemes in industrial establishments have gone steadily ahead.[2] But yet again this progress has affected only a selected number of industrial establishments; the small firms which still play an important role in industry generally remain outside.[3]

The need for more social medicine has been increasingly recognized during the war. The establishment in 1942 of an Institute of Social Medicine at Oxford with a substantial grant by the Nuffield Provincial Hospitals Trust is a fine contribution to a pressing need. There can be no doubt that *social medicine* is a necessary pillar of social insurance. But all the progress made and all the labour spent to develop social medicine must fail if the other essential requirement for national health, the *socialization of medicine*, lags behind. That National Health Insurance has not contributed in the way that was expected to this socialization appears as its greatest failure.

1 The successful experiments at Crewe, Leatherhead, the Royal Albert Docks and other pioneer centres of rehabilitation and vocational training of partially disabled persons have been supplemented of late by some Government action; the Training and Resettlement scheme of the Ministry of Labour, and some outstanding instances of private action, have also to be noted. The Birmingham accident hospital, the Mansfield rehabilitation clinic for coal-miners, and a similar scheme in Lanarkshire are fine examples of progressive spirit. The following important contributions may be consulted: Interim Scheme for the Training and Resettlement of Disabled Persons, Ministry of Labour, 1941; R. E. Gomme, Ministry of Labour scheme in *News Letter* of the Central Council for the Care of Cripples, Aug. 1942; *ib.* April 1941, 'Fractures in War Time'; *ib.* E. A. Nicoll, 'The Rehabilitation of Injured Miners (Mansfield)', Oct. 1940.

2 Cf. Industrial Welfare Society, *Health Services in Industry*, 1942, pp. 18 sqq., 44–6 and *passim.*

3 The Industrial Welfare Society, though asserting that this ought not to be the case, is well aware of the fact, cf. *ib.* p. 10.

CHAPTER XXXIV. REFORM

'If this appeal be not in vain...and the campaign against poverty, squalor and disease in our midst evokes the same patriotism that is always ready to leap to the call of external danger, then the National Health Insurance Act will prove to have provided a better and firmer foundation for our National greatness.'

DAVID LLOYD GEORGE, 1912.

THE appeal made by Mr D. Lloyd George, whose name will always be connected with British social insurance, just thirty years ago, has not been in vain. Britain adopted the idea of a national compulsory scheme of sickness insurance, an idea very alien to its traditional convictions and much opposed from many sides. Yet the country has never regretted that the step was taken. Dissatisfaction with the scheme as it actually developed in the next decades did not throw any doubt on the rightness of the original decision. But the incompleteness, the deficiencies, the inequalities and the pitfalls of the scheme from the viewpoint of insured persons were widely criticized. Tragically enough, the criticism fell on deaf ears. Neither the suggestions of the Holman Gregory Committee, as far as they related to National Health Insurance, nor the much wider recommendations of the Royal Commission's Report of 1926, nor the stringent admonitions of the Political and Economic Planning Report on the Health Services, backed by Lord Horder and many other medico-social authorities, secured the required response from successive Governments. Such progress as was made was in general only in the direction of widening the scope of the insurance scheme to include more persons, improving the position of the unemployed sick, and some minor sectional reforms.

The fact that all these recommendations for reform fell on stony soil was not merely due to the habitual neglect of the findings of advisory bodies by governmental and parliamentary circles.[1] The deeper reason was that reforms, which on the surface might seem only technical in character, would in fact have involved a complete alteration of the system of administration. It was this that was dreaded. It was here that the formidable obstacle of vested interests was encountered; and so, as in the case of Workmen's Compensation, for the same reason, reform was blocked. But the existing evils and deficiencies of the system could not be hidden or dispelled by complacent jubilee articles or occasional con-

1 Cf. for the point the excellent treatise by R. V. Vernon and N. Mansbergh *Advisory Bodies* (sponsored by Sir Arthur Salter, M.P.), 1940, *passim.*

gratulatory speeches by Ministers. These attempts discredited sickness insurance. They created the idea that something entirely different should be initiated in regard to social security, some new system in which National Health Insurance would disappear altogether in favour of an all-embracing plan for social protection. It was never recognized by these planners that what was wrong with National Health Insurance was not the principle upon which it was based, but the way in which it was practised. The principle of sickness insurance has been adopted successfully all over the world. It is not the principle of covering sickness by insurance that has failed, but the British system of National Health Insurance. A critical comparison with systems abroad and a close scrutiny of the principles of administration evolved by the International Labour Office from this international experience shows, as we have tried to show in this book, that it is the specific system of health insurance administration adopted in this country that has caused the gaps and deficiencies, the insufficiencies and inequalities of National Health Insurance. Recent recommendations for all-in social security legislation (see postscript on the Beveridge plan) would abolish National Health Insurance as a separate organization of the statutory social services. *The author believes that National Health Insurance can and should remain a separate statutory social service under an entirely different system of organization and administration.* He believes that such a reform alone can ensure the economic basis for (*a*) the extension and increase of cash and treatment benefits which have become so necessary and (*b*) that systematic and dynamic progress in preventive medicine and in the socialization of medicine which should crown the efforts of this social service.[1]

The present book, therefore, leads to the suggestion to abolish the system of approved societies and insurance committees and replace it by a system of territorial or occupational institutions. We believe that the system of administration by approved societies cannot be mended; it must be ended. The difficulties of effecting such a change should be fully recognized. The thousands

1 Cf. I.L.O., *Approaches to Social Security*, 1942, pp. 96–7: 'While providing efficient care for the individual, insurance schemes must, in the interests of the group which they serve, share in the campaign against diseases which are particularly frequent in the insured population, and which cannot be combated or prevented by medical treatment alone, but call for systematic preventive action combined with medical and social measures.' From the resolution adopted by the Second Labour Conference of the American States which are members of the International Labour Organization, Havana, Cuba, Dec. 1939.

of single financial units in the present administration must be compensated in some form or other, their staff transferred to other occupations, and the whole actuarial basis of National Health Insurance reviewed and adapted to the change. The formation of approved societies by well-established insurance companies and friendly collecting societies was originally accepted by the legislature 'faute de mieux'. The compromise has not been a success. It has not enabled the scheme to meet its most important requirements. Private insurance companies and their non-profit-making affiliates have not proved able or anxious, either here or in other fields of British social insurance, to tackle difficult and complex socio-medical tasks.[1] Private insurance agencies would be only too glad to leave the whole of medical care for the insured to State administration, say, to a State medical service, with the cost to be recouped out of general taxation. This would relieve them of a task which they have never grappled with properly; and the administration of cash benefits only would allow them to continue present business even at a high expense ratio. There is no evident reason why the most essential part of National Health Insurance should be handed over to other agencies outside of insurance, simply because under this particular method of administration approved societies and insurance committees have not been able to deal with it adequately or economically. The author, therefore, proposes the setting up of new administrative bodies, in the main municipal or rural, while leaving it open to large industrial and other establishments to have their own sickness funds on the same basis as the statutory funds.[2] A scheme of this kind, territorially or occupationally grouped with territorial or occupational funds, could take care of definitely integrated risks with only small variations from year to year. It would not be a system of equal contributions and flat-rate benefits. The rate of contributions should be arranged according to the earnings of groups or classes of workers; they should be flexible according to needs but restricted to statutory maxima. The rate of cash benefit, in order to avoid unfairness to low wage earners, should be proportionally higher

1 Cf. as evidence to that aversion Accident Offices Association, *Workmen's Compensation*, 1942, p. 5, where the point is stressed that cash payment is the 'immediate' and outstanding consideration as regards injured workers—in contrast to the stress laid in almost all existing foreign laws and by the Ministries of Pensions and of Health in Britain on cure and restoration to health as the principal aim.

2 Just as there are contracting-out schemes in Workmen's Compensation. Cf. for this Wilson and Levy, *Workmen's Compensation*, vol. 1, 1939, Appendix I.

in the case of low earnings. Flexibility in the rate of contribution would make it possible to cover the particular medical and sanitary requirements of each area, and thus stimulate the institution of the specialized treatment services that have been characteristic of foreign sickness insurance.

Such an arrangement of integrated sickness risks to be covered mainly by one single institution in each district would immediately reduce the cost of administration and set free finance for more important purposes. The overlapping of competitive administrative units would disappear.

The local sickness funds should set up district insurance bureaux to deal with claims, the payment of benefits, enquiries and advice. The simplified integrated basis on which the risk would now rest would make it possible to change over, actuarially, from the accumulation system to the assessment system. A semi-State organization of sickness insurance would not require a system of finance by which a large proportion of the premium income is ploughed back every year into reserves, thus diminishing the amount available for immediate benefits. The author does not believe that the shortcomings of panel doctors are any reason for changing the system to one of State doctors. The view of the Fabian Report[1] that a system of State doctors would result in a more careful certification cannot be regarded as valid. The patient would not appreciate the lack of free choice. He might, on the contrary, suspect, perhaps unjustifiably, that a State doctor has no more interest in his well-being than one of H.M. Inspectors of Taxes. Private profit need not extinguish in doctors the high ideal that they serve, it need not make their decisions unduly 'favourable' provided that their remuneration is adequate and their social position satisfactory; a composer does not compose 'pour l'art' alone. A doctor generally takes a greater interest in his patients than the profit-motive would dictate. If a territorial fund could provide possibilities of further research for him as well as close contact with patients in hospitals, this interest would grow. In a system where panel doctors would be closely linked with the agencies administering medical treatment there would be room for an ideal expressed by Prof. John A. Ryle of the University of Cambridge of a 'whole-hearted service working on behalf of the nation for advancement of human projects and National economy, of a preventive and curative medicine working in conjunction to secure a new and happier phase of social well-being and efficiency'.[2]

1 Cf. Fabian Society, *Social Security*, p. 10. 2 Cf. *B.M.J.* 21 Feb. 1942, p. 35.

If local authorities strove to raise sickness insurance funds to the highest possible efficiency as regards medical treatment, the maintenance of hospitals, laboratories, nursing homes, sanatoria, researchers of any kind, even the highest-paid specialists would feel themselves engaged, as they do in other countries,[1] with these administrative agencies in a common task.

The existing unsatisfactory relations between National Health Insurance and Workmen's Compensation, or more definitely between approved societies and the insurance offices and associations doing employers' liability business, can only be removed by a drastic and fundamental reform of the Workmen's Compensation Acts.[2] Industrial accident insurance in Britain should, as in most countries, be compulsory and administered by official or semi-official (i.e. statutory associations) agencies. A new Workmen's Compensation law might have a decisive effect on National Health Insurance. It should embrace, as in all socially progressive countries,[3] medical treatment including such after-care and following-up treatment as rehabilitation, physio-therapy, training and re-settlement. National Health Insurance would derive the benefit of greatly reduced expenditure. Workmen's Compensation funds would have to repay to the sickness funds any expenditure incurred by the latter on their behalf, for it is quite evident that a separate medical treatment organization by the Workmen's Compensation funds, which might be feasible for more severe injuries and those of a specific 'industrial' nature, would not be advisable as a general rule. Under Workmen's Compensation special agencies should be set up for the purpose of rehabilitation, such as model fracture clinics, and the sickness insurance funds could profit by using these facilities for non-industrial cases. Such a reform of industrial accident insurance would stimulate employees and their associations to make an active approach to the problems of medical treatment. Industries such as coal-mining, for instance, where rheumatic afflictions are general, might start their own specialized schemes of treatment. This would be invaluable, because it would be too much to expect that every sickness fund could do this on its own account all over the country.[4] Once started such special schemes might become models for districts or occupations

1 See McCleary's statement, *loc. cit.* p. 53. 2 Cf. above, p. 288.

3 See for details Wilson and Levy, *Workmen's Compensation*, vol. II, 1941, pp. 97–8, and whole chapters XI and XII.

4 Cf. Dr Ladislas Schmidt, 'Rheumatism and Industry', in *Physical Medicine*, Sept.–Oct. 1942, pp. 145 sqq., where a very creditable attempt at such special treatment by a big establishment is described.

which needed the same facilities, while other districts could participate if unable to establish the necessary facilities themselves.

From all these points it emerges that the extensions in scope and benefits necessitated by reformed National Health Insurance legislation, while undoubtedly involving considerably higher costs (the author refrains from making any conjectural estimate of this extra cost), might at the same time be accompanied by a considerable improvement in financial conditions. It should always be remembered that the higher costs of these services have been met in other countries, such as Germany, France, Czechoslovakia, Hungary, Poland and the Scandinavian States, without particular financial difficulty. Sickness insurance in those and other countries had not to cover such high administrative expenditure as National Health Insurance in Britain has had to meet for even the most primitive requirements of benefits. This is the point that matters. It is, as we have seen, quite misleading to compare the costs of social services between one country and another with the object of proving how much more is spent here than there. It is not the money spent but the service rendered that counts. In Britain too much money is spent for too little. In the reformed scheme outlined above, there would be:

1. A saving in administration (expense ratio) by the elimination of the overlapping of a multiplicity of competing agencies (overhead charges), and of outdoor staff (agents).
2. A saving by shortening the duration of sickness through more efficient treatment (to some extent offset by greater sickness-mindedness).
3. A saving by changing from the accumulation system of actuarial reserves to the assessment principle.
4. A saving by making Workmen's Compensation responsible for the costs of medical treatment.

The greater tasks charged to a new system of National Health Insurance might entail greater work and expense to the central department. We do not wish to minimize this point. But the extra cost might be reduced if the duties of the Ministry of Health in this matter were made the responsibility of a new Department which, so far as central administration is concerned, would consolidate the duties of all the various departments now connected with the statutory social insurance services. Such a Ministry of Social Insurance would be in a position, by a rationalization of the various expenses, to reduce considerably the administrative costs

involved in the present multiplicity of departments which deal with this social service. Yet it is not suggested that such a department should be more than a mechanism for central supervision, general financial control, advice and guidance. The impetus for action and progress should be left to the new territorial and occupational units of administration democratically organized and ruled, retaining the great British inheritance of individual initiative and ingenuity, and relying upon the central department only for general control, support and guidance.

If, as we sincerely hope, industrial assurance is to be abolished, and its benefits included more fairly and more economically in National Health Insurance, another financial source might be set free that would assist the stability and progress of the new scheme. This great 'thrift scheme' is actually a source of immense waste to the nation.[1] The expense of working-class burial does not require a machinery of costly private insurance. Every year some 500,000 corpses require burial. Even taking the very high figure of £20[2] per funeral, including some benefit which may go into mourning and other expenses apart from actual burial, and adding 10 % for the cost of administration, the whole cost should not be more than £11,000,000. This would mean, for a population of 45,000,000, an annual contribution of not more than 5*s*. per head. Instead, the premium income of industrial assurance in 1937 was nearly £70,000,000,[3] of which, of course, a proportion was due to endowment policies (of which, however, the vast majority include burial insurance as well). Even if we assume that not more than £50,000,000 of this sum[4] was actually devoted to burial insurance, the sum is enormous compared with the above estimate of £11,000,000.

But this does not exhaust the matter. Industrial insurance has accumulated vast actuarial reserves, which were simply necessitated by the fact that any life which insures to-day might die to-morrow. Such reserves would become unnecessary under a State or public scheme which would simply levy the necessary amount for a decent burial in the light of the hardly changing incidence of total annual deaths in the country. The reserve fund,

1 Cf. for details Wilson and Levy, *Industrial Assurance*, 1937, *passim*; also P.E.P. Broadsheet, No. 190, 14 July 1942, pp. 25–6.

2 Cf. for details of costs, etc. Sir Arnold Wilson and Prof. Hermann Levy *Burial and Funeral Costs*, 1938, *passim* and last chapter.

3 Cf. *Report of the Industrial Assurance Commissioner for* 1938, London, 1940.

4 It rose to £77,000,000 in 1941. Cf. *Report of the Committee on Man-power* Oct. 1942, p. 18.

which amounted to £409,651,000 before the War, would be set free. It belongs, as industrial assurance representatives have always asserted, to the policy-holders.[1] If industrial assurance were dissolved as a private or friendly society business, as proposed by the Beveridge Report, the fund would revert to the policy-holders. Policy-holders of endowment policies might be specially refunded. Profitable surrender values might be offered to them or their policies taken over by ordinary life insurance policies. The majority of policy-holders would get the reward for their insurance under the regulations of National Health Insurance. The interest alone on the fund so transferred would suffice to pay for the annual burial needs on the £20 basis. The amount saved by the working-class population through the elimination of weekly industrial assurance payments would go far to cover the higher premiums required for the extension of the scope of National Health Insurance, and the quantity and quality of benefits.[2]

Political imponderabilia, prejudice in favour of traditional systems of free competition and laissez-faire, an over-estimate of the 'achievements' of friendly societies, supported by the views of leading economists, and the opposition of powerful vested interests to any system which would curtail their commercial ambitions—these were the factors which prevented the introduction in 1911 of a system of National Health Insurance administration based on principles of economic and rational organization. The example of the German system was before the eyes of legislators; it had been an outstanding success.[3] Its striking medical features were described in 1913 in a Report which told in detail of the remarkable achievements of local sickness funds, of the comprehensive treatment of insured members, comprising X-ray applications, electrical treatment, mechanical exercises, medico-mechanical treatment, sanatoria and convalescent homes, and of the specialists 'with whom the larger sickness funds usually conclude agreements for the treatment of eyes, ears, nerves, skin, stomach and women's diseases'.[4] Yet, so little was this experience

1 Cf. *Insurance Mail Year-book*, 1935, p. 31: 'The fund is held on behalf of the policy-holders and covers the actuarial value of our offices' liabilities to policy-holders. It does not belong to the share-holders.' Cf. also Wilson and Levy, *Industrial Assurance*, Index under Fund.

2 This point was recognized by the late Joseph L. Cohen, before the Royal Commission, cf. Evidence of 25 June 1925, p. 953.

3 A deterioration of a serious nature began in 1933.

4 Cf. National Health Insurance, *Medical Benefit under German Sickness Insurance Legislation*, H.M. Stationery Office, 1913, pp. 7–9.

appreciated that the Royal Commission could still claim in 1926 that 'the wider the scope of these services the more difficult will it be to retain the insurance principle'—as if the German insurance system had not been instrumental in providing precisely the medical benefits that are still lacking in this country. From the mistake of entrusting administration to overlapping and expensively organized approved societies, reformers now go to the other extreme and suggest a medical service for the nation, separate from health insurance and administered by a central machinery. It is doubtful whether such proposals have any realistic value. Is it really practical to suppose that, all over the country, there can be realized the same application of the highest medical skill, the same provision of refined surgical, clinical, pathological, therapeutical institutions, the same uniform, nation-wide exploitation of the progress in radiography or physio-therapy or psycho-therapy, or of dental or ophthalmic treatment, and when will it be a tangible reality? It is easy to 'plan' from the top. In theory it is difficult, but it does at least promise some immediate practical effect, to organize from the cell. Social insurance organizes from the cell. It states certain contingencies which befall men in certain occupations or stages of their life. It tries to alleviate the financial burden of such contingencies and to overcome their physical effects by mutual and provident contributions of the people subject to these risks, within certain financial limits. It is based upon specialized risks, and through such specialization tries to isolate and integrate such risks in order to overcome their effects in the most rational manner. When National Health Insurance in Britain stands at cross-roads, as it does to-day, this great advantage of social insurance should not be overlooked. Reform as we have envisaged it might succeed in bringing to life again the high aims which the pioneers had in mind and which have remained unfulfilled. Britain would fall in with the experiences of most other great industrial countries and with the recommendations of the International Labour Office. And even such a reform, which may appear modest in comparison with the high-flying aims of more revolutionary, if most creditable, aspirations, will require the utmost wisdom, economic and socio-medical experience and devotion to the nation's family.

POSTSCRIPT

THE BEVERIDGE REPORT AND SICKNESS INSURANCE

WHEN this book was already written the Beveridge Report on 'Social and Allied Services' was published. This great social document will, whatever the fate of its specific proposals may be, rank among the classic official publications which, like Dr Edwin Chadwick's Reports on the social conditions in towns or Sir Seymour Tremenheere's Reports on factories or the Poor Law Commission's Reports of 1906–9, have left a deep influence on the development of British social life. No less than 250,000 copies, apart from the many abbreviated editions, were sold in less than three months, a fact alone which shows how the Report has aroused interest in the masses of the population, which in general are little inclined to devote much time to the complicated problems of social insurance. Where possible, references to the findings of this Report as they are related to the particular topics of this book have been inserted seriatim.

The recommendations of the Beveridge Report, as they touch the problem of security for the population in time of disability, show more distinctly and more vividly than ever before in an official document the total inadequacy of the present National Health Insurance services. They relate primarily to the scope and benefit of National Health Insurance. The scope of the persons to be covered by the Beveridge proposals would be really comprehensive—a position already reached in other countries, and so frequently urged in Britain. Dependants would at last be included. Cash benefits, though remaining on a flat-rate basis, would be large enough to guarantee a minimum of existence to the working-class family if its members were struck by illness or disease. The provision of 56*s*. per week for man, wife and two children (unlimited in time and without means test) would contrast strikingly with the present meagre 18*s*. a week.

An important step forward would be the inclusion of burial benefit in compulsory state insurance. It is of particularly great value that Sir William Beveridge has taken pains to scrutinize and criticize in a most detailed manner the business of industrial assurance and its interlockings with National Health Insurance,

and that he has reached, and fully emphasized, the conclusion that, in a genuine social security plan, burial benefit must be definitely a statutory benefit and not left to the arrangements of private or voluntary thrift agencies. Not less gratifying is the proposed increase of maternity benefit from £2 to double that sum. And the improved benefits for persons disabled by industrial accident and disease would contribute notably to the greater security which the sick worker would enjoy under this plan.

In order to justify these drastic reforms Sir William Beveridge had to deal deeply and persistently with the defects of the present system of National Health Insurance. A large part of the Report is devoted to an analysis of the system of approved societies and their deficiencies (paras. 48–76). Points to which my book has tried to give particular prominence, such as the blatant inequalities of the benefits offered by the societies, have been restated on the background of fresh material. The conclusion was inevitable that the approved society method of administration was inconsistent with the policy of a National Minimum; that equal benefits for equal contributions should become the criterion; and that approved societies should be replaced by other administrative machinery. From this conclusion came the idea of a centralization of the entire administration in the hands of the State and the provision of a Ministry of Social Security for that purpose.

It is not the purpose of this book, nor of this postscript, to deal with this plan for social security, of which security in time of disability is only one part. It is evident that National Health Insurance as this country has known it for thirty years would lose its separate existence in the Beveridge Plan. The present book is merely concerned with National Health Insurance as it exists and as it might be reshaped into a more efficient and better statutory social service. The Beveridge Plan is not concerned with this aspect of the matter. It deliberately suggests the experiment of a union of the statutory social services which all over the world, with the insignificant exception of a few smaller countries, have so far been separately administered with different aims. The present book recommends that the separate services should be retained. This does not mean that its author is unaware of the great deficiencies which the uncoordinated existence of various social services has led to in this country. These deficiencies have indeed been fully discussed here. But it seems doubtful to the author whether unification must always mean a higher degree of efficiency in any sense. It may in many instances mean merely uniformity on the

surface, which might easily become a check to flexibility. In its publication on 'Approaches to Social Security' the International Labour Office observed in 1942:[1] 'While retaining its original divisions, social insurance has nevertheless evolved; each branch—workmen's compensation, sickness insurance, pension insurance, unemployment insurance—has pursued a more or less independent career, adapting its structure and policy ever more closely to the nature of its tasks, as gradually revealed to it. . . . It is indeed remarkable that all the branches have been influenced by common tendencies, the sharing of which has brought them closer together.' Unfortunately, this cannot be said of the British system, as it is hoped this book has proved. Thus Sir William Beveridge's plan to merge all the services (though allowing for special arrangements particularly as regards hazardous industries) was a most understandable motive.

The solution which Sir William Beveridge chose for this fundamental problem necessitated a further important provision. A central administration would find it difficult, in a country with such diversified conditions of labour and earnings, to employ the wage-class system of contributions and to adjust benefits according to earnings. This system, which is that employed in most insurance systems in the international sphere, has never been criticized for giving unequal cash benefits. It has been found a fair solution to secure more than a bare minimum standard of living to workers with higher earnings and to ask from them higher contributions accordingly. Sickness insurance in such countries has allowed the worker in time of sickness an approximation to his normal earnings. Why approved societies cannot do this has been shown in this book. The disintegrated and competitive organization of the societies makes such a highly elaborate adaptation of benefits to earnings impossible. The Beveridge plan, by centralizing administration, would be in a similar difficulty. Therefore, once more, the flat-rate system of contributions and benefits has been adopted. Its simplicity is better adapted to central administration. Yet, as the author of the present book has been at pains to show, under other systems the system of benefits as a percentage of earnings has been carried on without any particular administrative difficulties. But it does necessitate definite integration or grouping of the risks on which to base sickness insurance, and therefore the grouping of such risks into territorial (local) or occupational funds. Again the International Labour Office may be quoted: 'In general,

1 Cf. p. 23.

the greater the degree of centralization, the more the assistance in question acquires the character of a right, just because a national scheme implies uniformity and award of assistance by rule of thumb. The small local authority, on the other hand, may well administer, though preferably with State help, those branches which involve great flexibility in the assistance granted, in which personal interest in the beneficiary and the enlistment of voluntary aid improve the quality of the assistance, and of which the cost per head of population is likely to vary little from one locality to another.' The system of such decentralized sickness funds has the advantage that instead of a costly accumulation of contributions for reserves, the assessment system which provides the necessary cash for a period of a year can be employed.

Sir William Beveridge has (cf. para. 385) to some extent recognized the necessity of decentralization of sickness administration; his Ministry of Social Security would keep 'close contact with local agencies of all kinds in dealing with the varied needs of insured persons'. Moreover, 'selection and training of staff with special regard to their functions in serving the public and in understanding the human problems with which they will be concerned' is considered as being of 'outstanding importance'. But such decentralization should be carefully distinguished from that of local or occupational self-supporting sickness funds, with financial independence and the right to adapt their finance by flexible contributions to such higher benefits as may be locally or occupationally desirable. Under the Beveridge scheme 'regional or local Security Offices' will hardly become entitled to draw up and, indeed, carry through plans for an improvement of such services in the local area as the cash-benefits are once and for ever fixed on a national basis, while medical treatment is altogether divorced from sickness insurance. The situation is not altered through that other proposal of the Beveridge plan (para. 392, see also 68) that friendly societies may under certain conditions act as the responsible agents for the administration both of statutory and voluntary sickness benefits of their members. The retention of the friendly societies for that purpose would perpetuate the existing system of a multiplicity of administrative agencies the higher cost of which would to some extent even offset the advantage (cf. para. 379) 'to encourage through these associations the greatest supplementation of State insurance by voluntary insurance'. Moreover, the disadvantage of 'segregation', that is, of scattered and disintegrated risks, would still remain as regards the insurance by friendly

societies and enhance the cost at which these supplementary voluntary benefits could be granted.

The most important deviation of the Beveridge plan, so far as sickness insurance is concerned, from international patterns lies in the fact that the medical service is to be divorced from cash benefits. Again, the disappointment experienced as regards the application and extension of medical treatment benefits by approved societies and insurance committees may have led Sir William Beveridge to adopt this course. If a service put forward as an ideal by the British Medical Association and other bodies could be comprehensively achieved in a measurable time no objection could be raised against this departure from the international patterns. But where progress has been necessarily costly and slow, it has been the aim to use the machinery of sickness insurance as an instrument to achieve more socialization of medicine. The Beveridge plan severs the two functions of sickness insurance—that of protecting the individual and, through its funds, that of promoting the application of medical progress. The National Exchequer and the local rates will have to meet the cost of the health and rehabilitation services with the help of a grant from the Social Insurance Fund representing the receipts from the contributions assigned to these services (para. 279 (vi) and *passim*). Sickness insurance, therefore, would not be based upon a self-supporting fund as regards the medical treatment benefits provided. The same line is taken, as regards the improved treatment of industrial injuries, by that important counterpart of the Beveridge Report, the Report of the Inter-departmental Committee on the Rehabilitation and Resettlement of Disabled Persons.[1] That medical treatment for almost all should be regarded as a social service, and its cost met and recognized as a public obligation, is one of the important assumptions of the Beveridge plan.[2] Where schemes similar to the Beveridge plan do not exist these services are strongly knitted to sickness insurance schemes, which have been able to provide medical treatment benefits of a high quality and variety, including hospitalization, specialist treatment and rehabilitation. In a similar way statutory associations of employers and employees or Workmen's Compensation Boards have been active in promoting the socialization of medical progress. The Beveridge plan fully recognizes, and aptly stresses, the importance of such progress. The Report makes another plea for the improvement of the medical treatment of the working classes.

1 Cmd. 6415, 1943.

2 Cf. pp. 158 sqq.

But it divorces the dynamics of this improvement from the insurance scheme, which will be limited to the function of contributing part of the cost. The question which the Government will have to decide is whether the acceptance of a comprehensive central plan, with very fundamental assumptions and financial implications which are difficult to foreshadow, is preferable to a system working on the basis of clearly assessable risks to be met by a system of integrated local and occupational funds.

The author of this book favours the latter solution. In his view it would be best to try to build up and reorganize sickness insurance in this country not from the roof but from the ground. It is true that, if it were possible, by accepting Sir William's 'assumptions' as they relate to health insurance, to carry out his plan in full, a new and very hopeful pattern of medico-social security may evolve. To have suggested and carefully analysed this solution is the merit of the Beveridge Report, and a great tribute must be paid to its originality and intuition. It may become of pivotal importance to a world which until now has preferred a very different system. But it is still no more than a hypothesis and an experiment; and it is certainly doubtful whether the experiment should be tried without the fullest regard to solutions and successes which have been achieved by sickness insurance in sixty years of international experience by methods of organization and administration, sharply contrasting with the system in this country as well as with the Beveridge scheme. If the author of this book has been able to contribute to this study his work will not have been in vain, whatever the actual future of British social insurance may be.

BIBLIOGRAPHY

I. Books, Pamphlets, Reprints

Approved Societies' Handbook. 1933.

Bell, Lady. At the Works. Ed. 1911.

Bourne, Aleck. Health of the Future. 1942.

Blackshaw, W. The Community and Social Service. 1939.

Braithwaite, Constance. The Voluntary Citizen. 1938.

Brend, Dr W. A. Health and the State. 1917.

—— Traumatic Mental Disorders in the Courts of Law. 1938.

Brieger, E. After-Care and Rehabilitation. (International Union against Tuberculosis.) 1937.

Carr-Saunders, A. M. and Wilson, P. A. The Professions. 1933.

Chiozza-Money, Sir Leo. Insurance and Poverty. 1912.

Clapham, J. H. The Economic History of Modern Britain. 1938.

Clark, W. Irving. Health Service in Industry. New York, 1922.

Clarke, John J. Social Administration. 1922.

Cohen, Joseph L. Insurance against Unemployment. 1921.

—— The Future of Unemployment Insurance. 1922.

—— Insurance by Industry examined. 1923.

—— Workmen's Compensation. 1923.

—— Social Insurance Unified. 1924.

—— Family Income Insurance. 1929.

Collie, Sir John. Malingering and Feigning Sickness. 1917.

Comyns Carr, A. S., Stuart Garnett, W. H. and Taylor, J. H. National Health Insurance. 1912.

Dodd, Walter F. The Administration of Workmen's Compensation. New York, 1936.

Eichelsbacher, Dr Franz. Reichsversicherungsordnung. München, 1938.

Fabian Society. Social Security. 1942.

Foster, W. J. and Taylor, F. G. National Health Insurance. 1937.

Garnett, W. H. Stuart. See under Comyns Carr.

Gray, Prof. Alexander. Some Aspects of National Health Insurance. 1921.

Grotjahn, A. Sociale Pathologie. 1923.

Hädenkamp, Dr Carl. Die Neuordnung der Deutschen Socialversicherung. München, 1937.

Hayek, H. von. Sociale und Socialisierte Medizin. 1925.

Herbert, Merwyn. Britain's Health. 1939.

Horsefield, L. G. Practical Methods in Industrial Assurance. 1935.

Insurance Mail Yearbook.

Lesser, Henry. The Law of National Health Insurance. 1939.

Levy, Professor Hermann. War Effort and Industrial Injuries. 1940.

—— Back to Work? The case of the partially disabled worker. 1941.

—— Retail Trade Associations. 1942.

—— See also under Wilson, Sir Arnold.

Liek, Dr. Die Schäden der Sozialversicherung. München, 1927.

Macadam, Elisabeth. The New Philanthropy. 1934.

McCLEARY, G. F. National Health Insurance. 1932.
MANSBERGH. See under VERNON and MANSBERGH.
MASTERMAN, C. F. G. The Condition of England. Ed. 1910.
MURRAY, D. STARK. Health for All. 1942.
National Health Services. (British Association for Labour Legislation.) 1941.
NEAL, L. E. Retailing and the Public. 1933.
Neuregelung der Beziehungen zwischen den Trägern der Krankenversicherung und Unfallversicherung. Berlin, 1936.
NEWSHOLME, Sir ARTHUR. International Studies on Private and Official Practice in Medicine. 3 Vols. Geneva, 1931.
—— The last Thirty Years in Public Health. 1936.
NEWSON, JOHN. Out of the Pit. 1936.
NORRIS, Dr D. C. Some Medical Problems in Accident Insurance. Reprint, 1937.
ORMEROD, REDMAN. National Health Insurance: its inherent defects. 1930.
ORR, D. H. and ORR, JEAN WALKER. Health Insurance with Medical Care. New York, 1938.
ORR, Sir JOHN BOYD. Food, Health and Income. 1936.
RAY, MATTHEW. The Treatment of Rheumatism. 1930.
ROWNTREE, B. SEEBOHM. Poverty and Progress. 1941.
RUBINOW, J. M. Social Insurance. 1913.
SHARPE, A. E. and TAYLOR, CHARLES. Industrial Assurance Salesmanship. 1936.
SIMEY, T. S. Principles of Social Administration. 1937.
SINCLAIR, ROBERT. The Metropolitan Man. 1937.
SMITH, HENRY. Retail Distribution. 1937.
SNOXHILL, JAMES. Notes on Approved Societies. N.D.
TAYLOR, CHARLES. See under SHARPE.
TAYLOR, F. G. See under FOSTER.
TAYLOR, J. H. See under COMYNS CARR.
THOMAS, R. B. The Health Services. (Fabian Society.) 1940.
VERNON, R. V. and MANSBERGH, N. Advisory Bodies. 1940.
WATSON-JONES, R. Fractures and other Bone and Joint Injuries. 2nd ed. 1941.
WEBB, SIDNEY and WEBB, BEATRICE. History of Trade Unions. 1902.
WEIZSÄCKER, VICTOR v. Soziale Krankheit und Soziale Gesundung. Berlin, 1930.
WICKWAR, W. HARDY. The Social Services. 1936.
WILKIE, G. B. Nationalisation of Insurance. 1931.
WILSON, Sir ARNOLD, M.P. and LEVY, Professor HERMANN. Industrial Assurance. 1937.
—— —— Burial Reform and Funeral Costs. 1938.
—— —— Workmen's Compensation. Vol. I, 1939; Vol. II, 1941.
WILSON, Sir ARNOLD, M.P. and MACKAY, G. S. Old Age Pensions. 1941.
WOODS, E. A. The Sociology of Life Insurance. New York, 1936.

II. STATISTICAL PUBLICATIONS, REPORTS AND MEMORANDA (OFFICIAL AND PRIVATE), OFFICIAL DOCUMENTS

Statistical Abstract for the United Kingdom.
Ministry of Health. Annual Reports.
—— Summary Reports for 1939–41 and 1941–42.

Ministry of Health. Annual Reports of the Chief Medical Officer.
—— (and other Departments). National Health Insurance. A Summary of the Acts. Memo 239. 1939.
—— Memorandum on Certification of Incapacity for Work. 1931.
Ministry of Labour and National Service. Memorandum on Medical Supervision in Factories. 1940.
—— Interim Scheme for the Training and Resettlement of Disabled Persons. 1941.
—— Fracture Treatment and Rehabilitation. 1942.
Home Office. Workmen's Compensation Statistics.
—— Memorandum on the Workmen's Compensation Acts, 1925–31. 1936.
Ministry of Pensions. Compensation for Civilians injured or killed in Air Raids. 1941.
Industrial Assurance Commissioner. Annual Reports.
Government Actuary. Report on the Fourth Valuation of the Assets and Liabilities of Approved Societies. 1937.
—— Report on National Health Insurance etc. Bill of 1941. Cmd. 6290. 1941.
Medical Research Council and Industrial Health Research Board. Industrial Health in War. 1940.
—— The Personal Factor in Accidents. 1942.
—— Annual Reports.
Report on Old Age Pensions. 1898.
National Health Insurance. Medical Benefit under the German Sickness Insurance Legislation. 1913.
Report of the Departmental Committee on Sickness Benefit Claims under National Health Insurance. 1916.
Reports of the Committee on Approved Societies Finance. 1916–17.
Report of the Royal Commission on the Poor Laws. Ed. 1909.
Report of the Royal Commission on National Health Insurance, 1926, ed. 1928; and Minutes of Evidence, 1925–26.
Report of the Committee on Industrial Assurance (Cohen Report), 1933.
Report of the Departmental Committee on Workmen's Compensation. 1922.
Royal Commission on Workmen's Compensation, Minutes of Evidence. 1939–40.
Social Insurance and Allied Services. Report by Sir William Beveridge, 1942, Report and Memoranda of Organisations.
Report of the Select Committee on Shop Assistants. 1930.
Interim and Final Reports of the Departmental Committee on the Rehabilitation of Persons injured by Accidents. 1937 and 1938 (Delevingne Report).
Reports of the Departmental Committees on Maternal Mortality and Morbidity. 1930 and 1932.
Report of the Departmental Committee on certain Questions arising under the Workmen's Compensation Acts (Stewart Report). 1938.
Interim Report of the Interdepartmental Committee on the Nursing Services. 1939.
Report of the Committee on Man-power in Banking and Allied Businesses, in Ordinary Insurance and in Industry. 1942.
British Medical Association. More Secret Remedies. 1912.
—— Report on Fractures. 1935.
—— Report on Miners' Nystagmus. 1936.
—— A General Medical Service for the Nation. 1938.

British Medical Association. Report of the Committee on Industrial Health in Factories. 1941.
—— Draft Interim Report of the Medical Planning Commission. 1942.
Medical Practitioners' Union. Memorandum on Home Treatment Service. 1940.
Industrial Welfare Society. Works Sickness Benevolent Funds. 1934.
—— Medical Service in Industry. 1936.
—— Health Services in Industry. 1942.
Political and Economic Planning (P.E.P.). The British Social Services. June 1937.
—— Report on the British Health Services. December 1937.
—— Planning Health in War-time. (Broadsheet.) April 1941.
Socialist Medical Association of Great Britain. Report on War, Tuberculosis and the Workers. June 1941.
Fabian Society Research. Report of the Health Services Sub-Committee, Social Services Committee. March 1939.
Trade Union Congress. The Trade Union Congress in War-Time (by Sir Walter Citrine). May 1941.
Accident Offices Association. Workmen's Compensation. 1942.
Royal Surgical Aid Society. Annual Reports.
International Labour Office. Compulsory Sickness Insurance. 1927.
—— Voluntary Sickness Insurance. 1927.
—— Benefits of the German Sickness Insurance System (Franz Goldmann, M.D. and Alfred Grotjahn, M.D.). 1928.
—— International Survey of Social Services. 1933.
—— The International Labour Organisation and Social Insurance. 1936.
—— International Survey of Social Services. 2 Vols. 1936.
—— Economical Administration of Health Insurance Benefits. 1938.
—— The Evaluation of Permanent Incapacity for Work in Social Insurance. 1938.
—— Actuarial Technique and Financial Organisation of Social Insurance (Lucien Féraud). 1940.
—— The Compensation of War Victims. 1940.
—— Approaches to Social Security. 1942.
Royal Social Board (Sweden). Social Work and Legislation in Sweden. 1938.
Final Report relating to Employers' Liability (Canada). Toronto, 1913.
House of Commons Debates.
House of Lords Debates.

III. Newspapers, Periodicals, Journals, etc.

American Journal of Surgery.
Amtliche Nachrichten für Reichsversicherung.
British Dental Journal.
British Journal of Tuberculosis.
Charity Organisation Society Quarterly.
Industrial Welfare and Personnel Management.
International Labour Review.
Journal of the Chartered Insurance Institute.
Journal of the Royal Army Medical Corps.
Journal of the Royal Institute of Public Health and Hygiene.
Ministry of Labour Gazette.
New Statesman and Nation.

News Letter (Central Council for the Care of Cripples).
Political and Economic Planning (P.E.P.) Broadsheets.
Public Health.
Reichsgesetzblatt.
Sunday Times.
The British Journal of Physical Medicine.
The British Medical Journal.
The Catholic Herald.
The Economic Journal.
The Economist.
The Insurance Mail.
The Lancet.
The Medical Officer.
The National Insurance Gazette.
The Policy.
The Practitioner.
The Times.
The Tribune.
Transactions of the Hunterian Society.
Transactions of the Ophthalmological Society.
United States Monthly Labor Review.
Zeitschrift für Gesundheitsversicherung und Gesundheitsfürsorge.

1943 Addenda

In 1943, partly in connection with the Report by Sir William Beveridge, a considerable number of publications was added to the literature of the British Social Services. While none of these publications could be utilized in the text of this book the more important of them, as far as they are related to the problems of National Health Insurance, may be enumerated as a supplementary source of reference:

Beveridge, Sir William H. Pillars of Social Security.
Central Council for the Care of Cripples. A Memorandum on the 'Report of the Inter-Departmental Committee on the Rehabilitation and Resettlement of Disabled Persons'.
Cohen, Professor Henry. A comprehensive Health Service. (Reprint from Agenda, February 1943).
Cole, G. D. H. Beveridge explained. (New Statesman Pamphlet.)
Department of Health for Scotland. Health and Industrial Efficiency. Scottish Experiments in Social Medicine.
Executive Committee of the National Federation of Employees' Approved Societies. Administration of Benefits by Approved Societies.
Government Actuary. Fifth Valuation of the Assets and Liabilities of Approved Societies. Summary Report by the Government Actuary with a supplement on Additional Benefit Schemes.
International Labour Office. Social Security Plans in Great Britain. The Beveridge Plan. Report of Medical Planning Commission. (Reprint from International Labour Review, January 1943.)
—— Social Security Planning in Canada.
Mitcheson, Sir George, M.P. British Fire, Accident and Casualty Insurance. (Pamphlet.)

National Conference of Friendly Societies. Social Insurance and Allied Services. Utilization of Approved Society Administration under the alternative scheme proposed by the National Conference of Friendly Societies and other Approved Society Organizations.

NEWMAN, T. S., President, National Conference of Friendly Societies. Social Insurance and Allied Services. Statement of Case presented to Minister of Health and Secretary of State for Scotland.

NISBET, JAMES W., GRIDLEY, Sir ARNOLD and BENN, Sir ERNEST, J.P. The Beveridge Plan. A Symposium. (The Individualist Bookshop.)

PEARSE, INNES H., M.D. and CROCKER, LUCY H. The Peckham Experiment. (Published for the Sir Halley Stewart Trust.)

Report of the Inter-Departmental Committee on the Rehabilitation and Resettlement of Disabled Persons (Tomlinson Report).

SAXTON, C. CLIVE. Beveridge Report Criticized. (Pamphlet.)

SINGER, H. W. Can we afford 'Beveridge'? (Fabian Society.)

Social Security. Edited by William A. Robson. (Published for the Fabian Society.)

The National Federation of Employees' Approved Societies. The Beveridge Report on the Social Insurance and Allied Services.

INDEX

Accident Offices Association, 343; and expense ratio, 84, 291–2
Actuarial position, 9, 23, 26, 67, 265, 321–2
Actuary, Government, 31, 66, 213–14, 223, 240, 245, 247, 250
Addison, Lord, 18, 330
Age-limit, 9, 35, 39, 45, 279
Appliances, medical and surgical, 59, 94, 96, 104, 195–9; (optical), 158; *see also* Royal Surgical Aid Society, 293
Approved Societies, accounts of, 213; and appliances, 198; Association of, 125; and benefits, 97, 101; and democratic control, 7, 221–37; finance, 33, 45, 96; financial shortcomings, 243–51; inequalities of benefits, 252–66; and legal proceedings, 286–8; and medicine, 192; membership of, 96; and N.H.I. Scheme, 7, 28, 69; 'No Profits', 7, 215–21; numbers of, 26; surplus and deficiencies, (table) 240; types of, (table) 235; (large and small units), 223–4, 249–50; (segregation of risks), 246, 249, 251, 255–6, 298, 308, 314–15
Approved Society, selection of, 263

Bearn, Mr E. G., 42, 190, 253, 323
Bell, Lady, 86–7
Benefit, domiciliary, 20, 175
Benefits, and contributions (flat-rate), 61–9, 78, 88–90, 257, 321–2; disablement, 67–9, 247; funeral, 91; inequalities of, 252–66; insufficiency of, 70–7, 81–2, 87, 90, 207–8, 323, 333; interlocking of medical and cash, 60, 87–8, 207; rates of, 62–4; (classifications), 53–7, 59; (special), 58–60; (Special, Class K), 45, 75
Benefits, additional, 14, 59, 241, 254–5, 258, 262, 327; (hospital treatment), 161, 179; (medical), table, 97; (statistics and rates of), 74–5: *see also under* Dental *and* Ophthalmic treatment, Convalescent homes, Appliances, Hospitals, Nursing
Beveridge, Report by Sir William, 217, 299–301, 348, 350–5
Black-coated workers, 320
Blackshaw, Mr W., 208, 226, 265
Bowley, Prof. A. L., 77
Brabrook, Sir Edward, 1
Brackenbury, Sir Henry, 134, 198, 327
Brend, Dr W. A., 2, 19, 21–3, 57, 95, 101, 110, 113, 161, 186, 204, 288
British Hospitals Contributory Schemes, 138, 161–2, 293
British Legion, 179
British Medical Association, 15–19, 49, 56, 107, 124, 147, 152; and Workers' Budget, 80; (on encroachments), 147; (on fractures), 56, 172; (on hospitals), 184; (on industrial health), 151, 209–10; (National Formulary), 311–12; (on patent medicines), 190; (on private practice), 128, 133, 152, 209–10
Brock, Mr L. G., 49, 105, 107, 132, 144

Capitation fee, *see under* Doctors, remuneration of
Carr, Mr Comyns, 10, 19, 58
Carr-Saunders, Mr A. M., and Mr P. A. Wilson, 130, 133, 158
Central Council for the Care of Cripples, 151, 171–2, 179, 199
Certifying surgeon, 149
Charity Organization Society, 254; (Mr Pringle on Industrial Accidents), 282
Clapham, Sir John, 14
Clarke, Mr John J., 3–4
Cohen, Mr Joseph L., 22–3, 26, 32, 84, 224, 227
Contract Practice Committee, 16
Contributions, 60–1, 71, 321–4
Convalescent homes, and additional benefit, 96, 182
Court of Enquiry, 145
Cripples, *see under* Central Council for the Care of Cripples

Democratic Control, 27, 221–7
Denmark, 44, 48, 317
Dental Benefit Council, 155
Dental benefit and treatment, 96, 111–13, 137, 153–6, 197, 274
Department of Health for Scotland, 31, 36; Memorandum on Prescribing, 311
Dependants, 49–50, 55, 60
Deposit Contributors, 13, 43, 58; Fund, 212
Dicey, Prof. A. V., 6
Disability Pensions, 33
Disablement Benefit, 59, 61, 67–9, 247
Doctors, and food, 87; and N.H.I. Scheme, 15–23, 57; remuneration of, 17, 122–37; *see also under* Manchester and Salford; service of, 61, 102–21
Druggists, 22, 106, 186
Duncan, Sir Andrew, 29, 65

Employment Exchange, 64, 277
Exempt Persons, 40–1
Expenditure, workers' weekly, 72, 79–82
Expense ratio, 84, 250, 289–301, 337, 346; and International Labour Office, 291; in various countries, 291 (table), 297

Fabian Society, 6, 100, 344
Factory Acts, 313
Flat rate, 54–5, 61–70
Florence, Prof. Sargant and Mrs Lella Florence, 103
France, 44, 66, 84, 199, 296–7, 317
Free choice of doctors, 17, 104–5, 117, 123–4
Free Insurance period, 277
Friendly Societies, 5–7, 10–11, 32, 76–7, 82–3, 88, 108, 226, 228, 232, 237, 320
Friendly Societies Act, 18, 96, 244
Funds (various), 13, 34, 36, 221, 264, 290, 314, 326–7

General Medical Service for the Nation, 56
German system, 14, 50, 61–3, 67–8, 84, 98, 124–5, 129, 138–9, 166, 179, 194, 199, 200, 245–6, 253, 255, 267, 306, 321, 348; and British system compared, 227–38
Gladstone, Mr, and Friendly Societies, 6
Gomme, Mr R. E., on training and resettlement, 340
Gordon, Mr Alban, on Insurance Committees, 268–9, 320, 322, 326
Gray, Prof. A., 29, 82, 236, 305

Hackforth, Mr, 64, 143, 323
Health Insurance Joint Committee, 62
Health Services, 49–50; (Scottish) 184
Herbert, Mr Mervyn, 137
Hetherington, Sir Hector, 69
Home Office, and certifying surgeons, 210; and Accident Offices, 290
'Home Service' (by Agents), 216–19
Horder, Lord, 93, 202, 208, 341
'Hospital Consciousness', 206
Hospital Contributory Scheme, 138, 161
Hospital Emergency Scheme, 174
Hospital Savings Association, 159, 162
Hospitals, 30, 94, 113, 161–85, 208, 341; voluntary, 163; (British Hospitals Association), 127, 162, 169; (admission and attendance figures), table, 168; (number of attendances), 127–8; (number of beds), 167; (Poor Law), 183; (waiting list), 170, 335

Illness, expectation of, 90; neglected, 304–5
Incapacity, permanent, 68–9; proof of, 36, 307
Industrial Assurance, 8, 11, 27, 33, 216–21, 332, 347; Agents, 11, 218, 219, 337; Commissioner, 121
Industrial Health Research Board, 102–3
Industrial Medical Officers, Association of, 169–70, 209–10
Industrial Welfare Society, 150, 163, 201–8
Insurance Acts Committee, 145
Insurance Commissioner, 17–19, 25–6, 196
Insurance Committees, 17, 20–2, 25, 34, 105, 115, 120, 212–13, 266–76, 315
Insurance Mail, 12
Insured Persons, 38–9, 43, 51, 212, 235, 330; categories of, 38–42, 43–4; (statistics), 67
International Labour Office, 40, 49, 92, 98, 184, 342, 349; on Approaches to Social Security, 352; and assessment of incapacity, 68; and death benefit, 73; on Economical Administration, 302, 309, 334; and flat-rate benefit, 55, 57, 58, 70; and hospital treatment, 166–8; and rate of benefit, 89; and specialist treatment, 140; on sickness and food, 189; and territorial system, 298, 316–18
International Medical Association, 202
Irish Free State, 296

Japan, 44, 295
Jones, Prof. D. C., 66, 80–1
Johnston, Mr T., 99
Johnstone, Prof. R. I., 147

Kinnear, Sir Walter, 47, 64, 102, 224–5, 256, 292; (on Approved Societies), 249

Lesser, Mr Henry, 109, 115, 267, 272, 277, 306
Liek, Dr, 303
Life Assurance Offices, 11 (*see also* Industrial Assurance)
Lloyd-George, Rt Hon. D., 1, 5–7, 12, 14, 21–2, 186, 257, 341
Local Authorities, 28, 29–30, 100, 132, 165, 167, 178–80, 269, 275; and appliances, 199; and Sanatorium Benefit, 176
Local Government Act, 1929, 164
London Charity Organization Society, 86

Macadam, Miss Elizabeth, 182, 226
Macdonald, Mr Ramsay, 11
Madge, Mr Charles, 47, 72
Malingering, 305–6; Sir J. Collie on, 203; Holman Gregory Report on, 204

Manchester and Salford scheme, payment of doctor, 125–6, 140, 310
Manual Labour, 38
Marks and Spencer, Dental scheme, 156
Masterman, Mr C. F. G., 33
Maternal Mortality, 100
Maternity Benefit, 58, 95, 99, 332
Medical Benefit, administration of, 17, 95; Sir A. Newsholme on, 30–1; types of, 95–102
Medical Education, *British Medical Journal* on, 133
Medical List, 267
Medical Officer of Health, 16
Medical Planning Commission, 56, 331
Medical Practitioners' Union, 105, 119–20, 131
Medical Research Council, 102
Medical treatment, 51, 104; by specialists, 137–53
Medicines, supply of, 185–95, 311–12; definition of, 187
Midwifery Legislation, 101
Ministry of Health, 31, 39, 46, 97, 113, 114, 118, 196, 212, 220, 222, 235, 267, 287, 335; and approved societies, 214; (on deceit), 204; (on Committee of Management), 244; investigation into panel practice, 131 (table), 192–3; and transfer, 263; and hospital-mindedness, 206, 335
Ministry of Labour, 71, 79, 80–1, 150
Ministry of Pensions, 69
Money, Sir L. Chiozza, 4–5, 14, 89, 122, 166, 228
Morgan, Dr, M.P., 114, 135, 141, 187

National Health Insurance Act of 1921, 34; of 1924, 35; of 1928, 35, 38, 248; of 1936, 36–7 (and throughout the book); of 1937 (Juvenile Contributors and Young Persons), 37, 39
National Health Insurance Joint Committee, 213–14, 220, 264
National Health Insurance and Contributory Pensions Act of 1932, 36, 248; of 1935, 36
National Insurance Act, 1911, 1, 9, 35, 67
National Insurance Benefit Society, 201
National Insurance Gazette, and competitive system, 325–6, 327
National Medical Service, 21, 327, 329
National Medical Union, 115
Neal, Mr L. E., 47
Negligence, cases of, 114–15, 118
Newman, Sir George, 100, 116
Newsholme, Sir Arthur, 30, 32, 101, 125, 329
Nicoll, Dr E. A., 273, 340
Non-manual workers, 34, 38
Norris, Dr D. C., on fractures, 119–20; on malingering, 204
Nursing (District), 162, 200–3, 293–4, 318, 332

Old-Age Pensions, 1, 29, 35, 278–9
Ophthalmic benefit and treatment, 59, 96, 111, 112, 137, 156–60, 197
Opticians, *see under* Ophthalmic benefit
Orde, Mr, 127–9
Ormerod, Mr J. Redman, on National insurance, 297
Orr, Messrs D. H. and J. W., on buying practices, 134; on treatment-mindedness, 207
Orr, Sir John Boyd, 81

Patent Medicines, 190
Peake, Mr Osbert, on Medicines, 190
P.E.P., 31–2, 75–6, 101, 123, 133, 137, 147, 223, 327, 341; (on tuberculosis), 175
Pharmaceutical benefits, 93, 104, 187; (Drug Fund), 188, 192
Pharmacy and Medicine Bill, 1941, 190
Physiotherapy, 150, 151, 274
Poland, 98
Poor Laws, 1, 3–4, 16, 29, 78, 164–5, 169
Post Office, connection with N.H.I., 213
Prescribing, 194; excessive, 186, 312–13
Pringle, Rev. J. C., on litigation, 282
Private patients, 128
Provident Funds, 13
Prudential Approved Societies, 219, 224
Psychotherapy, 141
Public Assistance, 165, 287
Public Health, 19–20, 222; Act of 1921, 56

Regional Medical Officers, 30, 145, 155, 306–7
Rehabilitation, 141, 340, 354; at Berry Hill Hall, 273; Delevingne Report on, 56, 172–3, 272
Reserves, assessment and accumulation systems, 323–4
Rheumatism, 148, 345
Rowntree, Mr B. Seebohm, 177, 208
Royal Commission on N.H.I., 23–37
Royal Surgical Aid Society, 196–8, 293
Rubinow, Mr I. M., 67, 228, 297
Russell, Professor William, 191
Ryle, Professor John A., 344

Sanatorium treatment, 55; *see also under* Tuberculosis
Saving, 72, 79
Scope of insurance, 43–52

Scottish Board of Health, 78, 250, 307
Seamen's National Insurance Society, 221
Sick visitors, 308
Sickness, actual and expected cost of, (table) 247, 313; excessive, 302–7; length of, 173
Sickness Funds, local, 5, 229–30, 326
Simey, Mr T. S., 218, 265
Sinclair, Mr Robert, 100, 170
Smart, Sir Morton, 93, 110, 149
Smyth, Mr J. L., 2, 305
Snowden, Viscount, on N.H.I. scheme, 6
Snoxhill, Mr James, 288
Social Medicine, Institute of, 340
Social Services, cost of, 84
Spearing, Mr T. A. E., 284
Specialists, treatment by, 30, 57, 137–53, 161, 257
Stewart Report, 259–60
Sweden, 295–6, 317
Switzerland, 44, 48, 139, 199, 292, 296, 317

Territorial system, 194, 275, 298, 313–14, 316–29
Times, The, on 1911 N.H.I. scheme, 5
Trade Union Approved Societies, 263, 283
Trade Union Congress, 2, 151, 198
Trade Unions, 5, 9, 226
Trumper, Dr, 130
Tuberculosis, 20, 174–80; period of treatment (table), 177

Unemployment (Arrears), 36, 62, 218, 277
Unemployment Insurance, 29, 65, 72
U.S.A., 44, 89, 199, 281; Rehabilitation in, 56
U.S.S.R., 99, 199, 253

Valuation of Approved Societies, 14, 96, 213, 222–3, 235, 240–1, 262; (Fifth), 241
Varrier-Jones, Sir Pendrill, 179–80
Vested Interests, 21, 37
Voluntary Contributors, 39, 41, 279
Voluntary contributory schemes, 162
Voluntary Insurance, 71, 76–7
Voluntary Social Services, 153, 208, 226, 332

War measures (1914–1917), 33
Watson, Sir Alfred, 1, 24, 216–17, 314
Watson-Jones, Mr R., 173–4
Webb, Sidney and Beatrice, 9, 294
Widows, Orphans and Contributory Pensions Acts, 35, 42, 279
Wilson, Sir Arnold, and Mr G. S. Mackay, on Old-Age Pensions, 278–9; and Prof. Hermann Levy, 151, 241, 250, 347
Wilson, Mr P. A., *see under* Carr-Saunders
Women and inequalities of benefits, 66
Workmen's Compensation, 116, 136, 152, 204, 220, 259, 284, 345; (contracting-out), 39; in Germany, 280–1; (Hetherington Commission), 42; Holman Gregory Committee on, 28, 143–4; (loss ratio), 290; and N.H.I., 51–2, 62–4, 75, 141–2, 280–8; in Ontario, 282, 284, 291; (statistics), 141
Works' doctor, 150
Worley, Sir Arthur, 126, 224–5, 256, 259, 321

CAMBRIDGE: PRINTED BY W. LEWIS, M.A., AT THE UNIVERSITY PRESS