King Edward's Hospital Fund for London

MEMORANDUM

ON

NATIONAL HEALTH SERVICE

10 OLD JEWRY,
E.C.2.

July, 1944.

H1BG

INDEX.

NATIONAL HEALTH SERVICE

Memorandum

To be read in conjunction with STATEMENT OF PRINCIPLES

1. In order to appreciate at their true value the views expressed in the Statement of Principles, it is necessary to examine much more fully some of the matters to which reference is made.

THE OBJECTIVES OF THE WHITE PAPER AFFECTING THE HOSPITAL SERVICES

2. The White Paper states:

> "When a hospital's services are needed, it is far from true that everyone can get all that is required. Here it is not so much a question of people not being eligible to get the services which they need, as a matter of the practical distribution of those services. The hospital and specialist services have grown up without a national or even an area plan. In one area there may be already established a variety of hospitals. Another area, although the need is there, may be sparsely served. One hospital may have a long waiting list and be refusing admission to cases which another hospital not far away could suitably accommodate and treat at once. There is undue pressure in some areas on the hospital out-patient departments—in spite of certain experiments which some of the hospitals have tried (and which should be encouraged) in arranging a system of timed appointments to obviate long waiting. Moreover, even though most people have access to a hospital of some kind, it is not necessarily access to the right hospital. The tendency in the modern development of medicine and surgery is towards specialist centres—for radiotherapy and neurosis, for example—and no one hospital can be equally equipped and developed to suit all needs, or to specialise equally in all subjects. The time has come when the hospital services have to be thought of, and planned, as a wider whole, and the object has to be that each case should be referred not to one single hospital which happens to be 'local' but to whatever hospital concentrates specially on that kind of case and can offer it the most up-to-date technique."

3. While there is a measure of truth in this summary of the deficiencies of the present system and the need for planning of hospital services on a wider basis is clear, it is none the less as it stands an inadequate analysis upon which to build a new system. If the new structure is not to repeat the errors of the past, it must be based upon a clear realisation of the causes which have led to the present deficiencies.

4. Broadly it may be stated :

(*a*) that the voluntary system, which is to-day the backbone of the hospital service, has in general provided services where they are most needed and most readily accessible—the legitimate criticism which may be made is that in certain areas, mainly such industrial areas as those on the outskirts of London, and in some of the more remote parts of the country, voluntary effort unhelped by public funds has been unable to keep abreast of the increasing costs of hospital provision on a scale sufficient to meet the public need ;

(*b*) that the supplementary provision made by the local authorities under the Poor Law prior to 1929, and since 1929 under the Public Health provisions of the Act of that year, has been hampered by several factors, not least by reluctance on the part of the rating authorities in some areas to incur the necessary expenditure : and that this reluctance has been most marked in just those areas where the provision of improved or additional accommodation has been most necessary. The principle of accountability to the public through the local government machinery has so far proved disappointing and with certain exceptions it has not sufficed to secure the general improvement of services which are well known to be deficient in many respects.

No new system which does not take adequate account of this fundamental defect is likely to secure a first-class hospital system.*

5. These are the main factors in the present deficiency, of which the new system must take full account. Had the reasons for the defects in the present system outlined in para. 4 above been indicated in the White Paper it is more than doubtful whether the statement that " there is no case for departing from the principle of local responsibility coupled with enough central direction to obtain a coherent and consistent national service " could have been made without qualification. If the principle of local responsibility is not to perpetuate the present defects, its defects must be freely and clearly stated by the Government, and full weight given to them in the framing of the proposals for the new service.

6. It is a mistake to confuse the issue by bringing into the picture such other matters as waiting lists and pressure on out-patient departments. They raise a question of principle of quite a different character, and one which certainly deserves full and thorough consideration.

* *See* Mr. Norman Wilson's review of the erratic provision of personal health services by the local authorities ; Public Health Services (1938), *e.g.* :

Page 151.—" Judged by a commonly accepted standard, all local authorities fall short in one respect or other, and as between one authority and another exhibit an astonishing range of variation. This may be due to several reasons : to financial inability to provide properly the services they consider necessary, to a genuine but unwarranted belief in that inability to do so, or to a lack of desire to provide anything beyond bare essentials. Whatever the reason, the point that calls for urgent consideration is whether the care of the public health should, in view of its vital importance, be subject to the financial capabilities of local authorities to undertake their responsibilities and their conception of the manner in which their powers should be exercised."

Page 200.—" Some of the obstacles which stand in the way of the attainment of a uniform provision of health services (that is, services in each area adequate to the needs of that area) have been discussed : financial incapacity and the ignorance, indifference, and hostility of local authorities and the public are the chief."

It may, however, be noted in passing that so long as there is progress in medicine and freedom of choice accorded to the patient, so long will there be pressure upon those centres where the best advice and treatment are to be obtained, and so long will some hospitals be more popular than others ; but it must be remembered that the reputation of a hospital does not depend solely on the scientific attainments of its medical staff. The quality of the nursing, the efficiency of the administration and last, but by no means least, the permeation throughout all departments of sympathetic consideration for the patients all play their part and help to explain why some hospitals have long waiting lists and crowded out-patient departments, while others have empty beds and in comparison relatively few out-patients.

7. Much can no doubt be done by the provision of additional and better facilities to secure an improved distribution of patients and by a more elastic system to reduce to reasonable proportions excessive waiting lists ; but this is a complicated question calling for much patient investigation if the principle of freedom of choice is to remain inviolate with all that it implies for the future standard of medical work.

8. The increasing tendency to specialisation, to which reference is also made in the latter sentences of the paragraph quoted from the White Paper in para. 2 above, is also, to some extent at least, a separate question. It is quite true that this tendency demands a closer collaboration between different hospitals than has usually prevailed hitherto, but the means by which proper reference can be secured will require much detailed consideration. Specialisation is essential, but it must not be over assertive. The present tendency to divide medicine into a number of isolated compartments must be critically considered. The various parts and systems of the human body are connected with one another; they are not separate entities and symptoms arising in one part may be due to or associated with disease in another. Medicine like the individual must be considered as a whole, and undue systematic segregation of patients according to their various diseases and conditions is to be avoided.

9. These latter questions, however—control of waiting lists, avoidance of undue pressure on out-patient departments, and the need to make provision for increasing specialisation—are rather examples of the kind of question with which those responsible for the hospital service are likely to be concerned than a justification for the proposals made in the White Paper.

CENTRAL HOSPITALS BOARD

10. It is to meet the real and practical difficulties described in para. 4 that the Central Hospitals Board is needed. The need springs from the great variety and inequality of the hospital services : there are now, and there will continue to be, wide differences between the level of efficiency of the hospital services in different areas. The great and fundamental danger is that a particular institution or whole group of institutions may become isolated from the stream of progress : that it may become stagnant and obsolescent and at the same time self-satisfied. This is true both of voluntary and of local authority hospitals, and its

truth has been brought home to many observers as a result of the upheaval caused by the war. It is one of the primary objects of the new service to establish machinery which will minimise its existence in the future. The Central Hospitals Board must, therefore, be a body that can accept something far more than a merely advisory responsibility : it must be given the scope and the machinery to enable it to exert a direct influence upon the progress both of voluntary and local authority hospital services, and to raise the standard of hospital provision wherever necessary.

11. This conception differs in many essential respects from that of the Central Health Services Council. This Council as outlined in the White Paper would be a body of about 30 or 40 members, representing all branches of medical work, and its function " to express the expert view on any general technical aspect of the service," in other words, to voice professional opinion. It is presumably intended that there would be a Hospitals Sub-committee concerned with the hospital services and discharging a similar function.

12. This is not enough, for while it is important that the Minister should have the advice of expert opinion, the true object of the creation of the new body should be to provide the country with something at present lacking, viz., effective machinery for the discovery of deficiencies, and to provide an authoritative body competent to indicate the means by which those deficiencies can be overcome, with a watching brief to ensure that the remedies are adopted.

13. It follows, therefore, that the proposed Central Hospitals Board would differ radically from a Hospitals Sub-committee of the Central Health Services Council, *e.g.* :

(i) its function would not be limited to the expression of expert opinion on the general technical aspects of the service : it would be concerned with concrete and administrative questions, and often with the development of services in a particular locality ;

(ii) It would have important financial functions, advising the Minister upon the basis on which payments should be made both to voluntary hospitals and to local authorities in respect of their hospitals : and it would thereby influence the development of the hospital services ;

(iii) it would need to be a small, compact, and to some extent at least a whole-time body of men ; but they should be appointed for a limited period only, say, five years ;

(iv) it would need to be closely identified with the work of the inspectorate.

14. The success of the whole plan and the quality of the future hospital service will largely depend upon the manner in which the conception is developed and handled. If the central advisory machinery is large, clumsy, and ill-adapted to its purpose, and if, moreover,

it is expected to function independently of the system of inspection, it will not be long before it is discarded and the system of inspection becomes a matter of departmental routine.

15. Experience proves this. When the Ministry of Health was established in 1919, provision was made for creating several new permanent bodies to give advice; four such Councils were established; three of the Councils issued Reports in 1920 and 1921, one of which anticipated by twenty years almost all the reforms recently put forward by the Medical Planning Commission; but after the latter year only one of them "did work of any importance," viz., that on National Health Insurance.* If, on the other hand, a compact and well-informed Central Hospitals Board is created, if its members are rightly chosen, and if it is made responsible under the Minister for the appointment and work of the inspectorate, and some of the inspectors are themselves members of the Board, then there will be a good prospect of success. It is essential that those who comprise the Hospital Board should possess among themselves direct personal knowledge of the problems upon which they are called to offer advice, and that whether paid or unpaid they should have adequate time at their disposal to obtain first-hand information by visiting the hospitals in question when necessary or desirable. The Board should, of course, be representative in the wide sense, *i.e.*, it should embrace persons with experience of both types of hospital service: and it should include medical men who are or have recently been actively engaged in hospital practice, and laymen of wide experience in active hospital management.

16. It is essential that at the centre there should be an impartial knowledgeable body of men whose primary concern is the welfare of the hospital services. These services are not a small side issue and the possibility that the decisions affecting the hospital services might be frustrated by a large body representing so many diverse interests as would be represented on the Central Health Services Council cannot be contemplated.

17. It is clear that the inspectorate would have an important part to play, and that from their reports would be derived much of the material that would come before the Regional Councils and the Central Hospitals Board. The responsibility for the work of the inspectorate should rest with the Central Hospitals Board and reports should be sent to the various Regional Councils who would forward them to the Central Hospitals Board. It is to be hoped that the Minister will agree that the term "Commissioner" or "Visitor" would be preferable, and would afford a better indication of their functions. These inspectors or commissioners should be nominated by the Central Hospitals Board and one commissioner for each region should be a member of the Board on the analogy of the practice of the University Grants Committee in its visits to Universities. The procedure with regard to the visits made to hospitals by the Commissioners would need to be carefully considered, and the experience of the King's Fund in this connection might be of value.

* For further details *see* Lord Donoughmore's speech in the House of Lords on March 21—*Hansard*, Vol. 131, No. 33, cols. 145–51.

18. These observations are indeed largely based on the experience of the King's Fund which has for many years to some extent, and within the limitations imposed by its constitution, acted as a central body for the voluntary hospitals of the Metropolitan area. The system of Visitors, inaugurated by the Fund as long ago as 1898, and the various other measures taken by the Fund, have assisted materially to raise the standard of the individual voluntary hospitals in London. The interchange of information and pooling of ideas thus made possible has broken down to a large extent the isolation of the individual unit while leaving to it freedom and initiative. The experience points the way to the wider application of the principles which have been embodied in the suggestions for a Central Hospitals Board.

RELATION OF CENTRAL HOSPITALS BOARD TO OTHER HEALTH SERVICES

19. Such a body as is needed could not be merely a Sub-committee of the Central Health Services Council: it would be more closely analogous to the Central Medical Board. Machinery would, of course, require to be devised to ensure close contact between the Central Hospitals Board and the various other health and ancillary services. It is too soon to say whether this purpose would best be achieved by the retention within the plan of a Central Health Services Council, itself comprising representation from the Central Hospitals Board and the Central Medical Board besides representation of other interests, and this is a question which should receive detailed consideration.

20. The very limited representation that such ancillary interests as Nursing or Midwifery could be accorded upon a Central Health Services Council would be quite inadequate to do justice to their claims, unless the whole Council were to be made so large as to deprive its decisions of any real value. So far as the hospital services are concerned it is apparent that an adequate liaison would much more readily be achieved by providing an appropriate series of Sub-committees attached to the Central Hospitals Board, and this would appear to be the proper course.

REGIONAL ORGANISATION: THE NEED FOR EXTENSION OF UNIVERSITY INFLUENCE

21. The Medical Sub-committee of the Co-ordination Committee of the King's Fund and the Voluntary Hospitals Committee for London came to the conclusion that to ensure the success of the new hospital service two things are essential—(*a*) the number of consultants must be greatly increased, and (*b*) the influence of the Universities and their Teaching Hospitals must be so developed that it will extend to all hospitals within their reach.

22. The need for more consultants is widely recognised. Their provision is already under the consideration of responsible bodies, and this, together with such matters as terms of service and conditions of work, need not be discussed here as it is outside the scope of this memorandum. It is beyond question that improvement in the general standard of work done in hospitals throughout the country will depend very largely upon the establishment of

machinery which will extend the influence of the centres of progressive thought to all hospitals both voluntary and local authority.

23. Variations in efficiency among hospitals in the same category must be accepted as inevitable. Stagnation and lack of progress in one hospital or another may be due to many causes, and hitherto it has been generally true that, with exceptions, the quality of medical work falls off with distance from a teaching school centre. Real and lasting improvement cannot be ensured by the simple expedient of providing commissioners or inspectors, and the problem lies in discovering the most effective way of raising the standard of the least efficient and thus diminishing the gap that lies between them and the best hospitals in their category.

24. This has been the subject of careful consideration by the Sub-committee. In their Second Interim Report they discuss the various ways in which the influence of the University Teaching Hospitals may be extended to other hospitals, particularly through their staff, both visiting and resident. They reached the unanimous conclusion that division of the country into a large number of isolated independent hospital areas would be fatal to progress. They are convinced that the areas must be grouped together into some 12 regions for England and Wales and that each region should be based wherever possible on a University centre.

THE NEED FOR NEW MACHINERY, REGIONALLY AND LOCALLY

25. Some form of regional organisation should therefore be established, the main object of which would be to co-ordinate the planning of hospital resources of the region, and to afford machinery whereby both voluntary and local authority interests might participate on an equal footing. In the Statement of Principles it is suggested that this should take the form of a Regional Hospitals Council. Attached to each Regional Hospitals Council there should be a Medical Advisory Committee which would be concerned, *inter alia*, with the medical staffing of the hospitals throughout the region.

26. Since, however, the region would be large and would include widely separated populous areas with their own strong local feeling, the establishment of a Regional Hospitals Council would not dispense with the need for Local Hospitals Councils. These should also be adequately representative of both voluntary and local authority interests. In this respect the plan would follow closely the lines already laid down by the Nuffield Trust, the difference being that these new bodies, both regional and local, would be given statutory duties, and that upon them would rest a definite responsibility with regard to the planning of the hospital services.

27. In considering the precise form which the organisation of the regional body should take and its relation to the different localities included within the region, care must be taken to reconcile two factors, both of which are important :

(*a*) on the one hand it is obviously desirable to avoid complicated and cumbersome arrangements involving a multiplicity of different bodies ;

(*b*) on the other hand, it is important that full weight should be given to the need of bringing together at each level round a common table the voluntary and local authority personnel.

28. Arrangements on these lines will involve a re-definition of the responsibility of the local authorities for the hospital services. It could, however, be laid down that where it appears to any local authority that the services provided by the scheme approved by the Regional Council are inadequate to the needs of the population, the local authority should have the right to appeal to the Minister. The Minister would then have power after consultation with the Central Hospitals Board and the Regional Council concerned to require a modification of the plan.

PAST LACK OF MUTUAL CONFIDENCE

29. An obligation laid upon a " joint authority " to consult with a body representative of the voluntary hospitals would by itself fail altogether to achieve this object, and would but perpetuate the failures of the past. Section 13 of the Local Government Act of 1929 provided that :

> " The council of every county and county borough shall, when making provision for hospital accommodation in discharge of the functions transferred to them under this Part of this Act, consult such committee or other body as they consider to represent both the governing bodies and the medical and surgical staffs of the voluntary hospitals providing services in or for the benefit of the county or county borough as to the accommodation to be provided and as to the purposes for which it is to be used."

The almost total failure of this effort to achieve a common mind was mainly due to the following factors :—

(*a*) the natural tendency on the part of the local authorities to work out their own proposals to a detailed stage before offering the voluntary hospitals an opportunity to comment or to make positive suggestions, and the absence of any real consultation such as can only be secured by meeting representatives of the voluntary hospitals in a common body. Bearing in mind the internal machinery of the local authorities and the multiplicity of considerations that must be taken into account, this is in no way surprising ; but whatever arrangements may be made for the future this tendency cannot be overlooked, and it is essential for the success of the service that provision shall be made which will ensure genuine consultation at every stage ;

(*b*) a wish on the part of the voluntary hospitals to retain their own position and secure their own future.

30. The voluntary hospitals must therefore be given solid ground for confidence with regard to their future, so that their representatives can sit down with the representatives of

the local authorities free from the sense that it is within the power of the local authorities if they wish so to develop their own services as to lead to the ultimate supercession of the voluntary hospitals. There will remain a natural and desirable sense of rivalry; what is important is that this rivalry should be friendly and devoid of mistrust. If the right arrangements are made at the start it should be possible to secure that it will be clearly seen by all to be in the interest of the area to encourage wholeheartedly the development of the voluntary hospitals within it.

31. In practice, however, it may be anticipated that if once the right relations are established between the voluntary hospitals and the local authorities and their representatives meet regularly in common bodies charged with definite duties for the hospital services, there will gradually develop a sense of understanding and co-operation. Without the right relationship at the start, the ideal "partnership" upon which stress has been laid by successive Ministers of Health may prove elusive.

FINANCE

32. Speaking in the Debate on the Cancer Bill in the House of Commons on December 12, 1938 (*Hansard*, col. 1668), Mr. Herbert Morrison said:

> "... it is a pity that local authority rates are being involved in grants to voluntary hospitals. The London County Council, for which I speak in this respect, would prefer that the Minister should make his own financial arrangements with the voluntary hospitals. This interlock between the local authority and the voluntary hospitals is embarrassing and is becoming difficult. I in no way wish the voluntary hospitals to pass; they have been doing a great work in London and elsewhere, but we shall be involved in very serious considerations if they should break. I do not want them to break, but it is better in financial matters that they should be dealt with by the State rather than by the local authorities.
>
> "If we continue to slide as we are doing we shall have such an interlock between the voluntary hospitals and municipal finance that the complications will be very serious. I am apprehensive that one of these days the voluntary hospitals may be landed, against their own will, into local politics and local electoral considerations. It will be a pity if the experience which local education authorities have had in regard to the vexed question of non-provided schools should be repeated in the case of voluntary hospitals .... One of the great problems of bringing public money into voluntary funds as a supplementary source of income is to do so without at the same time drying up the sources of voluntary effort and subscription. That is one of the points on which I am apprehensive regarding the rates being behind voluntary hospitals to a rather indefinite and elastic extent—not because I wish in any way to hurt the voluntary hospitals, but because of the fact that when public money comes into a service which was previously maintained by voluntary effort

there is a tendency for the hitherto voluntary subscriber to say 'I am paying through the rates and I need not pay by voluntary subscription any more.' We want the public to supplement the voluntary money and not replace it . . . ."

The King's Fund agrees with this view. An appropriate administrative structure will secure the necessary link between the voluntary and the publicly provided services and eliminate the need for contractual payments by the joint authorities. There can be no partnership if one party is put into the position of paymaster to the other, and any system which involves substantial payments by or *via* the local authorities to the voluntary hospitals will destroy the sense of security on the part of the voluntary hospitals which is essential for the effective implementation of the new scheme.

33. Serious exception can also be taken to a system of local contractual payments on the ground that such a system would of necessity restrict the patients' free choice of hospital. It is understood that it is not the Government's intention to restrict this free choice. One has only to picture the network of contracts that would be necessary to provide for the large proportion of patients from the rest of the country seeking treatment in London hospitals to appreciate the kind of problem involved. It would indeed be impracticable to arrange such a network to cover a case referred to London from the remote rural area. The reciprocal arrangements made by contributory schemes may appear to be analogous, but they are based upon an entirely different principle. In their case payment follows the patients; under the proposed local contractual arrangements this would be impossible, as the contract would be in respect of beds or other facilities provided for patients within the area, and no local authority would be willing to pay for beds for the use of persons from an area of another authority.

34. It would indeed be unfortunate if there were now to be introduced into the voluntary hospitals a system involving questions of domicile and chargeability as between one authority and another. This is a defect which, since Elizabethan times, has hampered the administration of poor relief in England. Rather it should be one of the primary objects of the new service to eliminate the features of this system which still attach to the local authority hospital services.

EXCHEQUER PAYMENT

35. In the Statement of Principles it is recommended in connection with the payment from the Exchequer (i) that it will be necessary to take fully into account the continual rise in hospital expenditure; and (ii) that the method of the University Grants Committee affords an analogy of the method which should be adopted.

INCREASE IN HOSPITAL EXPENDITURE

36. The following figures for hospitals on the books of the King's Fund afford some guide to the increase in hospital expenditure:—

BEDS, PATIENTS AND MAINTENANCE EXPENDITURE

Year.	No. of Hospitals.	Bed Complement.	No. of Beds Occupied.	No. of New In-patients	No. of New Out-patients.	Total Maintenance Expenditure.
						£
1921	145	13,300	11,070	172,200	1,545,000	2,929,000
1931	145	17,090	14,180	256,100	1,805,000	3,764,000
1938	146	18,857	15,518	294,400	2,017,000	4,832,000

It may be anticipated that the post-war comparable expenditure—excluding provision for the more extensive payment of medical staff, but including the increased salaries of the nursing staff as a result of the recommendations of the Rushcliffe Committee—will fall not far short of an increase of 50 per cent. over the 1938 figure.

INCOME FROM PATIENTS' PAYMENTS AND CONTRIBUTORY SCHEMES

37. The following figures will afford some guide to the increase in income from these sources :—

PATIENTS' PAYMENTS AND CONTRIBUTORY SCHEMES

Year.	No. of Hospitals.	Patients' Payments.	Contributory Schemes.	Total.
		£	£	£
1921	145	Separate figures not available		507,000
1931	145			1,101,000
1938	146			1,184,000
1939	146			1,380,000
1942	169	821,000	666,000	1,487,000

38. Past experience proves that the income from these sources, particularly contributory schemes, would have continued to expand materially after the present war. More and more patients were contributing ; the individual amounts were on the increase ; and contributory schemes possess the essential flexibility to admit of increases in the amount of the weekly contributions. Thus, for example, the Hospital Saving Association has quite recently decided upon an increase from 3*d.* to 4*d.* in the weekly contribution, which on the basis of last year's membership of 2,000,000 will result in increasing the annual income by some £400,000 per annum.

39. Under the proposals of the White Paper the insurance element in the contributory schemes would disappear, and the Minister has stated that the need for a source of revenue

which would make good this loss is the basis of the proposal for a new Exchequer grant of £10 million a year to the voluntary hospitals, and that " the total amount of the grant more than makes up for any losses which the voluntary hospitals may suffer under this head." There are many supporters of the voluntary hospitals who attach great importance to the preservation of the contributory schemes movement and deeply regret the omission of all reference to it in the White Paper. The amount contributed by the patients direct and through the contributory schemes is very large, and for this the Government proposes to substitute a cash payment derived from taxation and from the social security fund. The contributory schemes to-day cover, through the system of weekly contributions, some twenty million persons, and the hospitals have the support and interest of many millions of patients who have made their contributions and appreciate deeply the help that they have received from the hospitals. No tax or other monetary payment can replace this incalculably valuable moral asset.

40. If the decision of the Government that hospital services should be open to all without payment is irrevocable great care will be necessary in defining clearly the grounds upon which appeals can legitimately be made. The voluntary hospitals must not be debarred from appealing to the public for support, and patients and potential patients are naturally among those to whom the appeal must be directed. It is important not to lose sight of the distinction between the position of the voluntary hospitals and the publicly provided hospitals; the voluntary hospitals have always been " free " in the sense that no patient is refused treatment on account of lack of means, and patients' contributions have been voluntary. The position is entirely different from that of the publicly provided hospital which, with the exception of cases of infectious disease, is bound by law to seek recovery of the cost of treatment so far as the patient's means allow.

41. Moreover, no hospitals should be debarred from making provision for accommodation at a supplementary charge. There has been hitherto insufficient accommodation for those who wish for something intermediate between the ordinary ward and the private ward. If such beds were to be excluded from the scheme it would discourage the provision of this intermediate grade of accommodation and accentuate the cleavage between the ordinary and the private ward.

EXCHEQUER GRANT ON THE ANALOGY OF THE UNIVERSITY GRANTS COMMITTEE

42. In the Statement of Principles is suggested the outline of a scheme which would achieve the objects in view. It is necessary to secure a basis which, so far as maintenance is concerned, will be:

(*a*) sufficiently flexible to take account of major changes in the level of expenditure, whether caused by changes in the price-level, or by new methods and more costly treatment, or by the expansion of the amount of accommodation provided within the scheme;

(*b*) at the same time sufficiently stable to encourage rather than to stifle the initiative of the individual hospital. It is very necessary that the individual hospital should be able to calculate in advance over a reasonable period the amount of payment to which it will be entitled as a matter of right, and that there should be no question of reliance upon public monies to make up deficiency.

43. It is recommended, therefore, that the total amount of the grant should be laid down in advance for a 3- or 5-year period, and that it should rest with the Central Hospitals Board to recommend to the Minister the amount of the grant for the next following period. It would be part of its duty to collect the evidence upon which this should be based, and for the data it would look to the Regional Hospitals Councils which would in turn review the requirements of their areas: what new services required to be developed, and so forth. In this they would be greatly helped by having at their disposal the detailed reports of the Commissioners.

AMOUNT OF INITIAL PAYMENT

44. The Government have indicated a figure of £10 million. This is substantial, but it may well be found to be insufficient. It is difficult at the present stage to make an accurate estimate of the amount that will be required, but there will be general agreement that the extent of the facilities, the quality of the services and the progressive character of the work should not suffer as a result of the change. It is apparent that the developments of war time alone will, when applied to hospital equipment and procedures involve very great additions to expenditure, and that what was appropriate in 1938 will be inadequate in 1945. The emphasis must, therefore, be placed upon a formula capable of expansion to meet the changed circumstances.

45. It may be noted that if this question were to be approached on the basis of fixing the provisional payment at a figure based on the proportion which receipts from patients' payments and contributory schemes taken together bore in 1938 to the maintenance expenditure on the services involved, and if due allowance were made for the probable increase in post-war expenditure, the resultant figure would probably be somewhat in excess of £10 million.* Such a formula would still require that the voluntary hospitals undertake to raise from voluntary sources a similar proportion to that raised in 1938. In the light of the overall increase in expenditure, the high level of taxation, and the probable negative impact of the National Health Service, this would impose a severe and unwarranted strain on the voluntary hospitals.

* A rough calculation on the above basis would give the following result for the country as a whole. If £14 million is taken as the pre-war expenditure on the services likely to be included in the scheme, a 50 per cent. increase would give a post-war expenditure of £21 million. Since, in 1938, nearly £7 million was derived from patients' payments and contributory schemes, the ratio would be roughly 7 : 14, and the total payment therefore £21 million ÷ 2 = £10·5 million.

FORMULA FOR EXCHEQUER PAYMENTS

46. The distribution of the Exchequer payment should be strictly related to the services provided, or to be provided. A simple " per bed " formula is unsatisfactory. The distribution must be in accordance with a formula which would provide for variations arising through such circumstances as (i) range of services provided—*e.g.*, laboratory, deep X-ray departments, diabetic clinics, etc., etc.; (ii) the stand-by facilities, *e.g.*, casualty and other out-patient services; (iii) the standards of staffing adopted. For this purpose it would be essential that a system of grading of hospitals should be adopted, and it would be a function of the Central Hospitals Board to determine the system.* It would not be a difficult matter to prepare a simple system which might be adopted in the first instance pending modifications suggested by experience. The effect of such a system would be that the larger hospitals offering a full range of services would receive a payment of approximately double the amount " per bed " of that given to the small cottage hospital, reflecting broadly the present difference in cost between the services given.

47. It is important that, once the amount of the payment is determined, the total sum should be paid to the hospital without restrictive conditions or the need to account in detail for expenditure incurred otherwise than by the publication of duly audited accounts. The experience of the E.M.S., and generally of the publicly provided hospital service, shows the gravely hampering effect of a system which involves too close a control of expenditure from a distant headquarters.

RELATION TO INCOME FROM VOLUNTARY SOURCES

48. The formula for payment must be related solely to services and not to the income of the hospitals from other sources, such as endowments. This is fundamental unless the whole conception of payment for services is to be discarded and the way opened for a system of an altogether different character. If once the principle were to be accepted that in making payments out of public monies account should be taken of the extent of other means available to the institution concerned, whether as the result of endowments or other voluntary gifts, then the end of the voluntary system would be in sight, since the incentive to give would be removed.

49. The Exchequer payments must be clearly understood to be payments for services. It is essential to distinguish between payments for services made from public funds, of which the payments made under the Emergency Medical Scheme are an example, and receipts of a quite different category such as the grants for maintenance made by the King's Fund out of voluntary resources. Different principles apply. In the case of grants such as those made by the King's Fund, the grant is made towards the income of the institution, and it is appropriate that the income of the institution from other sources should be brought into

* It should be noted that the system of grading would need to take account not only of quantity, but of quality of work done.

account in determining the amount of the grant to the individual institution. But where the payment is for services rendered—and there is general agreement that the Exchequer payment should be on this basis—and where, moreover, it is made out of public funds, such considerations are out of place, and it is clear that if they were to be introduced the incentive to voluntary effort would disappear. It is of the utmost importance that this incentive should remain, and that the voluntary hospitals should continue to be able to raise large sums towards the work they do.

50. It follows that the amount of the Exchequer payment for services must be based upon the requirements of the great majority of the hospitals, and must be sufficient to ensure that they are able to discharge their responsibilities with such measure of voluntary support as they are able to secure; and not upon the financial position of the fortunate few that possess large endowments or other special resources.

OTHER FACTORS AFFECTING FUTURE MAINTENANCE: NEED FOR GRANTS IN RESPECT OF THE TRAINING OF NURSES AND MIDWIVES

51. It was suggested in paragraph 44 above that if the grant for the initial period were to be calculated on the lines proposed in the White Paper, a serious strain might be placed upon the hospitals; and that there might be other means of offsetting such strain. The Minister has referred to the special assistance likely to be proposed for the teaching hospitals by the Goodenough Committee; and it is appropriate to call attention to the need for an analogous system of grants in respect of the training of nurses.

52. Such a system was advocated by the Athlone Committee, and there are strong reasons why effect should be given to the recommendations. There is widespread agreement that the time has come to recognise that the quality of the training given to the student nurse should not be, as it is at present, to a great extent dependent upon the general finances of the hospital. Some notes dealing with this question as it affects both voluntary and local authority hospitals are given in the Appendix.

53. Similar considerations apply to the training of midwives: and perhaps in a lesser degree to other categories of hospital staff, *e.g.*, social workers, dietitians, etc.

54. It should also be remembered that the offer of financial assistance for special purposes is a valuable means of encouraging desirable developments, and that it might well prove to be the case that the Minister and the Central Hospitals Board would wish to have recourse to this method. Some such system might well be desirable for example in connection with research and record-keeping. It is a method which has been adopted for many years past by the King's Fund and the most recent example is that of the grants given or offered towards the establishment of groups of Preliminary Training Schools for Nurses.

CAPITAL GRANTS

55. In the Statement of Principles it is recommended that where major capital expenditure is required the Government should accept the principle of direct grants from the Exchequer to both voluntary and local authority hospitals on the recommendation of the Regional Councils and after consultation with the Central Hospitals Board.

56. The arrangements made in this respect are likely to be of great importance in post-war years. There are, for example, several areas on the outskirts of London where the need for additional accommodation is obvious, and where such accommodation could appropriately be provided by the voluntary hospital concerned if capital monies on a substantial scale are forthcoming. It must be recognised that lack of sufficient capital resources available to voluntary hospitals in such areas has, despite substantial assistance from the King's Fund, proved a handicap over the last twenty years, and that grants of public money to assist voluntary effort are needed if these hospitals are to be materially expanded as they should be in the general interest. The sums involved will be substantial: for these hospitals alone on the outskirts of London, perhaps as much as £10 million or more over the immediate post-war years.

57. The needs of different areas and of individual institutions for capital assistance vary very greatly, and there is here an obvious need for central allocation of resources to both voluntary hospitals and to local authorities. It will be the function of the Central Hospitals Board to advise the Minister in this respect. The local authorities will naturally take pride in the development of their own hospitals, and it is of the utmost importance that the voluntary hospitals should be placed upon an equal footing as regards access to capital grants from central funds for hospital purposes. They should not be obliged to seek assistance from the local authorities at the expense of the rates. A clear assurance upon this matter would go far towards meeting the widely felt apprehension that the voluntary system may gradually come to fall into relative obsolescence by reason of a readier access to public monies on the part of the local authorities.

10 OLD JEWRY, E.C.2.
July, 1944.

APPENDIX.

NOTES ON THE NEED FOR GRANTS TO TRAINING SCHOOLS FOR NURSES

> "Since the training of the nurse is a service performed for the country as a whole, we consider that grants in respect of such training should be made from national funds to hospitals recognised by the General Nursing Council as training schools and that these grants should be assessed upon the training work done by these hospitals. The grants for training should be made, without distinction, to both voluntary and municipal hospitals."

The above statement appears prominently in the Interim Report of the Inter-Departmental Committee on Nursing Services (1939). The Committee's parallel recommendation that there should be grants to meet the cost of increased salaries for nurses on a national scale has already been implemented. The inauguration of the National Health Service and the recasting of hospital finance involved offers an opportunity to implement the recommendation that grants should be made in respect of the training of nurses.

In this country the training of nurses has always been based partly on the "apprenticeship" system. This has contributed to the high standard of actual bedside nursing, particularly in the larger training schools, but on the other hand, it opens the way for hospitals to become training schools on inadequate grounds (*e.g.*, too small to give comprehensive experience, too low a ratio of trained staff to student nurses or of nurses to patients) and the quality of nurse training has suffered accordingly.* Many instances of the sacrifice of the nurse's training course to the needs of the hospital could be given from experience at the Nursing Recruitment Centre.

To put nursing on a satisfactory basis it would seem necessary to treat the training school as a separate entity from the hospital. The only case in this country where this has been attempted in some measure is to be found at St. Thomas's Hospital, where the Nightingale School has its own endowment and a separate system of accountancy.† It seems clear that some of the existing prejudice against nursing as a career for girls whose parents can afford to let them qualify for any profession would be removed by the emphasis on entry as a student in a training school rather than as an employee of the hospital.

The numbers involved are so large, and the apprenticeship system with consequent lack of trained staff for the work of the hospital is so firmly established, that it is not possible to

* *Cf.* Report of Horder Committee, Section II, Education and Training (1943).

† *Cf.* Worcester: "Nurses and Nursing" (1927): "The distinctive advance made by the Nightingale School was due to its independence. From the first its liberal endowment has allowed it to hold fast to its educational ideals. And there it has been proved that the best nursing service in a hospital can be given by pupil nurses of a school that has for its main purpose their education, and not the pecuniary advantage of the hospital."

demonstrate a complete parallel in the training of medical students and the recommendations of the Goodenough Committee. Nevertheless, if the entire cost of training and maintaining the student nurses at any hospital be assessed, the case for meeting a proportion by Government grant is very strong. The remainder would be met by payment from the hospital to the training school in respect of the services rendered by the student nurses. No doubt some adequate form of inspection would be required, and it should be a condition that the hospital provided the required minimum ratio of trained staff to student nurses. It would, of course, be necessary to ensure that the hospital kept an effective measure of control, and this could be secured in virtue of its contribution.

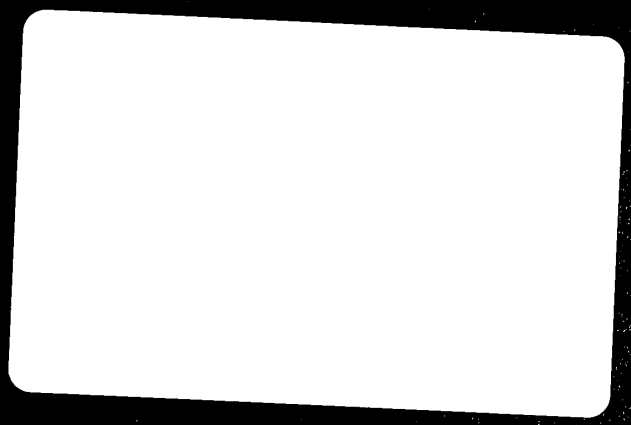
The grants for training would be applicable to all hospitals approved by the General Nursing Councils, voluntary and local authority alike, and this would be in keeping with the proposals for giving financial support to both systems.*

The cost to hospitals of maintaining Preliminary Training Schools, which form a valuable part of the training course, has been increased greatly by the Rushcliffe Committee's recommendation that the fees formerly payable for the Preliminary Training School course should be abolished, and that salaries should be paid throughout, although the student does not undertake ward duties until the completion of the preliminary course.

King Edward's Hospital Fund is offering grants to a total of £5,000 a year over a period of three years to encourage and assist the smaller hospitals in the Fund's area, which could not finance Preliminary Training Schools of their own, to co-operate in Group Preliminary Training Schools. The progress made in the establishment of Preliminary Training Schools since these grants first became available in 1943 has been remarkable, but these courses cover only the first two or three months of the three-year or four-year training course, and even so the hospitals find the financial liability a heavy one; in the provinces many training schools still have no preliminary course.

No official figures are available of the total cost to hospitals of training and maintaining student nurses. It may be noted, however, that in 1943 the number of student nurses in all Training Schools approved by the General Nursing Councils for England and Wales and for Scotland was in the neighbourhood of 37,000. In addition to teaching facilities and maintenance, the student nurses are given a salary commencing at £40 a year and rising to £70 in the fourth year of training. A total cost of £4,500,000 would therefore appear to be a conservative estimate.

* As regards complete training schools in general nursing, there are about 261 voluntary as against 130 local authority in England, Wales and Scotland. The normal bed complement of the two groups of training schools, however, is 54,500, as against 72,500 approximately. The great majority of the fever and mental training schools are under the local authorities; all but four of the children's training schools are voluntary.



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