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THE DAWSON REPORT

ON THE

FUTURE PROVISION OF MEDICAL AND ALLIED SERVICES

1920

AN INTERIM REPORT TO THE MINISTER OF
HEALTH BY THE CONSULTATIVE COUNCIL
ON MEDICAL AND ALLIED SERVICES



ENQUIRY
DESK

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INTRODUCTORY NOTE

The Dawson Report of 1920 is the forerunner of most of the current ideas of health care on a regional basis but has for some years been out of print and virtually unobtainable. This reprint is issued by King Edward's Hospital Fund for London so that it may again be available for study by those interested in the problems involved. We are indebted to H.M. Stationery Office for permission to do this.

10 OLD JEWRY,
LONDON, E.C.4.

PREFATORY NOTE BY THE MINISTER OF HEALTH.

1. This Report, the first to be received from the Consultative Council on Medical and Allied Services established under the Ministry of Health Act, 1919, is published in order to facilitate discussion of the questions raised in it.

2. Action is being taken by the Ministry of Health and the local authorities in relation to a number of matters touched upon in the Report; and proposals for action in other directions are in process of formulation.

3. Many of the Council's recommendations must necessarily be considered in relation to a comprehensive policy for the extension and development of health services (including the question of the future administration of services at present entrusted to poor law authorities), which will be submitted to Parliament by the Government in due course.

C. ADDISON.

May, 1920.

CONSULTATIVE COUNCIL ON MEDICAL AND ALLIED SERVICES.

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SECTION I.

To the Right Hon. CHRISTOPHER ADDISON, M.D., M.P.,
Minister of Health.

SIR,

1. In October last you made the following reference to the Consultative Council on Medical and Allied Services :—

“To consider and make recommendations as to the scheme or schemes requisite for the systematised provision of such forms of medical and allied services as should, in the opinion of the Council, be available for the inhabitants of a given area.”

To give a detailed report on this large and extended reference would take longer study and consideration than has been possible in the time at the disposal of the Council.

2. In view, however, of the urgency which attaches to the orderly building of a constructive health policy, and the close relationship which exists between medical services and the problems connected with poor law and local government, we think it will promote progress if we set forth the trend of our deliberations and conclusions, and we accordingly have the honour to present an Interim Report.

3. The changes which we advise are rendered necessary because the organisation of medicine has become insufficient, and because it fails to bring the advantages of medical knowledge adequately within reach of the people.

This insufficiency of organisation has become more apparent with the growth of knowledge, and with the increasing conviction that the best means of maintaining health and curing disease should be made available to all citizens.

4. The general availability of medical services can only be effected by new and extended organisation, distributed according to the needs of the community. This organisation is needed on grounds of efficiency and cost, and is necessary alike in the interest of the public and of the medical profession. Measures for dealing with health and disease become, with increasing knowledge, more complex, and, therefore, less within the power of the individual to provide, but rather require combined efforts. Such combined efforts to yield the best results must be located in the same institution. As complexity and cost of treatment increase, the number of people who can afford to pay for a full range of service diminishes. Moreover, enlightened public opinion is appreciating the fact that the home does not always offer the best hygienic conditions for dealing with serious illness, which requires special provision in order to give the patient a full chance of recovery.

5. In days gone by such conditions as appendicitis were treated with poultices and drugs in the patient's home. Now they are treated by operation, which is more effective, but requires more equipment, a team of workers, and a larger expenditure. Such conditions as diseases of the lungs formerly received clinical examination and treatment by drugs. They now may require, in addition, the attention of the pathologist and the radiologist.

This means greater efficiency, but more organisation and higher cost.

6. Preventive and curative medicine cannot be separated on any sound principle, and in any scheme of medical services must be brought together in close co-ordination. They must likewise be both brought within the sphere of the general practitioner, whose duties should embrace the work of communal as well as individual medicine. It appears that the present trend of the public health service towards the inclusion of certain special branches of curative work is tending to deprive both the medical student and the practitioner of the experience they need in these directions.

7. Any scheme of services must be available for all classes of the community, under conditions to be hereafter determined. In using the word "available," we do not mean that the services are to be free; we exclude for the moment the question how they are to be paid for. Any scheme must further be such that it can grow and expand, and be adapted to varying local conditions. It must be capable of comprising all those medical services necessary to the health of the people.

8. The foregoing are some of the considerations which have guided us in drawing up the scheme outlined below.

The services may be classified into—

Those which are Domiciliary as distinct from those which are Institutional.

Those which are Individual as distinct from those which are Communal.

9. We begin with the home, and the services, preventive and curative, which revolve round it, viz., those of the doctor, dentist, pharmacist, nurse, midwife, and health visitor. These we style domiciliary services, and they constitute the periphery of the scheme, the remainder of which is mainly institutional in character.

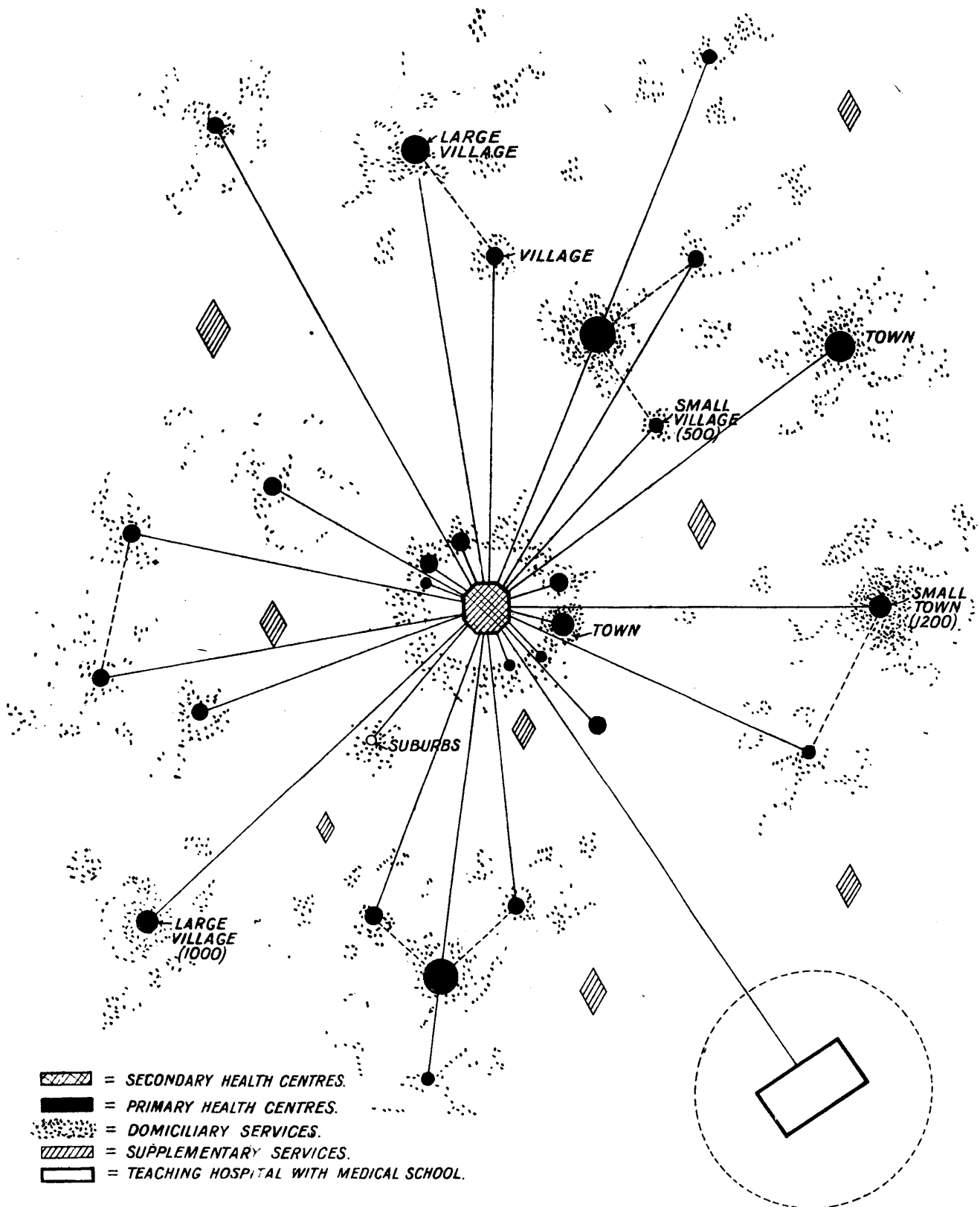
A Health Centre is an institution wherein are brought together various medical services, preventive and curative, so as to form one organisation.

Health Centres may be either Primary or Secondary, the former denoting a more simple, and the latter a more specialised service.

10. The domiciliary services of a given district would be based on a *Primary Health Centre*—an institution equipped for services of curative and preventive medicine to be conducted by the general practitioners of that district, in conjunction with an efficient nursing service and with the aid of visiting consultants and specialists. Primary Health Centres would vary in their size and complexity according to local needs, and as to their situation in town or country, but they would for the most part be staffed by the general practitioners of their district, the patients retaining the services of their own doctors.

11. A group of Primary Health Centres should in turn be based on a *Secondary Health Centre*. Here cases of difficulty, or cases requiring special treatment, would be referred from Primary Centres, whether

DIAGRAM OF AN AREA **SHOWING ALL SERVICES.**



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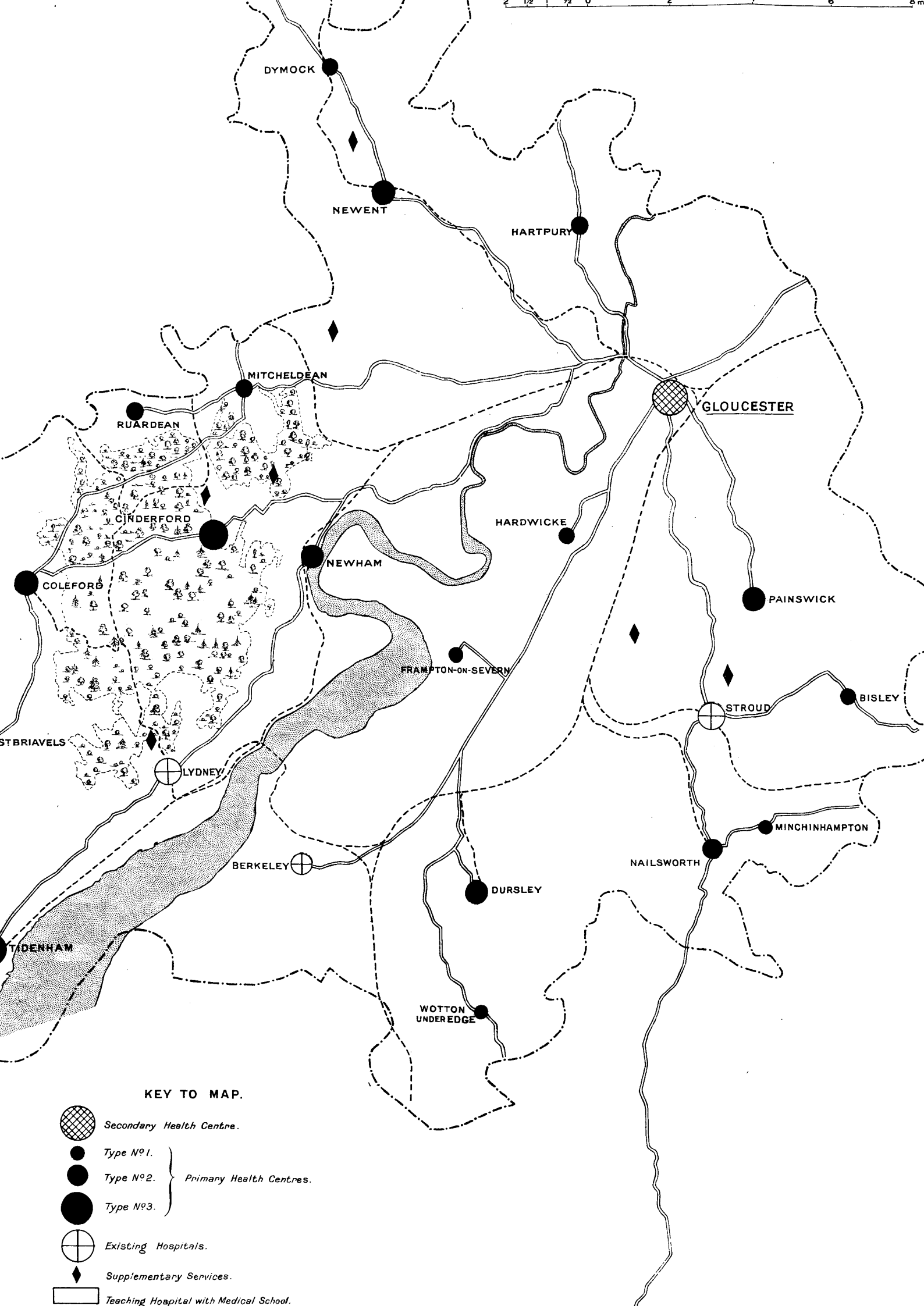
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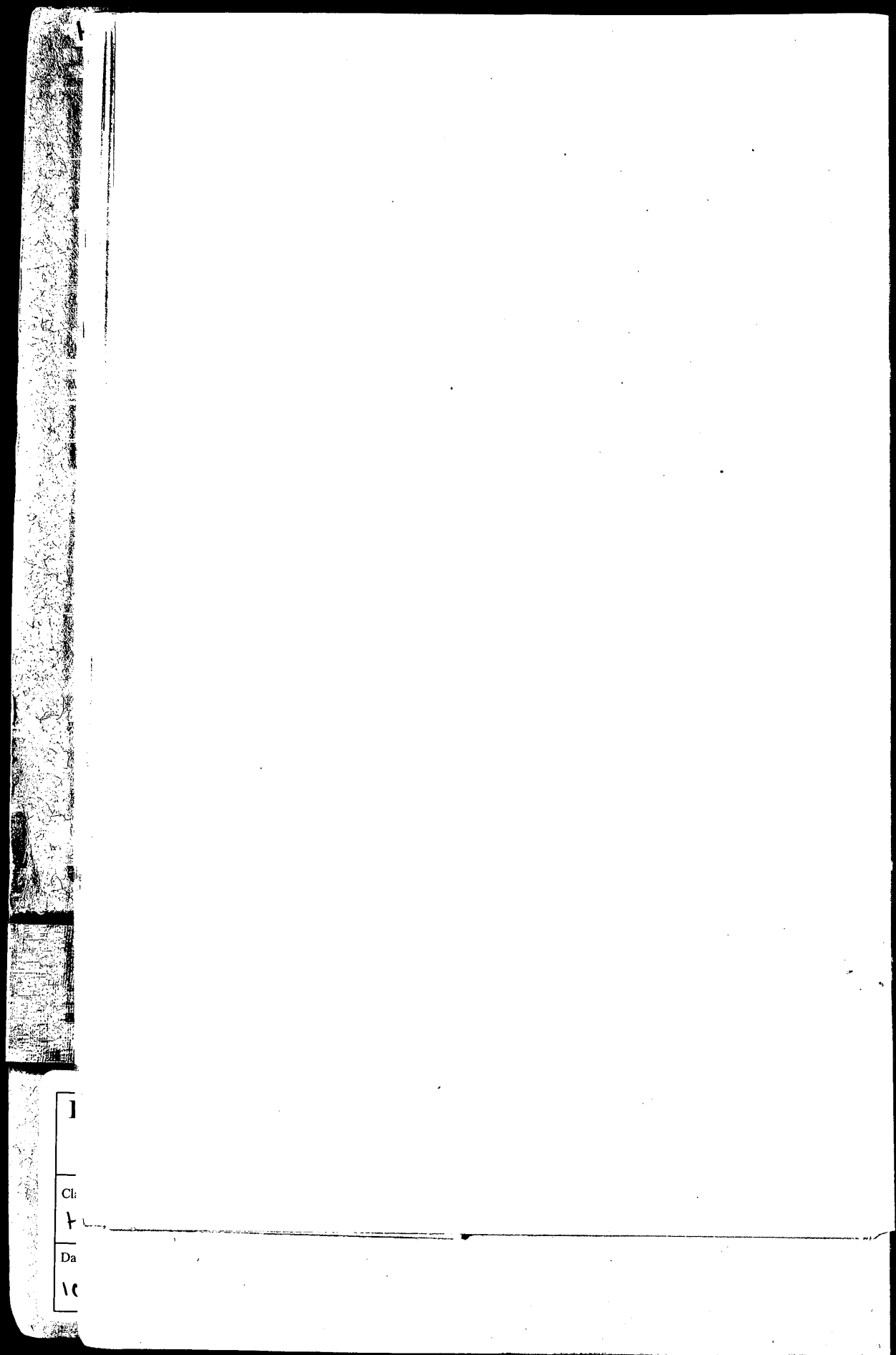
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special treatment, would be referred from primary centres, whether





the latter were situated in the town itself or in the country round. The equipment of the Secondary Centres would be more extensive, and the medical personnel more specialised. Patients entering a Secondary Health Centre would pass from the hands of their own doctors under the care of the medical staff of that centre. Whereas a Primary Health Centre would be mainly staffed by general practitioners, a Secondary Health Centre would be mainly staffed by consultants and specialists. It would be a consultant service in function and would be carried out by specialists or by general practitioners acting in a consulting capacity.

12. Secondary Health Centres must of necessity be situated in towns, where alone an efficient consultant service and adequate equipment could be expected, and the necessary means of communication exist.

The selection of these towns will need careful consideration, and full information will be required as to the extent of existing provision of hospital and allied facilities, and of its distribution in relation to population and means of public conveyance. In rural areas the natural currents of traffic and business and existing medical facilities will usually indicate the town or towns in which a Secondary Health Centre may best be placed. In this connection we would like to point out the importance of carrying out a "Hospital Survey" at an early date. The results of this survey would afford data for recognising the areas in which the existing provision is inadequate, and the degree of the inadequacy.

The Secondary Health Centres would vary in size and elaboration according to circumstances.

13. Secondary Health Centres should in turn be brought into relation with a *Teaching Hospital* having a Medical School. This is desirable, first in the interest of the individual patient, that in difficult cases he may have the advantages of the highest skill available, and secondly in the interest of the medical men attached to the Primary and Secondary Centres, that they may have the opportunity to follow the later stages of an illness in which they have been concerned at the beginning, to make themselves acquainted with the treatment adopted, and to appreciate the needs of a patient after his return to his home.

In those towns where Teaching Hospitals exist, Secondary Health Centres would sometimes be merged in them.

14. *Supplementary Services.*—Certain supplementary services would be a necessary part of the scheme. They would be in relation to both Primary and Secondary Health Centres, would often serve a wide area, and would require special staffs. They would comprise provision for patients suffering from such conditions as tuberculosis, mental diseases, epilepsy, certain infectious diseases, and for those in need of orthopaedic treatment.

15. The accompanying illustration shows the scheme of services in a diagrammatic way.

16. The scheme may be usefully illustrated by taking the actual example of Gloucestershire, where the local authorities in the County

and its towns, the hospital authorities, and all the doctors have agreed* on a plan of services not dissimilar in its aims to the one set forth in this Report.

Gloucestershire has been mapped out into areas, and we have selected that area of which the City of Gloucester is the centre. This area measures about 30 miles North to South and about 24 miles East to West. It is nearly bisected by the River Severn, with no road bridge below Gloucester and one railway bridge 14 miles below that city. It contains various types of population. There is the mining district of the Forest of Dean. At Lydney there are tinsplate works, at Cam cloth factories, and at Dursley engineering works, amongst other industries in the area. On the other hand, there are large rural districts, some of which are sparsely populated.

The map shows the places suitable for Primary Health Centres, having regard to distribution of population and communications. These centres are of three grades, according to the elaboration of provision needed. Existing Cottage Hospital accommodation and provision of supplementary services, actual and suggested, are shown. In the City of Gloucester, with its population of 50,035, would be located the Secondary Health Centre, and in Bristol is situated the Teaching Hospital with its Medical School.

We understand that a comprehensive scheme on similar lines for application to the Counties of Durham and Northumberland is being prepared under the auspices of the North-Eastern Hospitals Association.

17. Underlying our recommendations is the dominant purpose of providing the best services for the health of the people. Our recommendations are designed to secure—

- (1) Provision of buildings and equipment.
- (2) Services suitably correlated and available for all.
- (3) Opportunity for the best work and the furtherance of knowledge.
- (4) Co-ordination of preventive and curative medicine.
- (5) Freedom of action for doctor and patient.

Under existing conditions doctors are frequently without such provision or opportunity; they have imperfect access to such resources as those of Bacteriology, Biochemistry, Radiology, Electrotherapeutics; and they have inadequate means of assistance from consultants or specialists. Consequently they cannot always do justice to their patients or themselves.

The scheme of services we have outlined may on superficial reflection be deemed by some people to be so ambitious as to be impracticable. We are well aware that the realisation must be slow and, from the difficulty of adapting existing institutions and methods, may be imperfect. Apart from the lack of material equipment, trained personnel in adequate numbers is not at present available, though the acceptance and approval of this scheme by the profession and the

* This result has been achieved under the guidance of Dr. J. Middleton Martin, the Medical Officer of Health for the County.

public should give the educational stimulus to its production. To construct any part well, and to avoid mistakes in local effort, the whole design must be before the mind. This is an undertaking which can be at once begun and steadily proceeded with, and at a rate proportional to the enlightenment and determination of local public opinion—lay and medical. Any effort, however small and localised, can confer benefit, if it be designed in relation to the scheme as a whole.

A Primary Health Centre, with its organised services, established by local enterprise, will serve its community well if it is conceived in the right spirit, put up in the right place, and organised on the right lines.

SECTION II.

DOMICILIARY SERVICE.

18. Domiciliary service is the first element in any scheme of systematised medical services. It comprises the services of doctor, dentist, pharmacist, nurse, midwife, and health visitor.

19. *Doctors.*—A doctor should be so located as to be reasonably accessible to his patients. He would attend his patients either at their homes or his surgery, and would carry out such treatment as falls within his competence; or, if in his judgment a patient could be more advantageously treated in the Primary Health Centre, he would be able to arrange for the patient to be transferred there under his care. He would attend in child-birth in their own homes such patients as arranged with him, or, if desirable, would secure their transference to a maternity bed in a Primary Health Centre or special institution.

20. Where the assistance of a consultant or specialist was needed, and it was impossible to transfer the patient to the Primary or Secondary Health Centre, it should be possible for him to summon such assistance to the patient's home.

21. The custom whereby each general practitioner has his consulting rooms at his own house should, under ordinary circumstances, continue, but where, as in certain congested areas, it is impossible for a doctor to provide adequate accommodation at his own expense, it should be possible, if the public interest demanded it, for the Health Authority to provide such accommodation at the Primary Health Centre, or elsewhere, on such terms as are reasonable, and after previous consultation with a Local Medical Advisory Council. Where local conditions, and medical opinion, favoured the plan, collective surgeries might with advantage be tried, either attached to a Primary Health Centre, or set up elsewhere.

22. Work in preventive medicine by the general practitioner would be carried out both in the homes of his patients and in the Primary Health Centre, and the Health Authority should be enabled to make specific payments for such work.

23. We think that in any scheme of improved medical services the duty of the general practitioner to advise how to prevent disease and to improve the conditions of life among his patients should be an important element in his work.

24. The general practitioner, if adequately trained, should play a valuable part in the work of the communal services, *e.g.*, antenatal supervision, child welfare, both before and during school age, physical culture, tuberculosis, venereal disease. He will be the first link in any chain of services to improve the conditions of industry, and to prevent any unfavourable or injurious influence upon the health of the workers.

25. But in addition to these services by the medical practitioner to the individual patient, there has grown up in recent years a large department of work in preventive medicine which must require specially trained and experienced practitioners.

26. Medical expert service has been of enormous value in all matters relating to (1) Housing, (2) Drainage, (3) Sewage Disposal, (4) Scavenging—removal of Nuisances, (5) Water Supply, (6) Foods, their inspection and adulteration, (7) Epidemic Diseases, (9) Vital Statistics, (10) Factory Conditions, and (11) a large variety of other conditions which have a direct bearing on the health of the people.

27. For the efficient carrying out of their own work, doctors will require the help of such ancillary services as those of pharmacists, nurses, midwives, and health visitors.

28. *Pharmacy.*—In the domiciliary service patients would, as in the past, obtain medicines, appliances, and medical and surgical requisites from the pharmacists of their choice. The payment of the pharmacist would be made direct by the patient or through some such arrangement as pertains to the supply of these articles under the National Health Insurance Scheme.

29. *Nursing.*—Domiciliary nursing is an essential part of a health service.

This need, so strongly felt, has led to a variety of earnest efforts to meet it by various voluntary nursing associations. These associations are mainly supported by voluntary subscriptions, by fees, and by contributions from public authorities and societies. Concentration of effort is aimed at by the affiliation of district associations to County Nursing Associations, some of which in their turn are affiliated to Queen Victoria's Jubilee Institute for Nurses. These associations, however, cannot fully meet the need.

30. In our opinion nursing should be available for all illnesses and all persons when the doctor deems it necessary. The services of nursing for a district should be based on the corresponding Primary and Secondary Health Centres (*see* paragraphs 40 and 58 below).

31. The responsibility for the provision of a nursing service would rest with the Health Authority, which would no doubt avail itself, where possible, of the excellent existing organisations.

32. We propose, with your approval, to refer the further consideration of the nursing services under our reference to a special Committee. Pending that inquiry our remarks are only intended to give in outline our views as to the place of nursing in the general scheme.

33. *Midwives*.—We deal in outline with Midwifery services later in this Report (paragraphs 128 to 133), and propose in like manner to refer them to a special Committee for more detailed consideration.

34. *Health Visitors*.—The functions of a Health Visitor have not been discussed in detail. We are, however, agreed that the work of the Health Visitor should be primarily preventive. In the work among school children and among tuberculous persons it may be necessary for her to be associated with certain aspects of curative medicine. But she would not give advice as regards treatment to sick persons, nor, knowing them to be sick, visit them in her capacity as health visitor, unless with the consent and under the supervision of the doctor attending the case.

35. *Dental Services*.—Dental services should be partly domiciliary and partly institutional. Domiciliary treatment would usually be carried out at the dentist's own surgery, but occasionally at the patient's home. It would be sought by the patient either on his own initiative or on the advice of a doctor. Dental treatment should, where necessary, be carried out in co-operation with medical treatment. Whether a patient should attend at the dentist's surgery or at the Health Centre would, no doubt, be determined by the mutual convenience of the patient and dentist, the accessibility of the Centre, and other local conditions.

SECTION III.

PRIMARY HEALTH CENTRES.

36. In the Primary Health Centres would be gathered together the health services and activities of the districts they served.

The distinguishing feature of these Primary Health Centres, in contradistinction to Secondary Health Centres, would be that they would be staffed by general practitioners.

37. *Accommodation*.—There would be wards of varying sizes, and for varying purposes, including provision for midwifery. The increasing employment of open-air treatment of illness would be provided for. Clinics would be equipped where doctors could see their patients and consult with each other.

Further accommodation might include the following :—

- Operating room, with the necessary equipment ;
- Radiography rooms ;
- Laboratory for simple investigations ;
- Dispensary ;
- Baths, including simple hydro-therapy ;
- Equipment needed for Massage, Electricity, Physical Culture ;

A Public Mortuary ;

A Common Room which would serve as a meeting-place for the general practitioners of the district, and to store Clinical Records on an agreed and standardised basis.

38. Only some of these facilities would be found in smaller Centres, and the more fully-equipped Centres would render aid to those less well equipped.

39. *Communal Services.*—There would be accommodation for communal services such as those for pre-natal care, child welfare, medical inspection and treatment of school children, physical culture, examination of suspected cases of tuberculosis and occupational diseases, &c. These services should, where possible, be aggregated at the Primary Centre.

40. So far as midwives were not available in particular districts under other arrangements, their services could be provided from the Centre, and at the Centre residential accommodation could be found not only for nurses and midwives working there, but also for those engaged in rendering similar services in the neighbourhood.

41. *Dental Services.*—A Dental Clinic, with a staff of visiting dental surgeons, employed either on a part-time or, where necessary, on a whole-time basis, and nurses attached to the service, would be an important feature of the Centre. It would provide all ordinary forms of treatment for patients of all ages. The present school dental service could, with advantage, be transferred to the Clinic, where possible.

42. *Pharmacy.*—The provision of the necessary pharmaceutical services for those who would be treated in any of the institutions described in this scheme is a difficult matter and is receiving our careful attention. A Committee will be proposed to investigate and report upon the question of what should be the future functions of the pharmacist in relation to the services we are advising, and as to the most appropriate training and the necessary qualification for those who are to perform these functions. We hope to deal with these matters in detail in a later Report.

43. *Ambulance Service.*—An Ambulance Service would be a necessary part of the scheme. It would maintain communication between the Primary Health Centre and the homes of the people, on the one hand, and the Secondary Health Centre on which the Primary Centre is based, on the other.

44. The Ambulance Service would be capable of extension. Besides conveying the sick, motor transport could be used in the sparsely populated districts to serve as travelling clinics for both curative and communal services.

45. The provision of these Primary Centres would be required in both rural districts and towns, for *they are an essential part* of an efficient general practitioner service. Their design and scope would vary considerably in town and country and in different localities, but the underlying principle would be the same.

46. The illustrations reproduced in the Appendix, with their annotations, will convey in a clear way the comprehensive character of the services contemplated.* The simpler forms, though not so complete, probably represent for some districts what is necessary or realisable. These illustrations are meant to elucidate an idea and a policy, and although designs of complete structures are given, such completeness, while desirable, is not indispensable to the idea.

In many instances, existing buildings such as Poor Law infirmaries transferred to the Health Authority, or cottage hospitals, could be adapted for the purpose, at any rate as a beginning. On the other hand it would be important to guard against making expensive alterations to buildings which, from their positions or structures, could only be makeshifts. Health Centres and hospitals require adequate ground, so as to provide not only for future expansion, but also for open-air clinics, convalescent treatment, physical culture, and such like services. Many War Memorial Hospital schemes are likely to be defective because their promoters ignore these considerations, and fail to realise that a modern hospital should be part of a more comprehensive organisation.

47. *The Personnel.*—The general practitioner would attend at the Primary Centre such of his patients as required hospital treatment, irrespective of their status, though under varying conditions of service. Consultants and specialists from the staff of the Secondary Health Centre, to which the Primary Centre was attached, would attend under the conditions of the service at fixed intervals, and, under circumstances of emergency, on special summons. These or other consultants could attend patients other than those provided for at the Centre, if the patient paid for their services. The Primary Centre would provide the patient (on the terms described in paragraphs 72 and 73 below) with food, nursing, and all the equipment of efficient treatment, but not with medical attendance, which would be paid for either by the patient or through some method of insurance, or by the Health Authority.

48. *Staff for Communal Services.*—The communal services described in paragraph 39 above would, where possible, each be directed by a doctor (or more than one) practising in the area, such doctor having specially qualified himself for his post. The directorships of these communal services should be part-time posts paid on a time basis. For these services also, consultant advice should be available.

49. *Efficiency of Service.*—No small part of the advantage likely to follow from such institutional provision would be the raising of the standard of professional efficiency. Medical knowledge has far outstripped the means for its application. Within the hospital the student studies the problems of disease under favourable circumstances; he has near at hand, not only the equipment of the ward, but the laboratories of radiography, pathology, and chemistry; he can marshal his observations, and follow up results. Under existing conditions he leaves hospital for practice, and there is a sudden drop to the limited

* For these illustrations and the diagram referred to in paragraph 15 above the Council desire to express their obligation to Mr. C. H. Biddulph-Pinchard.

opportunities attached to the crowded surgery and the patient's home, and the more medical knowledge advances the bigger the drop becomes. In the Health Centre there would be the equipment and the encouragement to do good work, and opportunities for observation and investigation and self-improvement. Disease, too, would be detected in its earlier and, therefore, more curable stages. Judged alone by the effect on medical men and medical knowledge, it would be impossible to exaggerate the benefits that would accrue to the community by the establishment of these Health Centres.

50. The Primary Centre would be the home of the health organisation and of the intellectual life of the doctors of that unit. Those doctors, instead of being isolated as now from each other, would be brought together and in contact with consultants and specialists; there would develop an intellectual traffic and a camaraderie to the great advantage of the service. No doubt discussions and post-graduate instruction would in time be organised, and "study leave" to teaching hospitals could easily and advantageously be arranged.

51. *Nature of the General Practitioner Service.*—It will be seen under the scheme so far outlined that the work of the general practitioner would be mainly domiciliary but partly institutional, mainly individual but partly communal; that at the Primary Health Centre he would treat such of his patients as attended there; that at the Centre there would be provision of all needful equipment; and further, appointment as salaried director of one or more communal services would be open to him.

In this way the advantages of organisation, hand-in-hand with the preservation of liberty of thought and action, would be secured.

52. *Whole-time and Part-time Services.*—The alternative of a whole-time salaried service for all doctors has received our careful consideration, and we are of opinion that by its adoption the public would be serious losers.

No doubt laboratory workers and medical administrators who do not come in personal contact with the sick can, with advantage, be paid entirely by salary.

The clinical worker, however, requires knowledge not only of the disease but of the patient; his work is more individual, and if he is to win the confidence so vital to the treatment of illness, there must be a basis not only of sound knowledge but of personal harmony. The voluntary character of the association between doctor and patient stimulates in the former the desire to excel both in skill and helpfulness. It is a true instinct which demands "free choice of doctor," and there should be every effort, wherever possible, to make this choice a reality. In no calling is there such a gap between perfunctory routine and the best endeavour, and the latter, in our opinion, would not be obtained under a whole-time State salaried service, which would tend, by its machinery, to discourage initiative, to diminish the sense of responsibility, and to encourage mediocrity.

SECTION IV.

SECONDARY HEALTH CENTRES.

53. Secondary Health Centres must be situated in towns where an adequate equipment, an efficient staff of consultants and specialists, and the necessary means of communication can exist. Like Primary Health Centres, they should bring together in one organisation Preventive and Curative Medicine. It will, however, in actual practice be sometimes difficult to bring all these services on to the same site, for the reason that, in towns, existing buildings will have to be employed and adapted, while in rural districts, where land is acquired with less difficulty, buildings can more easily be either erected or extended.

54. The services of the Secondary Health Centres would be mainly of a consultative type. The Centres would receive cases referred to them by the Primary Centres, either on account of difficulties of diagnosis or because in their diagnosis or treatment a highly specialised equipment was needful. On the other hand, Primary Centres would ease the work of the Secondary Centres by treating less complex cases which are now sent to the larger hospitals, and by receiving patients from the Secondary Centres when the acute stage of their illness had passed. Although in some places, *e.g.*, in smaller towns, it would be necessary to have primary services also performed in Secondary Health Centres, these should not be allowed to interfere with the consulting functions of the Secondary Centre.

55. Most of the Communal Services of the Secondary Health Centres would resemble in function the Communal Services of the Primary Centres, but should be models of equipment and organisation, for they would have very important educational functions, and would be centres of post-graduate study for doctors and training for nurses and others.

56. A Secondary Health Centre should be completely equipped, since on the excellence of its service and organisation the efficiency of the Primary Health Centres and domiciliary services based upon it would, to a large extent, depend.

57. Such equipment would include :—

General Services.—Medical, Surgical.

Special Services.—Obstetric, Gynæcological, Ophthalmological, Throat and Ear, Dermatological, Orthopædic, Genito-urinary, Dental and Industrial Hygiene.

Laboratories.—Pathology in all its branches.

Other Services.—Pharmacy, Radiology, Electrotherapy, Hydrotherapy, Radiant Heat, Physical Culture, Massage, Nursing.

In existing circumstances some of these services might have to be in separated, though closely co-ordinated, institutions.

58. All these services would be in consultant relationship, and in some instances in administrative relationship with the Primary Centres. For instance, the organisation of the Nursing Service should be based

on a Secondary Health Centre. Only in this way could the varying needs of the different districts be met, a high standard of nursing maintained, and that change of work secured which is so necessary to retain a nurse's efficiency.

59. The Curative Services of Secondary Health Centres would have as their nucleus existing hospitals, for to and from these latter flow the currents of medical work, and they are part of the life of their districts.

In the comprehensive organisation contemplated, the functions of existing hospitals would be considerably extended, and the present buildings would not be large enough for such purposes, and would need to be either supplemented or enlarged.

In those areas in which there are modern and well-equipped Poor Law Infirmarys the necessary accommodation might be partly provided by the transfer of these institutions from the Guardians to the Health Authority.

We strongly urge that this reform should be carried out at the earliest possible moment.

If this were accomplished not only would much of the increased accommodation required be provided, but a better classification of cases would be possible. The Infirmary buildings could accommodate the large number of routine cases of illness which, though neither difficult nor dangerous, is disabling, and as such needs to be promptly cured so that breadwinners and mothers of families may be restored to their work. At the present time, with pressure on the beds in the hospitals, these, from an economic point of view, important cases are necessarily postponed on account of the claims of graver and more urgent illnesses.

60. It would, however, be necessary in many areas to establish complete and model Secondary Health Centres provided with every modern requirement.

The separation of the buildings which constitute a Secondary Health Centre, though sometimes in actual circumstances necessary, is a real disadvantage on grounds of both efficiency and economy, and should be regarded as a temporary expedient to be supplanted, so soon as practicable, by adequately equipped buildings grouped on the same site, thus securing collaboration and unity of control.

61. Cases referred for consultation or treatment would attend at Out-Patient Clinics, or would occupy In-Patient beds at the Secondary Centre. The medical staff of the Secondary Centre would be responsible for the treatment of these cases while at the Centre, but every facility would be afforded for general practitioners to keep in touch with their patients, and to resume their medical supervision on discharge.

62. *Consultant Services.*—Consultants would be appointed for these services, who would be correlated with the doctors and services of the corresponding Primary Health Centres.

Duties of Consultants (Clinical).—Their duties would consist of :—
(a) Regular attendance at fixed times in their Out-Patient Clinics, where they would see cases referred to them ; (b) Attendance in the

wards on cases referred to them ; (c) Periodical visits to the Primary Health Centres allotted to them ; and (d) Special visits of emergency to Primary Health Centres, and in certain circumstances to the homes of patients within their areas, always in consultation with the general practitioner.

63. *Method of Remuneration of Consultants.*—These consultants would be part-time officers and be paid on a time basis with extra fees for special visits. This would leave them time for their private consulting practice.

64. *Consultants (Non-Clinical).*—The pathologists, radiologists, and the officers connected with the Communal and Preventive services of the Secondary Health Centres would similarly visit in a consulting capacity the Primary Health Centres within the spheres of their Secondary Centre. Certain of these would be whole-time officers.

65. The personnel of the consultant services would, in practice, be on the staff of the hospital or of institutions associated with it. It is possible, however, that at the outset a portion of the staff of a hospital might be unwilling to participate in the medical service contemplated, but all new appointments might be made subject to such participation.

At the same time, provision out of public funds could only be made for such Out-Patient and In-Patient Clinics as were available for the needs of the systematised medical service here proposed.

66. The test of eligibility to serve as a consultant or specialist would be evidence of special training and experience of the requisite kind. This evidence would be afforded by consideration of such points as—

- (1) Special academic or post-graduate study ;
- (2) Tenure of hospital and other appointments affording special opportunities for acquiring experience ; and
- (3) Local professional recognition of competence in a consultative or expert capacity.

While all these points would afford indications to which due regard should be paid, no one of them would be considered to be in itself indispensable.

We contemplate that general practitioners should be eligible for these posts, and we should regard their representation in the consultant services and on the staffs of the Secondary Health Centres as an advantage.

67. *Method of Election.*—Any practitioner elected to the post of consultant or specialist in any subject would require to have Out-Patient and in some instances In-Patient accommodation provided for him within the Centre. This would mean that he would either be a member of the staff of the hospital before his election, or be associated with the hospital after his election. The hospitals, therefore, would have a vital interest in the election. The doctors of the area would also be closely interested, and the Health Authority would have responsibility, both financial and administrative. It is further, in our view, important that the Faculty of Medicine of the University within

whose sphere of influence the Secondary Health Centre falls should be recognised by suitable means as being concerned with these appointments. We therefore advise that the appointments of consultants and specialists under the scheme should be advertised, especially in the Medical Press, and that applications received should be considered by a Committee of Selection which would express the views of persons and bodies such as those mentioned above.

68. The selection of the best men for these consultant positions is of vital importance to the service, and it is therefore essential that medical men, who are best able to judge of professional qualifications, should form a majority of the Committee of Selection. The latter would report to the appointing authority, which would make the appointment, subject to a right of review by the Ministry of Health on the representation of the Committee of Selection.

69. *Provision of Private Wards in Health Centres.*—It would be advisable to allow for the provision of private and self-supporting wards as part of the fabric of Health Centres. The establishment of such wards in close contact with the organisation of Centres would clearly be conducive to their efficient and economical working. Further, the more a doctor's serious cases are limited to one place the better, because he is thus able to spend more time in caring for them and less time in travelling from one to the other. The essential services in the public and private wards would be identical.

70. The charge for private wards would vary according to the accommodation and local conditions. This would not include payment for medical attendance, for which the patient would be responsible. On the other hand, the patient would possess the right of selection of the consultants and specialists to assist in his treatment.

71. *Payment for Treatment at Health Centres.*—Certain members of the Council are of the opinion that curative services at Health Centres should be provided by the Health Authority free of charge to the individual patient. The majority of the members, however, consider that this course would impose a heavy burden on public funds. Preventive services must of necessity be publicly provided: their relation to the individual is less obvious and personal. On the other hand, illness is a direct personal concern, and experience has shown that the patient, when able, is willing to contribute in some form or other to the cost of its treatment. It could, as a rule, only be a contribution to the cost, for it has already been pointed out that efficient treatment will often be beyond the means of most citizens to provide in its entirety.

72. We recommend that standard charges should be made in the public wards and for other curative services, though it is possible this standard charge might vary in different parts of the country.

We contemplate that such charges would more often be met by some method of insurance, though private patients recommended by their doctors would have the right to avail themselves of these services by direct payment.

73. The standard charge at the Primary and Secondary Health Centres would include residence, food, nursing, and all equipment; at the Secondary Health Centre provision would also need to be made for the payment of consultant services. It would be open to any patient to request the advice of a consultant or specialist of his own selection, the patient being responsible for the fee.

SECTION V.

FURTHER ELEMENTS IN THE PROPOSED SCHEME.

Supplementary Services.

74. To both Primary and Secondary Health Centres there would be correlated certain institutional services from time to time necessary to each. Such services, termed "supplementary," may be exemplified by the following :—

- Sanatoria for tuberculosis.
- Recuperative centres (convalescent centres).
- Hospitals for curable or incurable mental disease.
- Institutions for the feeble-minded.
- Epileptic colonies.
- Orthopædic centres.
- Hospitals for certain infectious diseases.

Teaching Hospitals with Medical Schools.

75. In those parts of the country where it is geographically possible, it is desirable that every Secondary Health Centre should be brought into relationship with a Teaching Hospital. The academic influence, and the spirit of inquiry and progress associated with a Teaching Hospital, would permeate the system of secondary and primary health services within the allotted sphere of influence of such a medical school.

76. The Teaching Hospital would receive cases of unusual difficulty, and those requiring specialised knowledge or equipment, and in so far as is necessary, patients suitable for either primary or secondary hospitals should be freely admitted to Teaching Hospitals.

77. Similarly, the laboratories and special departments of this Teaching Hospital would be a court of reference and would inspire and lead the laboratory services of the Health Centres attached to them.

78. The Teaching Hospital could initiate and guide collective investigations in which the health centres and doctors connected with them could play an important part.

79. Post-graduate study at Teaching Hospitals should be further organised and extended. It should also include special training for the communal health services.

80. To this end model communal health clinics would need to be established in connection with the Teaching Hospitals, where doctors could receive the training necessary to enable them efficiently to staff communal clinics throughout the country.

Voluntary Hospitals.

81. The scheme for the provision of Primary and Secondary Health Centres which we have outlined necessarily raises the important question of the position of the Voluntary Hospitals.

Not only have these institutions carried on their work of supplying treatment to the sick poor—some of them for centuries—but they have been centres for the advancement of medical knowledge, for the education of the doctor, for the training of the nurse. Thus their service to the country extends far beyond the actual cure of the poor who visit them. All sick people benefit by their work; those who are not sick may owe their healthfulness to the work of these splendid institutions.

82. That the hospitals have fallen on evil days is known to all. The reason is two-fold. One is that the prices of all the commodities a hospital has to buy—its coal, food, linen, &c., as well as the salaries and wages it has to pay, have increased. The other reason is that the investigation and treatment of disease are becoming increasingly complex. So that not only are the old items of expenditure more costly, but there is hardly a year but some new method of diagnosis or treatment makes it necessary to incur fresh expenditure, and capital expenditure in a hospital differs from capital expenditure in business, in that when a business house grows, it grows in earning capacity, but when a hospital grows it grows in spending capacity. And therefore almost without exception every hospital in the country is facing increasing difficulty in carrying on its work.

83. Some hospitals, which on account of their endowments have not hitherto appealed to the public, are now beginning to do so, their endowments being insufficient to meet the increased expenditure. Their entry into the field has made it still more difficult for those who have hitherto depended entirely on subscriptions.

84. We hope that the scheme we have suggested will help these institutions, since these institutions are an essential part of the scheme. They should receive grants in aid for work carried out, and we hope that those of them which are suitably equipped may receive grants in aid for carrying on research, and that those with schools attached may also be assisted in their most important work of medical education.

85. We take this opportunity of expressing our admiration of the way in which the Voluntary Hospitals have carried out their magnificent work, in spite of innumerable difficulties and through long years, when less interest was taken than now in the health of the poor, or in the painstaking research which has for its purpose the prevention of disease.

86. If no hospital exists in a given area it would have to be provided. If a Voluntary Hospital does exist its assistance would be welcomed, both in the provision of beds and equipment, and in the accumulated experience of its medical staff and management, which would be valuable to any Health Authority. The benefits they would receive under the scheme would be in proportion to the extent of their co-operation and their readiness to come into co-ordination with the general plan.

Research.

87. We hope that the scheme of services which we suggest would facilitate inquiry into the causes of disease and the possible remedies.

The facts which indicated the need for such inquiry might, we think, often be brought together in the first instance by the medical practitioners in a given locality.

There are great and important opportunities for research in preventive medicine, which at present are scarcely dealt with by any organisation, and mostly are not attempted by individuals.

Encouragement of research in the prevention of disease should, we think, be developed, for the materials are everywhere, and the results would undoubtedly be valuable.

The nature of the agency or agencies best qualified in each case to carry out the inquiry could only be determined by a consideration of the subject-matter, but for the purposes of research into fundamental problems the profession would no doubt look to the Universities and the Medical Research Council for guidance and assistance.

Standardised Clinical Records.

88. It would promote efficiency and further knowledge if a uniform system of records of illness based on the card index method were established throughout the service. These records would at the Primary Health Centres be, in most cases, simple, so as to avoid an undue tax upon the staff, whereas at the Secondary Health Centres and Teaching Hospitals this system of records would aim at completeness, and would be organised for all branches of the service—clinical, pathological, and communal.

89. In the event of a patient being transferred for consultation or treatment from one Centre to another a copy of his record would accompany him.

90. At the Secondary Health Centres and Teaching Hospitals there would need to be officers whose duty it would be to maintain the efficiency of this system of records. Such an organisation, properly directed, would be of great value in the promotion of national health.

91. These records could be utilised for purposes of research and for acquiring accurate knowledge of disease and of the after-results of its treatment.

The Teaching Hospitals would undertake the direction of the system of records in their respective zones, so that it might result in knowledge and usefulness rather than in an accumulation of lifeless statistics.

The ultimate direction would lie with the Ministry of Health, which would no doubt seek the co-operation of the Medical Research Council.

Administration.

92. We have set forth in outline a scheme of services, proceeding from the simple to the complex. In it, all the services, curative and preventive, would be brought together in close co-ordination under a single Health Authority for each area. Wherever possible, the

buildings needed to accommodate the services of all types should be grouped in such juxtaposition as to form one institution, styled a "Health Centre."

The more complex services belonging to Secondary Health Centres and Teaching Hospitals would of necessity be located in towns of a certain size.

93. It is vital to the success of any scheme of Health Service that there should be unity of idea and purpose, and complete and reciprocal communication between the associated Teaching Hospitals, Secondary Health Centres, Primary Health Centres, and the Domiciliary Services, whether the Centres are situated in town or country.

Existing methods of Health Administration, involving as they do considerable diversity of responsibility, would not secure this essential condition, and there will be need for a new type of Health Authority to bring about unity of local control for all health services, curative and preventive.

94. As regards the nature of this new Health Authority, there are some who favour a Statutory Committee of an existing Local Authority, whereas there are others who favour the establishment of an *ad hoc* independent body for the purpose of administering health services alone. The question which of these courses is preferable is one upon which we would rather defer any final expression of opinion.

95. Whatever may be the nature of the future Health Authority, it will be necessary to devise machinery for securing the complete intercommunication and co-ordination above referred to, and what we desire to emphasise here is that such intercommunication is vital to an efficient health organisation.

96. *Relation of the Medical Profession to Administration.*—In the opinion of the Council, one of the conditions of efficient service is that the medical profession as such should come into organic relation with health administration. The success of the service will depend upon the co-operation and the enthusiasm of the medical profession, and if doctors play a responsible part in the administration, the Health Authority will have the advantage of their knowledge, and the local profession will feel its reputation and interests identified with those of the service.

97. To carry this idea into effect, we recommend: (1) that the medical profession be represented as such in the future Health Authority; and (2) that a local Medical Advisory Council be associated with each Health Authority.

98. *The Composition of the Health Authority.*—The representatives elected by popular vote should hold a majority on the Health Authority. We suggest that they should constitute three-fifths of the membership, and that the remaining two-fifths be made up of persons whose special knowledge would be of value in health questions, a majority of whom should be medical representatives nominated by the Local Medical Advisory Council.

By such an arrangement, the elected representatives would hold the majority of votes, and the nominated members would contribute to the skilled knowledge necessary for successful deliberation.

Methods should be provided whereby the Health Authority could obtain the advice and ascertain the collective opinions of those engaged in allied services, such as pharmacists, nurses, or midwives.

99. *Local Medical Advisory Council.*—In any areas in which there is established a Health Authority, we advise the setting up of a Local Medical Advisory Council, consisting of, say, ten to twenty members, the number varying according to the needs of the area. This Council should be elected periodically by and from all the registered practitioners resident in the area by means of the postal vote or otherwise, and the Health Authority might be made responsible for conducting the election. The Principal Medical Officer and the two Chief Assistant Medical Officers (as defined below) should be ex-officio members of this Advisory Council.

100. *Power to appoint Specialised Committees.*—The Local Medical Advisory Council should have power to appoint committees for special purposes within their competence, and each such committee should have power to co-opt persons specially skilled in the subject under consideration.

101. This Council could give valuable advice to the Health Authority on questions affecting the health of the area, such questions being either referred to it by the Health Authority or raised on its own initiative. As already stated, it would nominate medical representatives on the Health Authority.

102. On purely professional matters, which must arise in connection with the service, the Health Authority would probably invite and be guided by the advice of the Council. Though its functions would be primarily advisory, it would be able to perform other useful duties in connection with the service, and would be a means for communicating to the Health Authority the collective opinion of the practitioners in the area.

103. *Medical Officers of the Health Authority.*—The Principal Medical Officer of the new Health Authority would be the administrative head of the medical service, whether under a readjustment of the existing authorities or under an *ad hoc* authority, and would have duties and responsibilities more extensive than those attaching to the existing Medical Officer of Health.

104. Under the Principal Medical Officer, we recommend that there should be two Chief Assistant Medical Officers, of whom one would be specially concerned with the administration of the curative services, and the other would be occupied more especially with preventive services. Under these again would be Assistant Medical Officers, the number varying with the size and needs of the area concerned. On the staff of the Principal Medical Officer would be the professional heads of the various services in the area, e.g., the Principal Dental Officer, the Principal Matron, &c.

SECTION VI.

DETAILS OF CERTAIN FORMS OF PROVISION.

105. We think that it may be helpful to give some account of the manner in which we anticipate that certain services under such a scheme as we recommend could be provided either in the home or in the several types of institutions mentioned in this Report. For this purpose we have endeavoured to describe as a whole the provision which should be made under the various headings of systematised scheme for (a) Laboratory services; (b) Dental services; (c) Maternity and Child Welfare services; (d) Physical Culture; and (e) Recuperative Centres.

(a) Laboratory Services.

106. *Primary Centres.*—At each Primary Centre would be a laboratory of which the first and essential function would be to give facilities to the general practitioner himself. It would be so equipped as to enable him to make personally any examinations which fell within his scope and desires. The equipment, which would be supplied from the Secondary Centre, would have to keep pace with any increase in knowledge, skill, and interest that might be displayed by the practitioners concerned.

107. It is clear that some assistant would in all cases have to be in charge of such a laboratory, but the nature of his qualifications might vary with the size, geographical situation, and special needs of the Centre. At the smallest Centres the part-time services of a moderately skilled attendant might be sufficient. At larger Centres assistants with more training would be provided, and it is a matter for consideration whether, in certain cases at any rate, such individuals might not combine the duties of the pharmacist with those of the laboratory assistant. At the largest Primary Centres two assistants might be required, and it would be desirable that the senior of these—especially at centres farthest removed from a Secondary Centre—should be able to report, at least provisionally, in cases of urgency; as, for instance, when diphtheria is suspected.

It would be well if those who work at the Primary Centres were, as a matter of routine, to spend occasional periods at the laboratory of the Secondary Centre for the improvement of their skill and knowledge.

108. The staffing of the Primary Centres should in any case be in the hands of the Director of the laboratory at the Secondary Centre to which the smaller organisations were affiliated. It would be his business to know the special and varying needs of the latter, and he would see that they were staffed in accordance with these needs. It would be one of the great advantages of an organised service that in cases of emergency, as on the outbreak of an epidemic, laboratory assistance could be concentrated locally by the transference of workers.

109. The laboratories of Primary Centres would all be in telephonic communication with the proper Secondary Centre, and they would be further linked to it by a motor transport service. Examinations involving difficulty would either wait for the routine visits of a consultant

from the Secondary Centre, or materials could be rapidly sent to the latter. Considerable elasticity in the possibilities of procedure would clearly exist. Certain types of work—histological examinations, for instance—might, as a matter of routine, go at once to the Secondary Centre, while, on the other hand, when materials have to be taken from the patient, and especially when quantitative methods are involved, a visit by the consultant to the Primary Centre might be necessary.

110. *Secondary Centres.*—The laboratory at a Secondary Centre would have important duties. Accommodation should be ample and the senior staff highly qualified. The work would in part be the same as that of the Primary Centres, but it would comprise also the prosecution of more difficult investigations sent up from the smaller laboratories, together with examinations carried out for the Clinical Staff of the hospital at the Centre. The laboratory would, furthermore, have functions in connection with post-graduate teaching. The head of the laboratory should be a thoroughly well qualified pathologist, and his staff would comprise specialists in Morbid Anatomy, Bacteriology, and Pathological Chemistry. These would add to their intramural duties the function of consultants at the smaller Centres. Some of them would be preparing for the highest posts in the service; others would belong to an intermediate class. Their assistants would be of a class suitable for staffing the Primary Centres, and would comprise individuals temporarily seconded from these for educational purposes.

111. The Secondary Centre laboratory would in its turn be linked to the related Chief or University Centre, but it would only pass on to the latter problems of exceptional difficulty, or investigations involving very special or expensive technique.

112. *University Centres.*—At each University Centre it would seem that there should be a special laboratory devoted to the Health Services. It should be distinct from the Professional Departments although in close contact with them. Knowledge, and perhaps material, would be interchanged between them, while the services' staff would necessarily get help and stimulus from the University organisation. But the existence of the separate laboratory would protect the academic staff from the burden of routine, and leave it wholly free for the teaching and fundamental research work which are its proper duties. The staff of the public laboratory would, moreover, be recruited from the service itself, and the appointments would depend, not upon professorial needs or caprice, but (ultimately, when the scheme was developed) upon meritorious performance within the service itself. On these lines *esprit de corps* and sense of security would be built up within a real public service for the encouragement of its smooth working. At the same time no rigid barrier need be established between academic Pathology and Pathology as applied to the Health Services, and circumstances would often cause individuals to pass from one to the other.

113. The Health Services laboratory at a University Centre would inevitably be occupied in part with work of the kind done at Primary and Secondary Centres. But it would also carry out more difficult

and more costly investigations referred to it from its subsidiary centres, and without interfering with the privileges of the University Department it would undertake much of the routine work for the large hospital of the Centre. Within its walls, moreover, new methods would be tested or initiated, and the knowledge so gained would be passed down to subsidiary centres. The Directorship of such a laboratory would constitute the blue ribbon of the service. The authority of the Director would rank with that of the University Professor. He would usually be a distinguished pathologist whose tastes inclined to organisation and administration rather than to teaching duties.

Research.

114. Suggestions for independent research could hardly fail to arise in the minds of individuals engaged in the work of any of the Centres. It would be bad for the Service and for science if individual research were discouraged.

115. But in relation to research as a whole, the great advantage of a national organisation of laboratories in touch with other branches of the Health Services would be the opportunity thus provided for systematic investigation and team work. It would be possible for the Director at one of the Chief Centres, on his own initiative, or on that of his academic colleague, to start the machinery for the intensive investigation of any urgent problem on a great quantity of material which, assuming the goodwill of the practitioner, could comprise cases which would never be available in the wards of hospitals. Such organised research might in particular deal with the earliest stages of disease. It would seem to be a natural function of some such body as the Medical Research Council to keep in touch with work of this kind, and, when necessary, to subsidise it.

(b) Dental Services.

116. It is necessary that the schemes devised for making dental treatment available for all classes of the community should be closely co-ordinated with the general plan of medical services—curative and preventive—and form part of the whole.

The tendency is for treatment of the mouth and teeth to become more preventive in character, but all forms of dental treatment, even when definitely curative, constitute in the strict meaning of the term a branch of preventive medicine.

117. The object of dental treatment is to procure normal formation of the jaws and dental arches, and a clean and healthy mouth at all ages. It is obvious that most of the impediments to attaining this end are to be sought either in conditions governing pre-natal growth or in the environment of early childhood. On the other hand, the ill effects of dental disease and oral sepsis throughout life are well recognised. Dental treatment, therefore, comes into close relation with medical treatment at all periods.

118. A dental clinic staffed by one or more visiting dental surgeons should form part of every Primary Health Centre. The work of this clinic would consist of all forms of ordinary treatment of expectant and nursing mothers, young children under school age, school children and the ordinary adult population. Artificial dentures would be fitted. The dental surgeons would have opportunities of giving instruction in the elementary principles of oral hygiene. The institution of these Primary Health Centres would be the means of overcoming many of the difficulties which have hitherto stood in the way of the provision of dental treatment for school children in rural districts. A nursing service in connection with dentistry should be attached to each centre.

119. At Secondary Health Centres there would be similar dental clinics to meet the requirements of the immediate neighbourhood, but on a larger scale, especially as regards the fitting of artificial dentures. For this purpose, which in the case of any patient is only an occasional want, there is not the same need to provide treatment near home, as, for example, in the case of children, and in a large town the Secondary Health Centre would absorb most of the artificial denture work otherwise carried out in the more remote Primary Health Centres. At each dental clinic in a Secondary Health Centre there should be an orthodontic department.

120. A dental laboratory would be attached to each dental clinic at a Secondary Health Centre, in which all prosthetic and orthodontic and some surgical appliances would be made for the area served by the Centre.

121. The staff of the Dental Clinic would consist partly of whole-time officers and partly of visiting dental surgeons, together with a staff of nurses and mechanics. Selected members of the Dental Staff of the Health Centre would act as consulting Dental Surgeons at the correlated Primary Centres, paying the latter periodic visits.

122. Intimate co-ordination between the Secondary Health Centre and the Primary Health Centres within its area would be essential. As regards all ordinary forms of preventive, conservative, and remedial treatment, each clinic at a Primary Centre would provide for patients of all ages.

Artificial dentures would also be fitted, but as the actual making would be at the Secondary Centre, means should be provided for transmission of models and of dentures in various stages of manufacture. Simple cases of irregularity of the teeth could be treated at Primary Centres, but more difficult cases of abnormal jaw development would involve at least occasional attendance at a Secondary Centre, and in most cases the necessary appliances would be provided from it.

123. Provision should be made for dental treatment of all persons admitted to recuperative centres, convalescent homes, sanatoria, and other institutions belonging to the Supplementary Services.

124. Attached to the Teaching Hospitals are Dental Schools responsible for education and research. From them the Secondary and

Primary Centres must be staffed, and there should be close association between these three grades of dental service. Post-graduate study should be fostered.

125. The number of dentists at present on the Dentists' Register is not nearly large enough to enable any kind of comprehensive scheme of dental treatment to be put into operation, a fact fully recognised in the Report of the Dentists' Act Committee.

126. *Payment for Dental Treatment.*—All forms of dental treatment provided at the Clinics and Primary and Secondary Health Centres should be regarded as part of the necessary medical treatment.

127. The remuneration of the dental surgeons attending the clinics should be on a time basis, and arrangements might be made by which dental surgeons would make use of the clinic for private patients. The payment of Dental Consultants would be on the same basis as that for other consultants.

(c) *Maternity and Child Welfare Services.*

128. We have already stated (paragraph 33 above) that it is our intention to ask you to approve the appointment of a Committee for the special purpose of considering in detail such services as fall under this head. The following paragraphs are accordingly restricted to a statement in outline of the scope and character which we think proper to such services.

129. The services would be divided into :—

I. Domiciliary.

II. Institutional—

- (1) at Primary Health Centres ;
- (2) at Secondary Health Centres ;
- (3) at Teaching Hospitals.

I. DOMICILIARY.

130. This should include :—

- (a) Advice and treatment for pregnant women unable to attend at a Health Centre.
- (b) Provision for the conduct of labour and its after attendance at the woman's home. A doctor and a midwife should be available for every labour, and, if occasion requires, an anaesthetist should be available also. Attendance by midwives trained to know when a doctor is needed, but prepared to wait on natural labour, is of importance in assisting to diminish puerperal infection, and to prevent birth injuries to mother and child. Additional assistance might be obtained from a service of home help exercising carefully defined functions and working under proper supervision.

A sterilised maternity outfit should be obtainable from the Primary Health Centre. The practitioner should be able to summon an expert obstetrician, with the necessary assistance and outfit, in a case of difficult labour, if he desired it.

- (c) Supervision of the welfare of the mother and infant and any necessary medical attendance in cases in which attendance at the Primary Health Centre was impossible. This service would, of course, require to be developed in suitably organised relation to existing forms of provision directed to the same end.

II. INSTITUTIONAL.

131.—(1) *Primary Health Centre*.—The service should include :—

- (a) Care and instruction of pregnant women, who should be encouraged to attend the Health Centre for that purpose. In the event of abnormality or disease being discovered, the patient would either be treated at her own home, or be taken into the Health Centre, or be transferred to one of the higher Centres, according to the circumstances of her case.
- (b) Beds available for labour and after-care, and means of isolating any case of sepsis after delivery, should be provided. The services of a consultant from a Secondary Centre should be available if the practitioner desired it. Beds available for ante-natal, maternity, and post-natal cases in the wards of a Primary Health Centre would necessarily be limited. If a demand should arise in any district for extended institutional accommodation for such cases, this would be met by the provision of an annexe or of a separate institution for that purpose.
- (c) Diseases and abnormalities resulting from child-bearing fall under the head of gynaecology. Gynaecological cases would be taken into the wards of the Primary Health Centre, or sent on to a consultant at the Secondary Health Centre, or be treated as out-patients at the Primary or Secondary Centre, as their practitioner might determine to be best in each case. When necessary, residential accommodation should be provided for the infant with its mother.
- (d) An infant welfare department should be part of the Primary Centre, to which mothers should be encouraged to bring their children for medical advice and care. Sick or ailing infants unsuitable for domiciliary treatment should be taken into the Primary Centre or be transferred to the Secondary Centre.

132.—(2) *Secondary Health Centre*.—It would appear that in many cases these Centres would also act as the Primary Centre for their immediate district. In so far as they would act as a Primary Centre, the foregoing sketch would apply to them also. In so far as they are Secondary Centres the service would be conducted by an obstetric or gynaecological specialist, and would include :—

- (a) The seeing of expectant mothers sent up by the practitioner for expert opinion or treatment either as out- or in-patients.
- (b) Lying-in beds and labour ward completely equipped and with a resident obstetric officer.

- (c) A gynæcological out-patient department for cases sent up by the general practitioner for opinion or treatment.
- (d) Beds for gynæcological cases.
- (e) The treatment either as out- or in-patients of ailing or sick infants sent up by the general practitioner. The treatment would be carried out by that expert (surgeon or physician) who was most suitable for the case.
- (f) Provision should be made for the despatch of an expert obstetrician with the necessary outfit to a woman's own home in cases of difficult labour in which the practitioner in attendance requested such assistance.

133.—(3) *Teaching Hospitals*.—The obstetric and gynæcological departments already existing would continue as heretofore, but should be linked up with the corresponding departments of the Secondary Centres in the area served by the Teaching Hospital.

In many cases the Teaching Hospital might itself be the Secondary Health Centre for its immediate district, and the existing gynæcological, and particularly the existing obstetric departments, would need enlarging.

The opportunities for students and post-graduates to acquire practical experience in obstetrics and its kindred subjects are at present insufficient and largely unorganised.

The linking up of Secondary Centres with their corresponding Teaching Hospital would make available for students the clinical work necessary for efficient obstetric teaching, the importance of which to the public cannot be urged too strongly.

(d) *Physical Culture*.

134. Physical culture, with the qualities of character it engenders, is a vital necessity to the health of the nation.

It plays an important part in preventive and curative medicine, and should hold a place in any scheme of medical services. In the recognition of its value this country has been a laggard, a fact brought home by recalling that Ling gave to the world his system of Physical Culture as long ago as 1813, and by contrasting its strong and established position in the educational and social life of Sweden and other countries with its recent and slender growth in this country.

135. Physical culture has a wide application in promoting the health of the community. This application may be either constructive and educative (of body and mind), or recreational or remedial.

136. Physical culture aims at producing a healthy and strong body, with balance and grace of movement; brain control—quick and perfected response and concentration of purpose; the joy of achievement; discipline; playing for the side rather than self, loyalty, comradeship.

137. Experience in the training and convalescent camps during the war, and in the Elementary Schools, has shown that physical training should consist not only of formal exercises but of games which are either free or have an educative design. It has been found that the

objects aimed at by a formal exercise can often be attained by providing the setting of a game, and with the latter there is a spontaneity and exhilaration absent from the former. A proportion of formal exercises is desirable for their physically corrective and disciplinary effects, but these should be limited in time and be followed by educative games. The latter merge into recreational training, such as is afforded by dancing, swimming, football, cricket, &c.

138. During school life physical training can be thorough and systematic, because it is part of the curriculum, but it needs to be more than this. It is here that the love of physical training for its own sake should be engendered, so as to ensure its voluntary continuance when the period of school life has passed, and the establishment of a taste for outdoor pursuits. This requires well-trained and inspiring teachers who know how to adapt exercises and games to pupils of varying taste and temperaments.

139. For the past ten years physical education has been progressively developed and fostered by the Board of Education in our Elementary Schools under the guidance of Sir George Newman and his staff. The extension of the school age will no doubt carry with it a corresponding extension of these advantages of physical training to adolescents. In fact, the Education Act of 1918 gives the Education Authorities wide power to provide facilities for physical education and recreation. The organisation of physical culture, however, needs to include provision of physical recreation and training for the adult population. It is thus that health and fitness can be maintained in spite of town life and the strains and disadvantages of various employments. At the present time the mass of the active population has no physical recreations.

140. Every community should possess grounds specially provided and maintained for physical training and recreation at the public expense. The gain in the improved health of the people and the diminution of illness would more than repay the cost.

The ground should be so planned and equipped as to meet the needs of different ages, of the children, the adolescents and the adults.

Although a public authority would provide and administer the ground, the recreations and games should be left as free and unfettered as possible, and in the hands of voluntary associations, such as Athletic Clubs, Boy Scouts, Girl Guides, &c.

In populous districts spaces of quite modest proportions, if suitably equipped, would serve well for the physical training and recreation of boys, girls and youths.

141. Remedial physical treatment includes—

- (a) Active exercises.
- (b) Passive exercises.
- (c) Massage.

The range of application of this treatment to varieties of disability and disease steadily widens and is still imperfectly understood. In importance it often overshadows medicinal treatment.

It is related to the curative work at the Health Centres and in patients' homes on the one hand, and to the physical education of the

adult on the other. In the schools such defects as early flat foot, commencing curvatures, mouth breathing, deformed chests, &c., require suitable physical treatment.

At the Orthopædic Centre, massage and exercises are extensively used.

Physical culture is thus concerned with education, with the maintenance of the health and recreation of the people, and with the curing of disease and disability; and there is no sharp line of demarcation between these functions.

142. For purposes of administration we would suggest that physical culture should be under the control of Health and Education Authorities by means of a joint committee with power to co-opt members having special knowledge of physical culture.

143. We recommend that a doctor specially skilled in this subject should be attached to each Secondary Health Centre. This specialist would supervise the work and training of the masseurs and masseuses, and act as a consultant and adviser throughout the area. This is a speciality of great importance hitherto neglected by the medical profession, but offering the attractions of scientific interest and public usefulness.

144. Those who practise in the various branches of physical culture are insufficient in number, and are often inadequately trained. The length and nature of the training for the practice of the various grades of educational and curative work need careful inquiry. At present there is provision for the training of women, but there is no training college for men, and such a college in the Metropolis of the Empire is an urgent need.

We propose, with your approval, to set up a Committee to consider this question of Physical Culture.

(e) *Recuperative Centres.*

145. Recuperative Centres are intended to serve the double purpose of restoring patients to health either after illness or before their ill-health has become disease. A large number of patients attending doctors' surgeries or out-patient departments of hospitals need rest, regime, fresh air, suitable food, physical training and recreation, to restore them to health and prevent the development of disease. The victims of anæmia, of functional dyspepsia, of constipation, of the various minor infections, of debility (which means weak defence against illness)—to give only a few examples—can in this way be restored to health and vigour instead of being burdened with chronic ailments or developing organic disease.

146. Such institutions are essential to any scheme of medical services. They would be a great field for preventive medicine and for the study of the early manifestations of disease. They need to be situated in the fresh air and require sufficient ground. They do not require elaborate buildings, and hutted camps offer many advantages; some of those still in existence might well be secured before they are broken up. In the organisation and management of these Recuperative Centres there is a wealth of experience available in the Army

Medical Service, for the convalescent and rest-camps in the War were notably successful and played an important part in the maintenance of the health of the Army. The experience of these camps also shows that the success of a recuperative centre would depend largely upon the possession by the staff of special aptitudes and training for this work.

SECTION VII.

SUMMARY OF RECOMMENDATIONS.

147. We append a summary of the effect of our various recommendations as to the elements which should in our view be included in schemes for the systematised provision of medical and allied services for the inhabitants of a given area. This summary is to be understood not as governing or placing an interpretation upon the fuller paragraphs of the Report, but only as drawing attention in a conveniently brief form to the main conclusions.

We recommend that schemes should include provision for the following services and personnel :—

Services.	Personnel.
A.—DOMICILIARY (paragraphs 18 to 35) (including both curative and preventive work).	Doctors. Pharmacists. Nurses. Midwives. Health Visitors and other officers of the Health Authority.
B.—PRIMARY HEALTH CENTRES (paragraphs 36 to 52) including— Medical, surgical and maternity beds ; Out-patient clinics ; Dental clinics ; Accommodation for equipment needed for treatment and investigation ; Accommodation for the work of Communal Services : Accommodation for workers in ancillary services ; Ambulance Service.	General Practitioners. Visiting consultants and specialists. Officers engaged in Communal Services. Visiting dental surgeons. Workers in ancillary services.
C.—SECONDARY HEALTH CENTRES (paragraphs 53 to 73) including— Facilities for curative services in cases requiring highly specialised diagnosis or treatment ;	Consultants and specialists. Officers engaged in Communal Services.

Services.

Personnel.

C.—SECONDARY HEALTH CENTRES

—*continued.*

Accommodation for the work of Communal Services ;	Dental surgeons. Workers in ancillary services.
Dental Clinics ;	
Accommodation for workers in ancillary services ;	
Ambulance Service.	

D.—SUPPLEMENTARY SERVICES

(paragraph 74) including—

Provision of facilities for specialised treatment of such conditions as Tuber- culosis, Mental Disease, &c.	Specialists in the appropriate forms of treatment. Workers in ancillary services.
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E.—TEACHING HOSPITALS WITH

MEDICAL SCHOOLS (para-
graphs 75 to 80) including—

Facilities for treatment of cases of unusual difficulty ;	Consultant, teaching, and re- search staff.
Facilities for research ;	Workers in ancillary services.
Facilities for post-graduate study (including training for Communal Services).	

148. We further recommend that schemes should include provision for :—

F.—The encouragement of research (paragraph 87), and

G.—The operation of a system of standardised clinical records (paragraphs 88 to 91).

In conclusion, we have submitted recommendations as to the principles of administration which should govern such schemes of services as we have in view, including (paragraphs 92 to 104) :—

H.—The establishment of a single Health Authority to supervise the local administration of all medical and allied services, whether curative or preventive ;

I.—Representation of the medical profession on each such authority ; and

K.—Establishment of Local Medical Advisory Councils.

149. We have added, in Section VI of the Report (paragraphs 105 to 146), details as to certain important forms of provision which should find a place in schemes put into operation in accordance with the foregoing recommendations.

150. We have been authorised by the Council to sign this Report on their behalf as Chairman and Vice-Chairman.

We are, Sir,

Your obedient servants,

DAWSON OF PENN, *Chairman.*C. J. BOND, *Vice-Chairman.*

APPENDIX.

MEMORANDUM ON DESIGNS FOR HEALTH CENTRES.

The accompanying plans are intended to illustrate the text of the Report, and must not be considered as standardised models, but only as a basis of the lines which might be followed in erecting new buildings or in the conversion of existing ones.

An attempt has been made in the drawings to visualise the kind of accommodation which would be required in order to carry out the various services under consideration, and to produce workable schemes for buildings which would indicate types of general planning and grouping of the various departments. Plans prepared on these lines must necessarily be of a very general description, as exigencies of site, local conditions and requirements, &c., would certainly play a great part in the actual planning of such buildings in concrete cases.

PRIMARY HEALTH CENTRES.

SITE.

This should be on high ground, if possible, with a slope to the South or South-East, and with access from a road either on the East, West or North, and, if possible, sheltered towards the North and North-West. The site should be large enough to provide for a garden and also space for future extension and various subsidiary buildings which might be erected as required.

DESCRIPTIVE NOTES.

TYPE 1.

Ground Floor.

- (1) Examination rooms and consulting room for Clinical and Communal Patients.
- (2) Child Welfare.
- (3) Minor operations and dentistry.
- (4) Laboratory. X-ray and dark room.

First Floor.

- (1) A hospital for 16 beds for both sexes.
- (2) A small minor operation or Labour room.

Second Floor.

- (1) Residential accommodation for Matrons and Nurses.
- (2) Kitchen and mess accommodation for Nurses and Staff.

If the local requirements are such that a larger building is necessary, Type 2 would be more suitable, but in the type under consideration an attempt has been made to plan a building which would procure suitable accommodation for "first instance" only.

The minor operation room, X-ray, laboratory, and the rooms generally, are purposely designed on the small side, as difficult and complicated services could not be carried out here.

Economy in construction has been aimed at, and, therefore, the design has been so planned that all the various services can be carried out under one roof, though the clinical and communal patients can be kept quite apart from the in-patients of the hospital on the first floor.

It will be noticed that the minor operation and X-ray rooms, &c., can be used by all kinds of patients, the large lift shown on the staircase to the first floor being so placed that patients from the wards can easily be brought down to the operating room, and the clinical and communal patients can be taken in directly through the anaesthetic or recovering room.

It is understood that the consulting rooms and examination rooms would probably be used for different purposes at stated times during the day, and it is not therefore necessary to have numerous rooms for special purposes.

The first floor is so arranged that adults of both sexes and children can be treated. There are two special observation wards which might be used for paying patients, if required.

Some provision is made for maternity cases, which, however, would usually be accommodated in a special annexe.

The second floor plan only gives accommodation for six nurses and a matron. This number is considered sufficient for the ordinary working of this type, and accommodation for ward maids and any additional nursing staff would probably be in an adjoining building, or in their own homes if occasion demanded a larger staff to work the building.

The kitchen department shown on this floor would serve the patients' ward by means of a lift into the servery on the first floor, and it has been considered more advisable, in this case, to have the kitchen at the top of the house than on the ground floor, as the chief services required from this department are on the second and first floors. It was not thought advisable that the kitchen and servery should be in a separate building, connected by a corridor, as in Types 2 and 3, the plan shown being more economical in construction and service.

TYPE 2.

Ground Floor.

(1) Two consulting rooms and examination rooms, and separate entrances for Clinical and Communal Patients, also entrance for Mothers and children.

(2) Minor operations and dentistry, X-ray, laboratory, dispensary, and two dark rooms.

For In-Patients.

Reception room and lift to first floor.

Kitchen, offices, and servants' mess rooms.

First and Second Floors.

Accommodation for 16 adults on each floor and for children if necessary.

Third Floor.

Residential accommodation for Matron and Nurses.

This plan represents a building which would be suitable for the service of a small town or group of small towns or villages.

In this building, as in the last, the various rooms would be used at separate times for different purposes.

Care has been taken, therefore, so to arrange the position of these rooms that they can be used for special examinations, if necessary, taking into consideration the various classes of patients who will use the Health Centre.

It will be observed that a small labour and operating room has been provided on the second floor, but it is not intended that this floor should be used entirely for maternity work, for which special buildings should be provided.

Probably in this Health Centre there would be several subsidiary buildings, such as isolation, disinfectant, heating, lighting, and further residential accommodation for staff. Perhaps, also, some provision might be made for physical culture in the grounds if space allowed. The accommodation for Nurses is not, perhaps, adequate for the hospital part of the building, but additional rooms could be arranged on the third floor and it is thought that accommodation for

more nursing staff, if required, would be in separate buildings, which, perhaps, would also contain quarters for the ward maids and kitchen staff. The accommodation shown is considered sufficient for the ordinary working of the hospital, except in times of emergency.

It will be noticed that in this plan the services lift connects with all the floors, and it is not thought necessary to have further kitchen accommodation (except the ward kitchen) than that shown on the ground floor.

TYPE 3.

In this plan the accommodation for various services is more distributed than in the other two types. The plan is roughly divided into four blocks :—

Block A.—Curative and Communal.

Block B.—The Wards.

Block C.—Residential.

Block D.—Kitchen and Servants.

Block A.—Curative and Communal.—In this building the clinical work would be carried out on the ground floor and the communal on the first floor. The accommodation and arrangement of rooms are generally much the same as in the other types, but naturally some departments which occur in the other types are transferred to Block B.

A large site would have to be found for a Health Centre of this description, as there would be more subsidiary buildings in connection with it (not shown on this plan), and these would have to be in close proximity. Such buildings would provide for Isolation, Physical Culture, Remedial Baths, a Mortuary, Disinfecting, Heating, Lighting, and further residential accommodation for staff, &c.

Block B.—The Wards.—This scheme, which is rather unusual, is put forward as a type of planning which might be advantageous from the point of view of economy in construction and working.

The main point to be noted in the plan is the fact that the maximum of sun, and therefore sunny air, is obtained in all the wards and rooms used by the patients. The corridors are on the sunless side of the building, though the corridors in the garden court could be used, if desired, for open-air treatment, as the beds can easily be run out from the wards which adjoin them.

The wards would have windows down to the ground, which would allow of the beds being pushed through them on to the terrace on the South-West and South-East sides. These wards are also ventilated on the North-East and North-West sides by windows above the corridors, so that perfect ventilation is obtained, and any objection to the light and ventilation being on only one side of the wards is thereby overcome.

It is considered probable that most of the in-patients in a Centre of this description would not be allowed to remain there during convalescence. A dining room and three day rooms are provided, and could be used as occasion demanded, and more accommodation of this description is not considered necessary.

The operation block and X-ray blocks are so placed on the plan that they can be used for both clinical and communal patients.

Block C.—Residential.—This is a purely residential building, to be used by the Matron, nurses, staff, and also the Lady Almoners and midwives of the district.

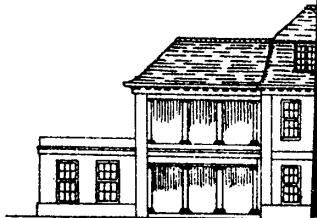
The ground floor contains dining rooms for staff, sitting rooms and kitchen, and there are 15 bedrooms on the first floor.

Accommodation for 20 maids is provided on the second floor.

If further accommodation is required, this block could be enlarged, but it is thought that the rest of the staff would probably live at their own homes, and there is further provision for housing the kitchen staff in Block D.

Block D.—Kitchen and Servants.—The kitchen department is to the north of the Curative Block, and is sufficiently separate from it by a corridor, to avoid unpleasant odours reaching the patients. The kitchen itself is lighted at the north end and also at the top. The passages round it allow of easy access to the various stores, and also to the servants' quarters, without passing through the kitchen. The passages on the south-east side of the kitchen provide for soiled plates, &c., being taken direct into the scullery.

PR

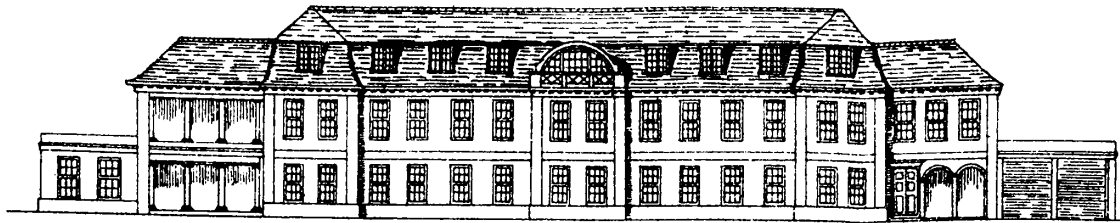


NOTES

The heating for this building would be entirely by means of radiators, gas if possible being used for cooking. The lighting should be electric. A special plant to be installed if local supply is not available. Hot water should be supplied by means of separate boiler to that used for radiators.

PRIMARY HEALTH CENTRE

TYPE N°1

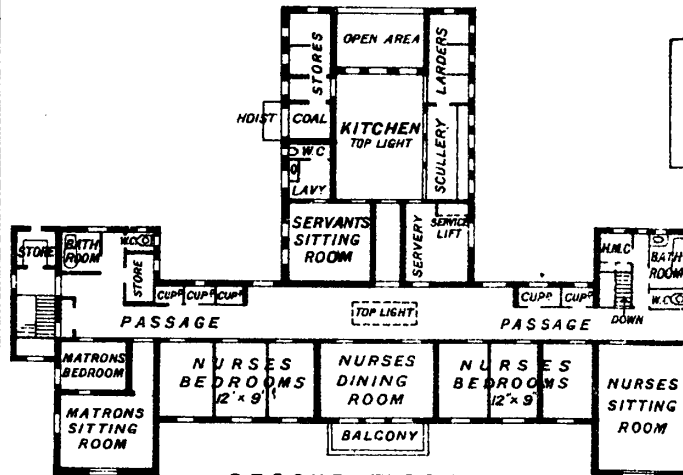


SOUTH ELEVATION

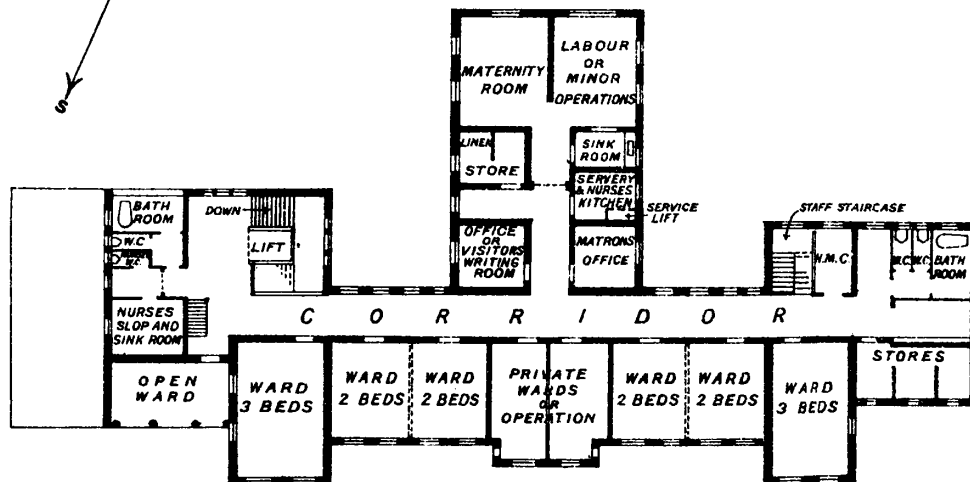
NOTES.

The heating for this building would be entirely by means of radiators, gas if possible being used for cooking. The lighting should be electric. A special plant to be installed if local supply is not available. Hot water should be supplied by means of separate boiler to that used for radiators. The building is so designed that it can be carried out with Brick-Stone or Concrete walls, and tile or slate roof and the windows, doors and joinery of a practically standardized pattern could be adopted, internal fittings and fixtures should be of the simplest description and of good quality. Approved composition floors are the most satisfactory; angles should be rounded, and walls finished in hard cement plastering and distempered.

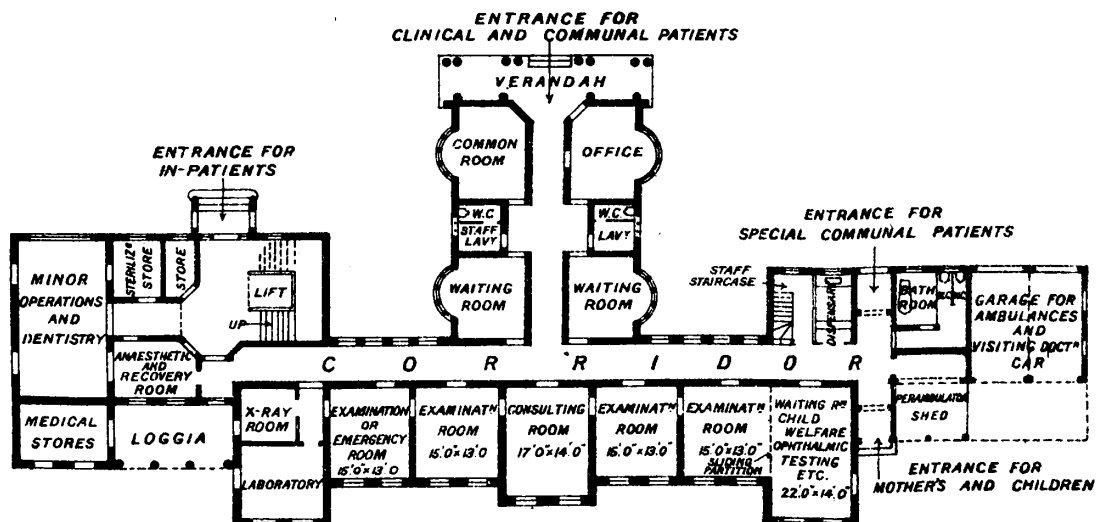
Provision would be made in connection with this building for Heating, Lighting Hot water, Disinfecting, a small Laundry, Isolation, and a Maternity annexe, also some accommodation for additional staff as required.



SECOND FLOOR PLAN



FIRST FLOOR PLAN



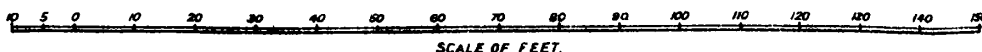
GROUND FLOOR PLAN

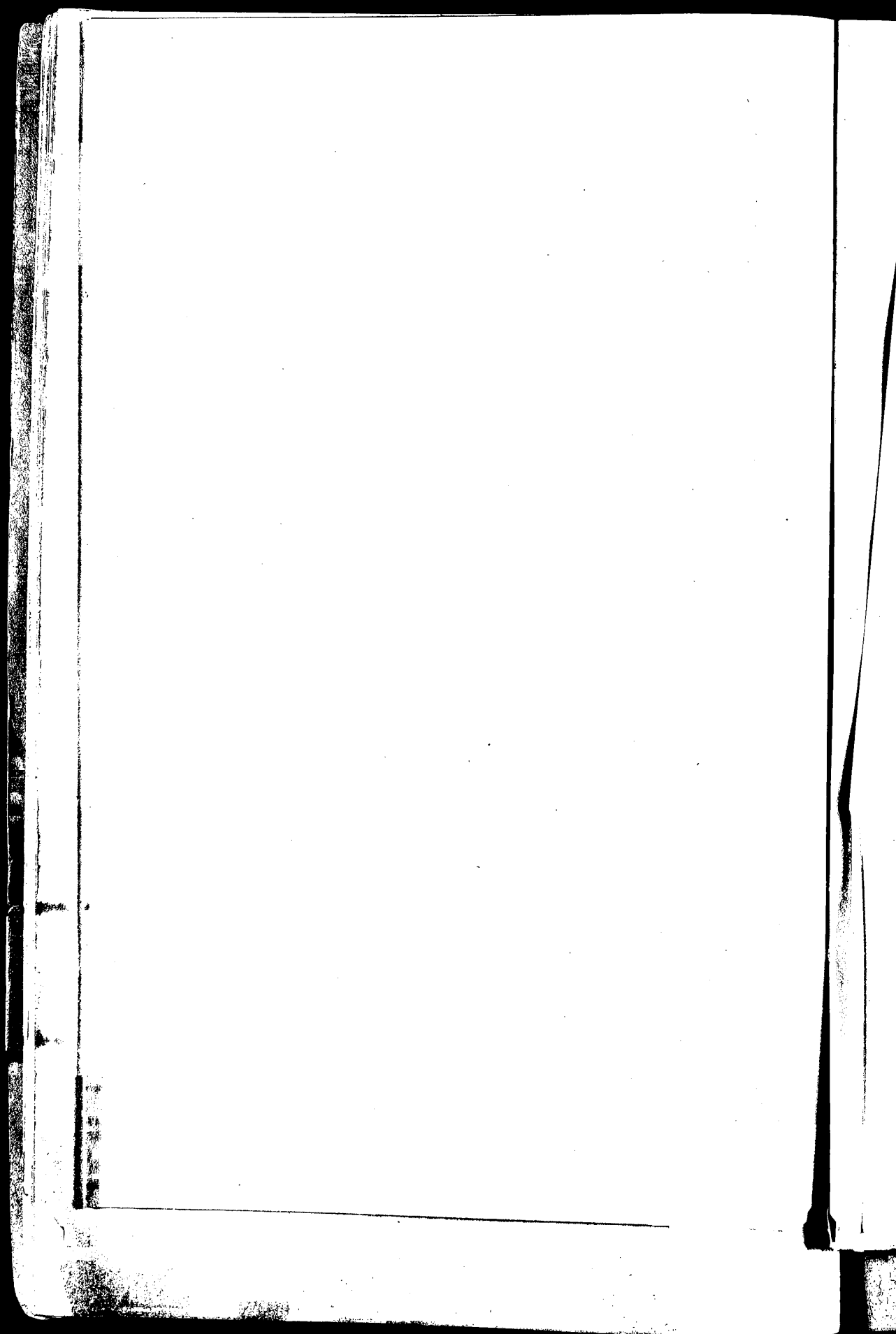
C. H. BIDDULPH-PINCHARD,

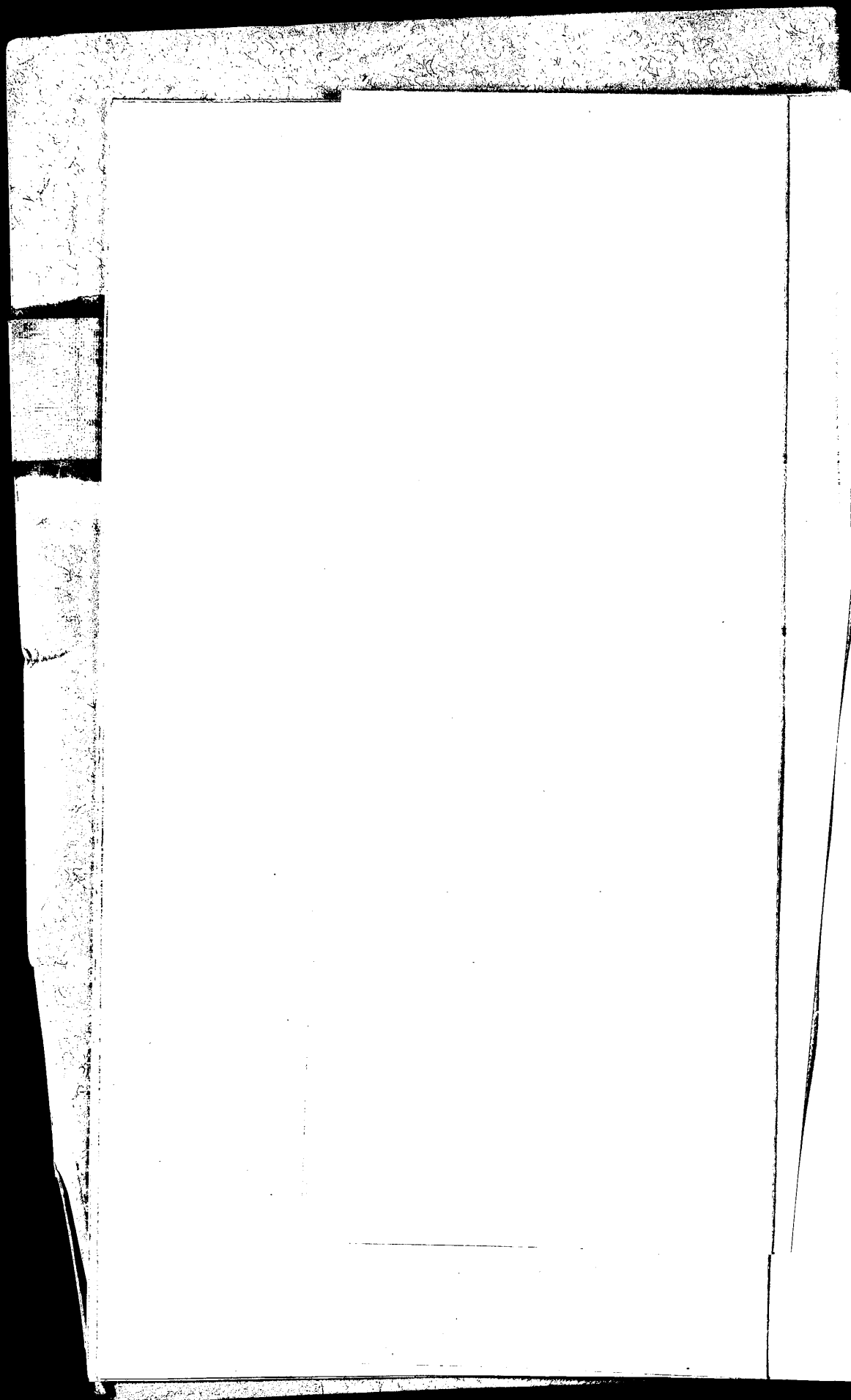
Architect,

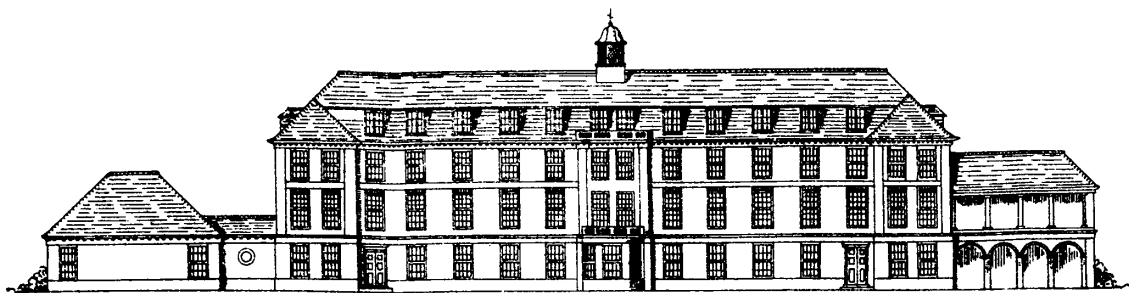
9, Staple Inn.

W.C.





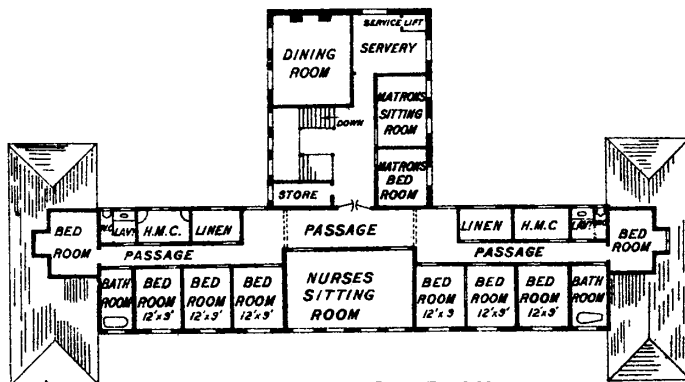




SOUTH ELEVATION

NOTES

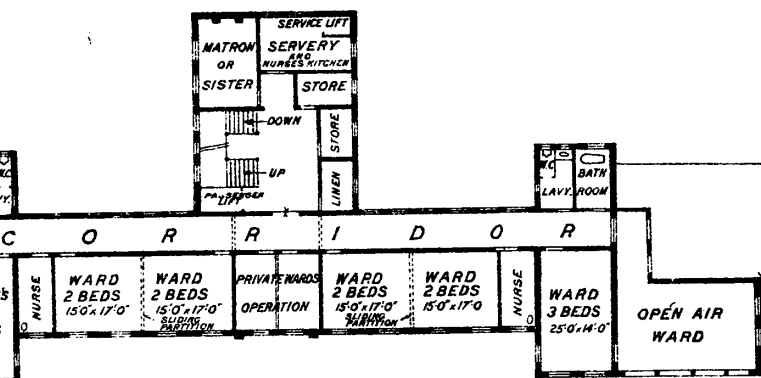
made in connection with this
ing-lighting-hot water-disinfecting-
-a maternity annexe etc. and further
additional staff if required.



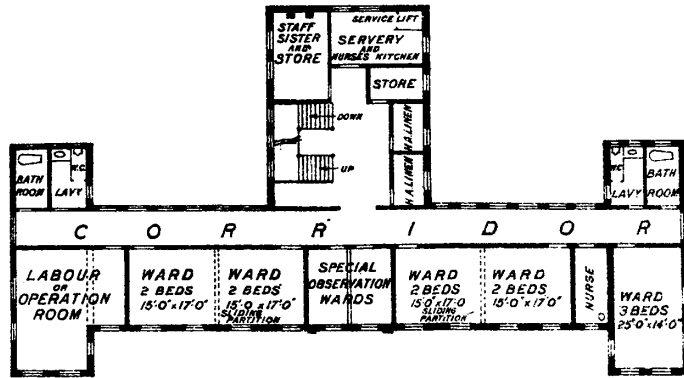
THIRD FLOOR PLAN

NOTES

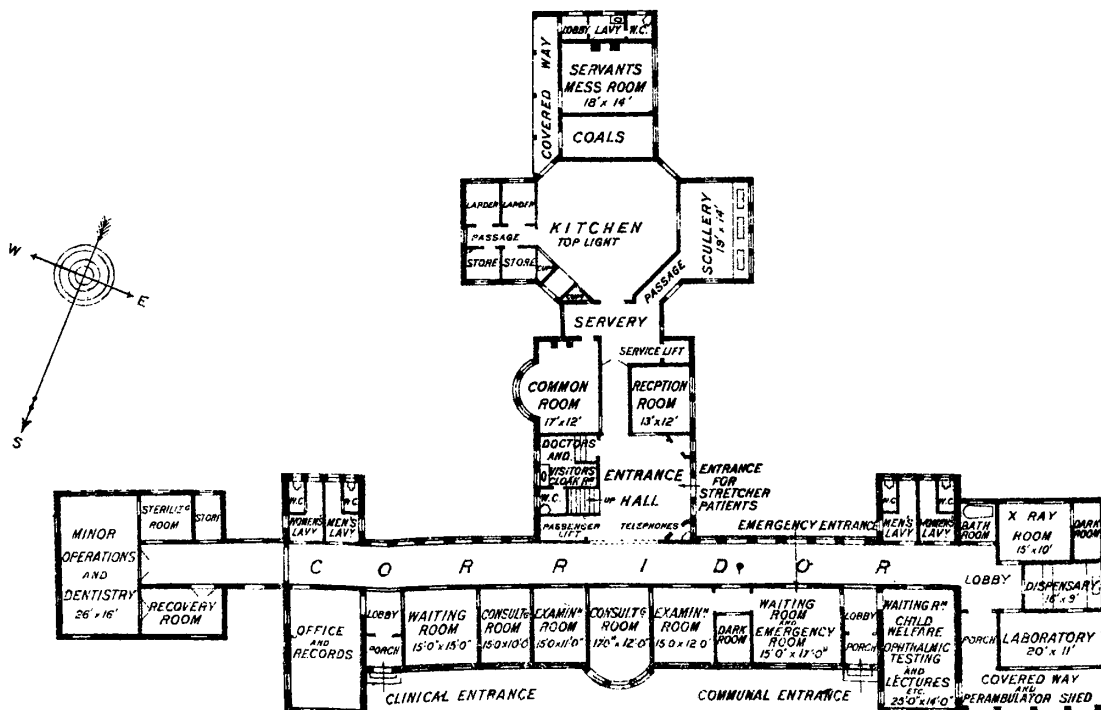
This building could be carried out in either brick-stone-
or concrete construction, with a tile or slate roof. The
windows doors and joinery could be of a standardized
pattern. The walls internally should be finished in hard
cement plastering with rounded angles and distempered
or enamelled.



FIRST FLOOR PLAN.



SECOND FLOOR PLAN

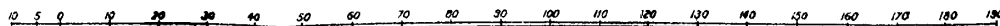


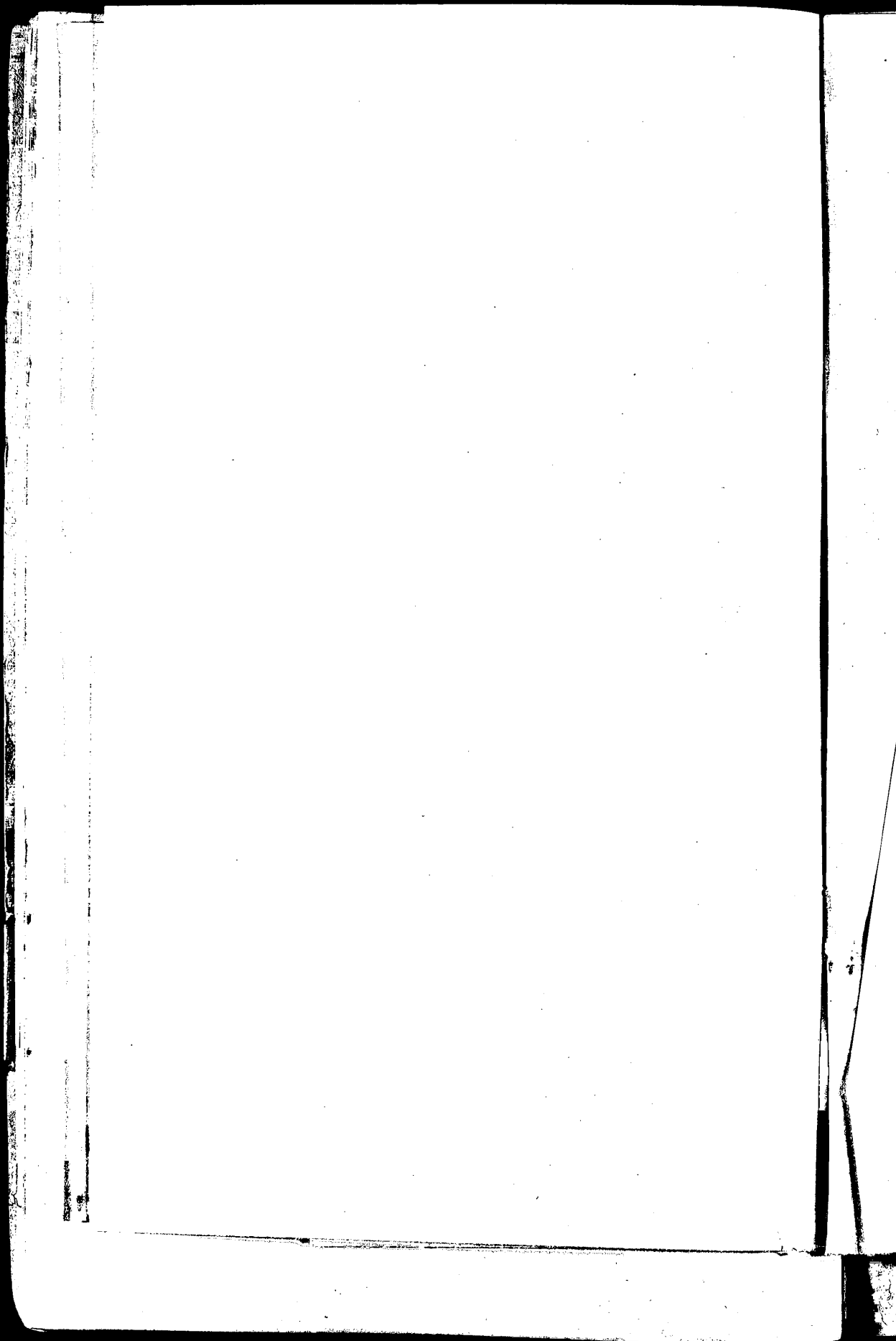
GROUND FLOOR PLAN

C. H. BIDDULPH - PINCHARD

Architect

9, Staple Inn.





TRE.

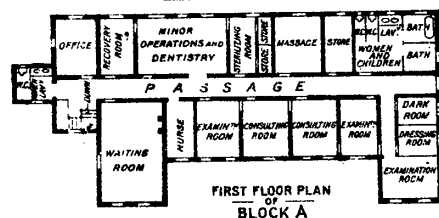
VEL

k D.

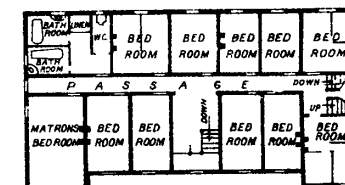
PRIMARY HEALTH CENTRE.
TYPE Nº 3.



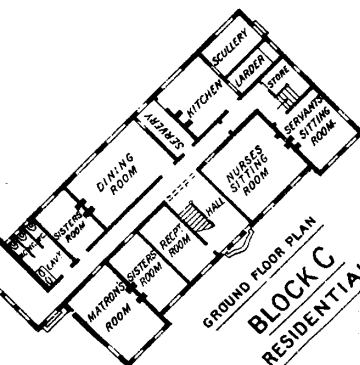
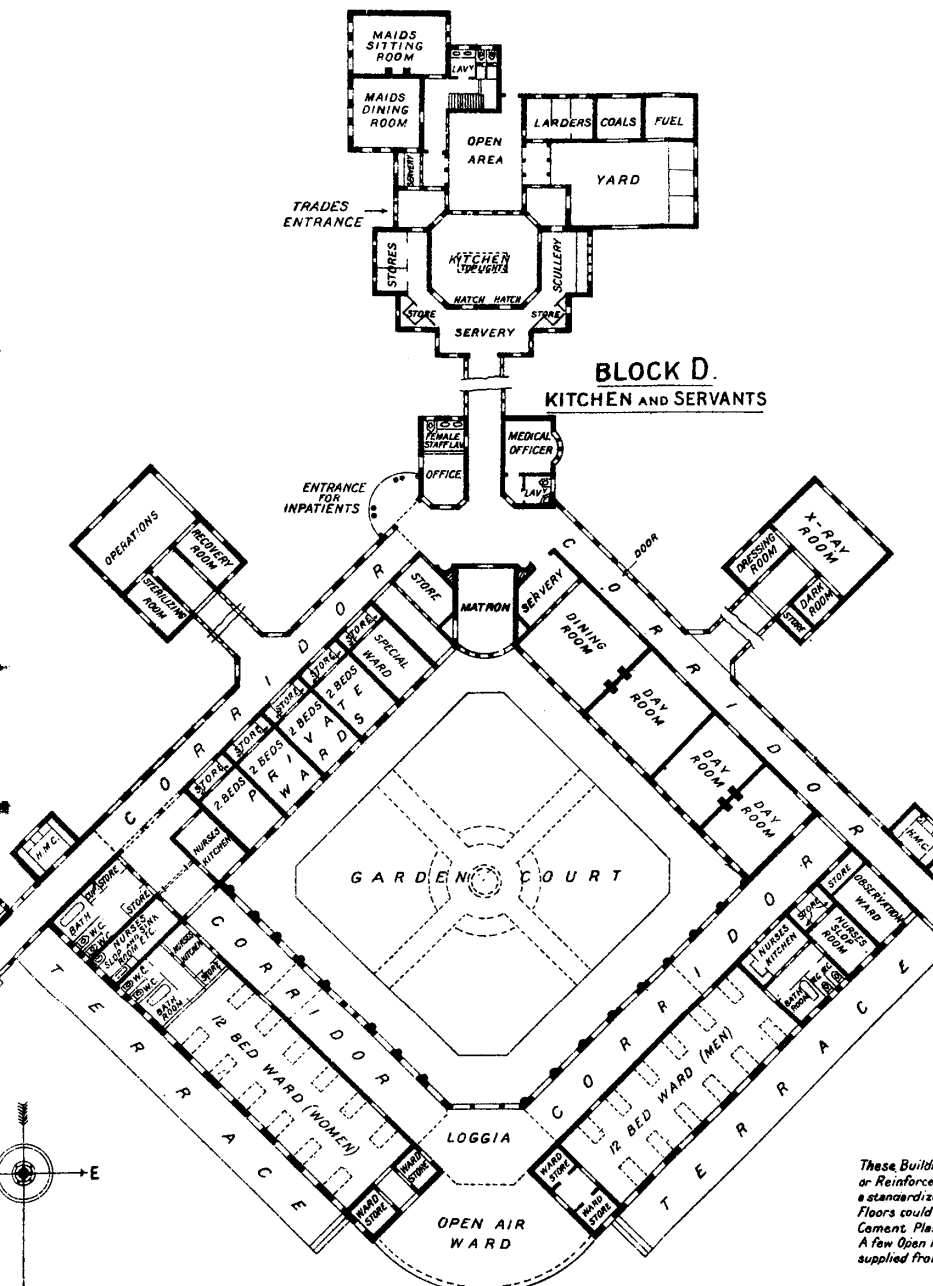
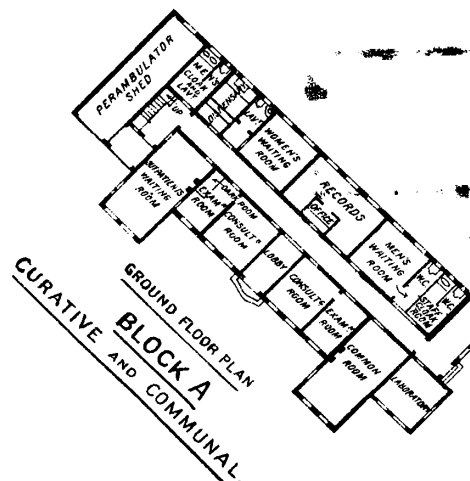
ELEVATION OF BLOCK A



ELEVATION OF BLOCK C.

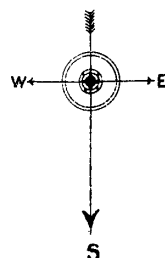


FIRST FLOOR PLAN
OF
BLOCK C.



— NOTES. —

Separate Blocks or Buildings would have to be erected for the provision of Heating, Lighting, Disinfecting, Laundry Incinerator and Isolation. Provision for the following should also be made. Physical Culture, Remedial Baths, Maternity Annex. A Garage and also further accommodation for Staff the relative position of such Buildings would depend on the Site, local conditions and requirements.



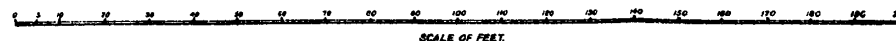
— NOTES —

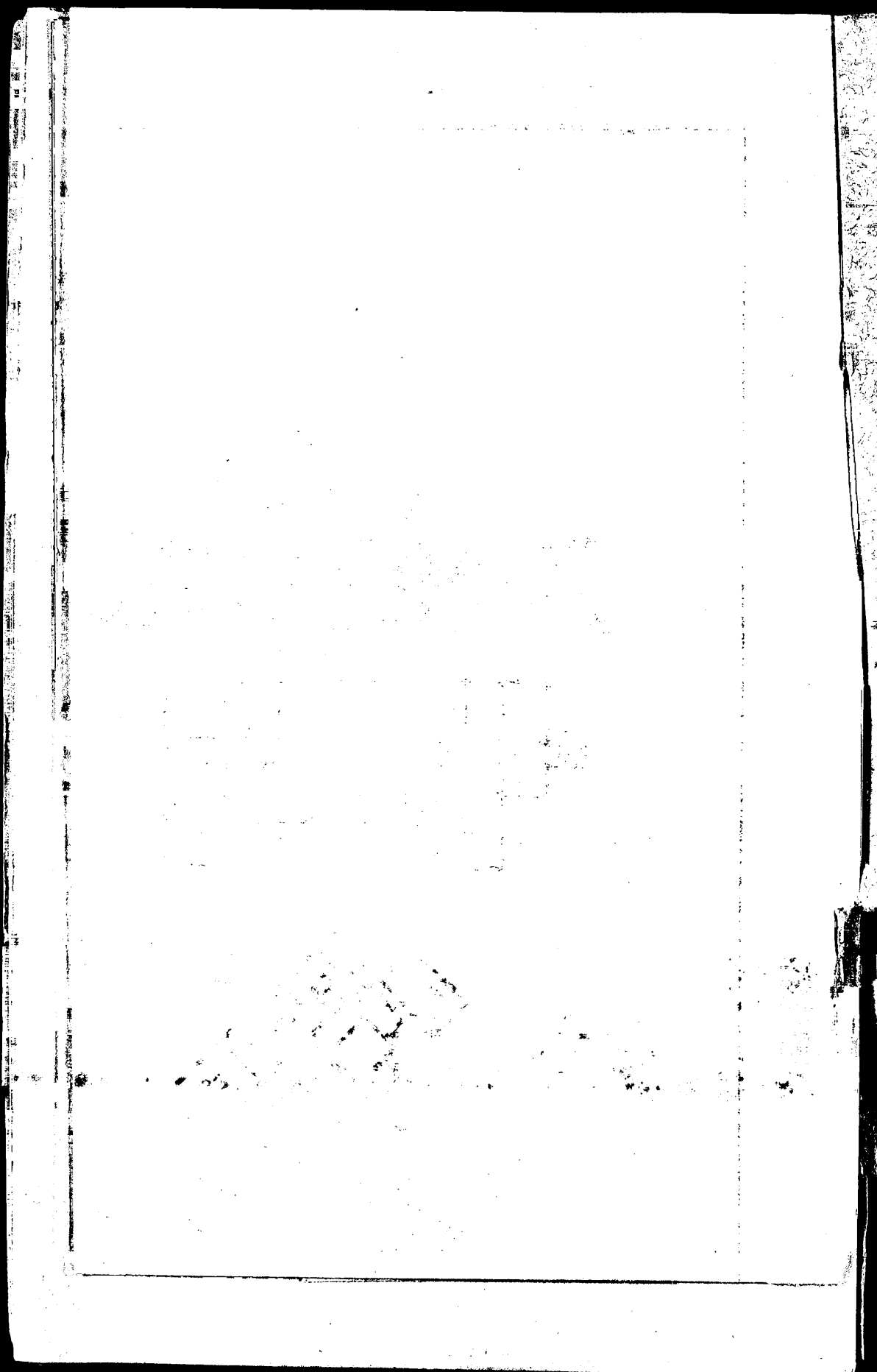
These Buildings could be carried out either in Brick, Stone, Concrete Blocks or Reinforced Concrete. The Windows, Doors and Joinery, generally could be of a standardized pattern, and internal fittings should be of the simplest description. Floors could be of approved composition and walls finished internally with Hard Cement, Plastering and Distempred. Heating could be by means of Radiators. A few Open Fireplaces are also shown in Blocks A and C. Hot Water should be supplied from separate Boilers.

BLOCK B.
THE WARDS

NOTE:- BLOCK B CAN BE ENLARGED BY REPEATING THE ENTIRE PLAN AS A SECOND FLOOR.

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King's Fund



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