insurance. There is definite proof of the fact that people are well aware of the value of prepayment medical care and are not only willing but anxious to protect themselves through prepayment medical care programs. The reason for the small coverage, therefore, must be found elsewhere.

The growth of voluntary insurance is blocked by many barriers. Its development is often impeded by such controversy that the potential subscriber is often incorrectly or indifferently informed as to the real value of the plan. The eligibility requirements which plans must keep in force in order to protect themselves financially exclude many who would be glad of an opportunity to participate. The plans are too costly for the type and amount of services provided, charges are prohibitive for low-income families, and in many instances persons with incomes over a specified amount are accepted as members only on the condition that physicians providing services to them may make additional charges. Also plans now in operation are unequally distributed and there are still large areas where prepayment plans are not in operation, or, if they are, where eligibility is limited to some particular industry or group. Finally voluntary plans are limited in growth by the very fact that they are voluntary. Many families among the moderate and high-income groups will not participate on a voluntary basis; and the low income groups, those most in need of care, because of the pressure of high living costs prefer to "take a chance" in the hope that they will escape expensive illness.

Consideration of these difficulties has led many persons to doubt seriously that voluntary plans can ever reach the public in such a manner as to achieve national coverage or anything approaching it. In their opinion voluntary plans are valuable not only for the services they are rendering at present but as an experiment which can point the way to a broader program. They believe that in the future the experience of these plans in business and medical administration, and in the provision of services, can be of definite assistance in developing a national health program, but that voluntary insurance can never be considered as a substitute for compulsory health insurance.

Britain's New Health Service

By NORMAN WILSON

THE first provision of medical care at the public expense was that made by Justices of the Peace for the sick destitute, long before the Poor Law Commissioners in 1837 authorized their successors, the Boards of Guardians, to give medical relief and to appoint medical officers for the purpose. It was not until thirty years later that an institutional service especially for the sick poor was inaugurated, treatment being provided in infirmaries maintained separately from workhouses or in sick wards in or attached to workhouses. The definition of destitution was gradually broadened; and during this century it has generally been accepted that although a person may be able to secure out of his own resources food, clothing and shelter he may be destitute in the sense that he cannot secure necessary medical care. As a consequence accommodation became more and more readily available in Poor Law general hospitals which steadily expanded in number and size. When the Boards of Guardians were abolished by the Local Government Act, 1929, hospitals containing 130,000 beds were transferred to the county and county borough coun-

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cils. The Local Government Act required that a patient, or, if he is unable to do so, certain relatives, shall pay the full cost of his maintenance, which shall only be reduced or remitted in case of hardship. Many of these hospitals are now administered under the Public Health Acts; but a considerable number of Local Authorities continue to operate them as Poor Law hospitals in the belief that the power of recovery of cost of treatment is more specific under the Poor Law Act.

While some of the voluntary hospitals were founded several centuries ago, the great majority of them have been built since the onset of the industrial revolution. Though these are far more numerous than public hospitals, their bed accommodation is materially less. For a long time their income was derived from invested bequests, subscriptions and gifts, and such payment as patients were in a position to make. Of recent years, however, a growing part of their revenue has come from payments made by Local Authorities and from various kinds of hospitals savings associations, members of which in return for a small weekly contribution are guaranteed free treatment. The income of the voluntary hospitals is sufficient to cover their running costs; but the heavy expenses of improved and extended buildings, more expensive staffs and technical equipment have imposed great financial strain on all of them and has made it impossible for many of them to provide satisfactory services. Voluntary hospitals are reluctant to admit chronic or non-paying patients, who are in general accommodated in Local Authority hospitals.

Municipal Hospitals

Isolation or infectious diseases hospitals are provided wholly and mental hospitals almost wholly by Local Authorities, who also, to a much greater extent than voluntary organizations, are the owners of sanatoria for the treatment of tuberculosis and residential institutions for mental defectives. Except in regard to isolation hospitals, where other types of Local Authority also exercise powers, the provision of hospital and institutional accommodation is a function of the councils of counties and county boroughs only.

It will be seen that in regard to hospital treatment the Local Authorities have invaded and increasingly encroached upon a field of medical service which for long was occupied exclusively by voluntary associations. There are, in effect, especially as regards general hospitals, two hospital systems. Though Local Authorities are required by the Public Health Act, 1936, to consult with the governing bodies and medical staffs of voluntary hospitals, co-operation in fact, for various reasons, does not exist to any considerable extent, and the best use is not always made of the resources which are available.

The Family Doctor

Until the early part of the present century personal medical care, in the patient's home or in the doctor's surgery, was obtainable either by private arrangement between doctor and patient or on application to the Boards of Guardians, who were obliged to appoint medical officers to attend the medically destitute. The National Insurance Act, 1911, instituted a scheme of health insurance, whereby in return for weekly contributions employed persons received, in addition to cash benefit, the free services of any general practitioner willing to accept them on his panel of patients, the practitioner being limited in the number of his patients and being remunerated on a per capita basis. The scheme did not and does not include the dependents of insured persons, who now, as a result of several extensions of the original scheme, total about half of the adult population. Personal or "family doctor" care is therefore provided on three different bases: by payment of fees, by Poor Law medical officers, and by right of insurance contribution. It is necessarily the case that a good many people who are not or who do not want to declare themselves medically destitute

and who are not insured persons find it difficult to afford to pay for a doctor and in consequence may be without medical care which is necessary. Working-class wives especially are sufferers in this respect.

In certain circumstances and for certain conditions, however, such care, in some cases with an important limitation, is available without charge. The Education (Administrative Provisions) Act, 1907, required Local Education Authorities to provide for the periodical medical inspection of all children attending public elementary schools, and authorized them to provide certain forms of treatment. The scope of the Act has been extended from time to time. By the Act of 1944 not only must all children attending publicly provided schools be medically examined at regular intervals: the Local Authorities must secure that all necessary treatment is made available free of cost. Expectant and nursing mothers and children under school age can take advantage of the very extensive provision of maternity and child welfare clinics, most of which is made by Local Authorities. The essential function of these clinics is to furnish medical supervision and hygienic advice, and to endeavour to arrange for medical treatment, when necessary, to be given by such agencies as provide it. Domiciliary treatment is expressly excluded from the scope of a maternity and child welfare scheme. It is the duty of a midwife, however, to call in a doctor to her patient should he be required. The Local Authority is under obligation to pay his fee, but need not recover this or any part thereof in cases of financial necessity. Some Local Authorities also pay the fee of an obstetric specialist called in by a family doctor.

Specialist Care

Certain other forms of specialist care may also be provided by Local Authorities. They may hold specialist maternity clinics; part-time specialists may be attached to public health hospitals and sometimes be in attendance at out-patient clinics. But in general other arrangements have to be made for specialist attention. Patients who can afford to do so can consult a specialist either in his rooms or in their own homes. In the great majority of cases, however, they are referred by a general practitioner to a voluntary hospital and there wait their turn for a consultation, a matter which usually involves long waiting in a cheerless, overcrowded out-patient department. It should be noted that medical benefit under the National Health Insurance scheme does not include specialist service. Even for those in a position to pay for consultation with a specialist there may be, except for the wealthy, difficulties in the way of their obtaining it. Specialists tend to be concentrated in the vicinity of the teaching hospitals, of which there are less than twenty in the whole country, and they are in consequence very unevenly distributed. As a result it may be necessary to travel long distances for a consultation, which apart from inconvenience may add materially to the expense.

A similar uneven distribution is seen in the case of general practitioners, who naturally enough prefer to practise in residential areas with cultural and other amenities rather than in industrial districts, where fees perforce must be low and where more patients must be dealt with to secure a reasonable income. Some parts of the country are therefore relatively over-doctored and others under-doctored. The Government's proposals to remedy this maldistribution have encountered some of the strongest opposition from some sections of the profession.

Maldistribution

While it is true that medical care is much more freely available to the community as a whole than it was at the beginning of the century, it is still far from the case that all people in all parts of the country and at all times can secure without delay all the care which may be essential. As the late Government's White Paper on a National Health Service expressed it: "Whether people can do so depends too much upon circum-

stance, upon where they happen to live or work, to what group (e.g. of age, or vocation) they happen to belong, or what happens to be the matter with them. Nor is the care of health yet wholly divorced from ability to pay for it . . . there is not yet, in short, a comprehensive cover for health provided for all people alike."

The present provision of medical care in fact is a conglomeration of different services administered by a number of different agencies with imperfect coordination and co-operation, and exhibiting in consequence considerable overlapping, numerous gaps and many anomalies. It is a patchwork without any discernible pattern. Since it is now generally accepted that the health of the individual is not a matter which concerns him only but which is of consequence to the community, it is also generally accepted that no circumstance of income, occupation, place of residence or type of physical or mental disability should stand between the individual and all the medical attention which he may need. To achieve this aim it is necessary that the medical services must be comprehensive, free of charge and integrated. It is such a service which the Government's National Health Service Bill hopes to introduce. The Bill, it should be noted, applies to England and Wales: a similar Bill to deal with Scotland is to be introduced later.

Three-way Service

Structurally the service will fall into three main divisions: (a) hospital and specialist services; (b) personal medical and dental practitioner services; and (c) supplementary services such as midwifery, maternity and child welfare and home nursing. Responsibility for the health of schoolch ildren was laid upon cou nty and county borough councils by the Education Act, 1944. Spectacles, dentures, surgical and other appliances will be provided. The service will be free to all who choose to make use of it in the sense that no specific charge will be made; but part of the contributions to be made under the new National Insurance Scheme will be earmarked towards financing the service, the greater part of the remaining cost being borne by the Exchequer, and a small part by the Local Authorities. The total annual cost in the early years is estimated to be £152 million. A charge will be made for replacement of spectacles and other appliances broken through negligence and for such articles of higher cost than those normally supplied; and for such amenities as private rooms in hospitals.

In order that hospital resources may be fully utilized and that hospitals may be so planned as to meet all the need for their services, they are to be nationalized and thus become the direct responsibility of the Ministry of Health. Hospitals include mental hospitals and residential institutions for the mentally defective. Similar responsibility is to be assumed for all specialist services associated with the hospitals, the advice and services of specialists being available to general practitioners both at the Health Centres to be provided by county and county borough councils and in patients' homes. The actual administration of the hospital and specialist service will be entrusted to Regional Hospital Boards. There will be sixteen to twenty of these Regions, each based upon a university medical school. The administration of the teaching hospitals will be in the hands of Boards of Governors, who will be outside the jurisdiction of the Regional Boards and thus retain a large degree of independence.

Pro and Con

There has naturally been a considerable amount of heart-burning on the part of Local Authorities that their hospitals, upon which they had spent a great deal of money and in which they had effected material improvements in recent years, should now be lost to them, although the consequent saving of locally-raised money (about £25 million annually) will no doubt act as a compensatory factor. There has been much opposition on the part of the governing bodies of voluntary

hospitals, sometimes expressed in rather extravagant language. They have made much play about the drying up of the charitable impulse which will ensue; declare that freedom of experiment and research will disappear; and suggest that there is a tie of association between the voluntary hospital and its local community which in fact is somewhat tenuous. Managers of voluntary hospitals and the medical profession generally for some time have advocated some form of regional administration, but not under any form of public control.

The Government's argument is that public need is the criterion by which the method of hospital organization must be judged, and that if this need is best met by single responsibility, large-scale planning and improvements which can only be secured by the expenditure of public money, all other considerations must be sacrificed. But central responsibility is not to mean centralized administration. This is to be entrusted to the Hospital Board, so far as each Region is concerned, and within the Region to local Hospital Management Committees; one for each hospital or related group of hospitals. Within the scope of the Minister's general regulations and any particular directions which he may give, the Regional Board will have considerable freedom to plan and carry out planning for a co-ordinated hospital and specialist service in its area. The Hospital Management Committee will be concerned with the running of its hospital and will appoint its nursing and other general staff.

Boards and Councils

The Regional Boards will be appointed by the Minister after consultation with the university, with organizations representative of the medical profession, with Local Authorities, with such other organizations as appear to the Minister to be concerned, and (so far as the original members of the Board are concerned) with organizations representative of voluntary hospitals. The Minister is not, therefore, committed to appoint members of Local Authorities; nor is the Regional Board, in its turn, obliged to do more than consult the Local Authorities when appointing Hospital Committees, even though they have been hospital owners. Local Authorities in consequence have urged that they shall be guaranteed a definite proportion of representation on both the Boards and the Hospital Committees.

Arrangements for personal medical and dental care and for the supply of drugs, medicines and appliances are to be in the hands of Executive Councils, to be established in the area of each county and county borough council. Half of the members of each Executive Council are to be appointed through the representative committees of local doctors, dentists and chemists, one-third by the Local Authority and the remainder, together with the Chairman, by the Minister. Doctors wishing to take part in the new service will be in contract with the local Executive Council, and members of the public will be free to choose their own doctors, who will not be debarred from engaging also in private practice for fees. Payment for the public service will be on fixed part-salary and capitation fees: the latter will be graduated so as to diminish in scale as the number of patients rises, thus tending to check the temptation to have an excessive number of patients.

Health Centres

Doctors will be free to practise, as now, in their own surgeries, or in the Health Centres which it will be the duty of the Local Authorities to provide, equip and staff, and which will be used also for the various clinic services of the Local Authorities and which may be used as out-patient departments, associated with the hospitals. Support for the conception of the Health Centre has been steadily growing and is now widespread. The Centre will provide the opportunity for general practitioners to work together in small teams and to have available all necessary equipment and clerical assistance. They will be brought into much

closer contact with the Local Authorities' medical and other staff, to the gain of both sides and to their patients, since the general practitioner has usually known very little of the medical services which are publicly provided. Association with other doctors will, as the Minister of Health recently observed, do much to break down the professional and intellectual isolation in which the family doctor has tended to exist, in conducting his practice in and from his own home. The Executive Councils will provide the means whereby the functions of the family doctor and of the Local Authority can be demarcated and in consequence a great degree of local integration should be achieved.

Improving Distribution

Two expedients are to be employed to secure a better distribution of general practitioners. The first seeks to attract doctors to less popular districts by offering a higher fixed part-salary. The second requires a doctor who wishes to join the public service after a certain date or who, being already in it, wishes to practise elsewhere, to obtain the consent of a new body to be called the Medical Practices Committee, which will be entitled to withhold consent only on the grounds that the area in question is already adequately served. The Medical Practices Committee will be appointed by the Minister after consultation with bodies representative of the medical profession. Of its membership of nine, seven (including the Chairman) will be doctors, five being in active practice. The so-called "direction" will, therefore, be in the hands of a body of persons whose composition suggests that they will be unlikely to exercise their powers harshly. Since doctors may be prevented from taking up practices in an area which is sufficiently doctored, the owners of such practices would be unable to sell them. To prevent inequity, therefore, the sale of all such practices is to be prohibited, and owners are to be compensated for the loss.

The arrangements for a public dental service will ultimately be similar to those to be made for the family doctor service. Until there are sufficient dentists to make this possible, however, priority will be given to expectant mothers and young people through the Local Authority's maternity and child welfare and school health services.

Rates of remuneration for doctors and dentists have not yet been fixed.

The councils of counties and county boroughs are to be responsible for those parts of the service which can be efficiently administered in areas smaller than those required for the hospital and specialist services. Certain permissive functions are to be obligatory, and some powers and duties are to be extended. Local Authorities are to provide clinics for expectant and nursing mothers and for children under school age, and to supply cod-liver oil, fruit juices and other supplements to diet. They are to secure an adequate midwifery service, either by employing their own staff or by entering into arrangements with voluntary organizations. A general practitioner working in the public service need not undertake to attend women in confinement but midwives will continue to have the duty of calling in a doctor if the need arises. The present power to provide a health visitor service for mothers and children will be converted into a duty and expanded so as to include visitation of all sick persons. Home nursing for those in need of it must also be provided. Local Authorities are to be given a new power, and duty if the Minister so orders, to make arrangements for the prevention of illness and care of the sick by way of the provision of special foods, blankets and extra comforts. A charge may be made. The wartime extension of powers to provide domestic help in the homes of expectant and nursing mothers so as to include other cases of need is to be made permanent: here again a charge may be made.

Committees

Local Authorities will be required to appoint Health Committees, to which the exercise of all the council's functions may be delegated and on to which suitable persons who are not members of the council may be co-opted.

The Minister is to be given power to act in default of any Local Authority or other body constituted by the Bill, if after the issue of a specific directing order he is not satisfied with the manner in which the functions are being undertaken.

Although the Minister will have the responsibility of promoting the physical and mental health of the nation, he will be assisted by certain advisory bodies. Of these, the most important will be the Central Health Services Council, consisting of doctors and other health workers, and of people with experience in local government, mental health and hospital management, appointed by the Minister after consultation with the appropriate representative bodies; the senior officers of the six principal medical bodies serving ex officio. Of the forty-one members, only five are to be persons with local government experience, which appears to be too small a proportion. The Council is to be free to advise the Minister on its own initiative: it will make an annual report to him, which he will be required to lay before Parliament. In addition to this body, various standing Advisory Committees on especial technical aspects of the service (e.g. mental health) are to be constituted.

Criticism

The Council of the British Medical Association, while being in favour of a complete health service, is opposed to certain aspects of the Government's scheme. They object to the direction of doctors, to their payment on a part-salary basis, and to the abolition of the sale of practices, on the grounds that these ultimately will convert doctors into civil servants, with a consequent and harmful change in the relations between doctor and patient. They consider that the taking over of all hospitals by the State will cause a loss of local interest and discouragement of financial and other support, while welcoming the proposal to plan all hospitals over a natural hospital region, provided the Boards are properly constituted. This last is an important issue; and it is reassuring that the Minister has stated that the criterion for membership will be personal ability and experience rather than representation of particular interests. It is also reassuring that Boards and Hospital Management Committees are to have complete financial freedom within the limits of their annual budgets and that the Hospital Committees will have the greatest possible degree of independence that is practicable within the regional framework. If these assurances are fulfilled, there will be preserved scope for initiative and exercise of free responsibility together with the planning which is essential if satisfactory hospital and specialist services are to be made available.

A further and more weighty criticism made by the British Medical Association is one which has been advanced from other quarters. This is directed against the division of administrative and medical responsibility between Regional Boards, Local Executive Councils and Local Authorities. As between the second and third, this division is not of material consequence, since both bodies will operate over relatively small—in some cases, very small—areas, and association in practice is bound to be close. But as between the first and the other two, the division is more clear-cut, and coordination may be difficult to achieve. The Royal College of Obstetricians and Gynaecologists, for instance, has voiced its protest against the failure to introduce a unified maternity service, point-out that an expectant mother may be successively in the care of a Local Authority doctor, a general practitioner and a hospital medical officer. There can be no doubt that the degree of integration in the Government's plan will fall far short of what is desirable, although

intelligent and willing co-operation should be capable of minimizing the consequences of division. Yet in view of the unsatisfactory structure of local government, it is difficult to suggest what other arrangements the Minister could have devised. The areas of many Local Authorities are far too small for them to be capable of providing effective hospital and specialist services. But since these services are a vital element in medical care, the creation of areas which are suitable is essential, even though they may be different from and larger than those of the great majority of Local Authorities and under different administration. Is there, however, any reason why these new administrative bodies should not be responsible for the health service as a whole, and thus the splitting of responsibility be avoided? The object tion to such an arrangement is that it could take away from Local Authorities those parts of the service which they are well capable of providing, and thus add to the resentment they already feel at the loss of their hospitals. They would oppose such an arrangement unless they alone constituted the administrative bodies; the doctors and the voluntary hospitals, for their part, would raise strong objection to any constitution other than that proposed in the Bill. Nevertheless, the efficiency of the service should be the principal consideration, and there can be little doubt that this could be best secured if the service were integrated under single direction and responsibility. There does not, however, seem to be any overriding reason why the hospital region should not be a good deal smaller than is proposed in the Bill and yet large enough to fulfil its purpose. Were it smaller, and were the Local Authorities represented on the directing body to an extent greater than it appears is proposed to be the case in regard to the Regional Boards, two major objections to the scheme as it is at present would disappear. Not only would integration be secured: local interest in the health service would tend to be greater. It is clearly important to develop some sense of ultimate public responsibility for and control over public services rather than to have a mere passive acceptance of what is provided.

It is very unlikely, however, that the Bill will be altered except in detail in its passage through Parliament. Nevertheless, it represents an extremely important development in the British social services. The year 1948 will be notable not only as the centenary of the first Public Health Act, but for the inauguration of a system of medical care which should raise materially the nation's at present far from satisfactory standard of physical efficiency, with all the beneficial consequences that will result to the national well-being.

The Effect of The War on Canadian Schools

By A. S. Mowat

THE immediate effect of the war upon education in Canadian schools has been like the curate's egg, good in parts, and may be summed up in the phrase "streamlined administration, increased expenditure and decline in quality." The decline in quality was inevitable in a period of stress and strain when for the time it became more vital to ensure the preservation of our present liberties than to prepare our young people for a way of life whose very existence was in jeopardy. It is true that attempts were made by raising salaries and other means to attract more and better entrants to the teaching profession and by "freezing" teachers in their jobs to retain what quality we had. But the attempts were made too late to arrest what has now become the most serious ill-effect of the

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