The reform of our voluntary medical charities : some serious considerations for the philanthropic / by Robert Reid Rentoul.

VOLUNTARY MEDICAL CHARITIES

RENTOUL

BAILLIÈRE TINDALL & COX

THE REFORM
OF
OUR VOLUNTARY MEDICAL CHARITIES.

BY THE SAME AUTHOR.

The Causes of the Financial Depression at the London Hospitals. Sturge Prize Essay. *Philanthropist*, 1886.

The Growth and Progress of Provident Dispensaries. *British Medical Journal*, June, 1887.

The Midwives' Registration Bill, or the Proposed Repeal of the Medical Act. 20 pp. 1s. F. & E. GIBBONS, Liverpool.

Notes on a Visit to the Canary Isles. *Provincial Medical Journal*, June, 1888.

The Causes and Treatment of Abortion. With 31 engravings and 2 coloured plates. 271 pp., 8vo. 10s. 6d. Y. J. PENTLAND, Edinburgh.

The Dignity of Woman's Health, and the Nemesis of its Neglect. With 5 engravings. 144 pp. 3s. 6d. J. & A. CHURCHILL, London.

THE REFORM

OF OUR VOLUNTARY

MEDICAL CHARITIES:

SOME SERIOUS CONSIDERATIONS FOR THE PHILANTHROPIC.

BY

ROBERT REID RENTOUL, M.D.

LONDON:
BAILLIÈRE, TINDALL, AND COX,
20 & 21, KING WILLIAM STREET, STRAND.
1891.

CONTENTS.

CHAPTER III.—*continued.*

CHAPTER IV.

SOME EXISTING OBSTACLES TO THRIFT.

CHAPTER V.

SOME REASONS WHY THE INDUSTRIAL CLASSES SHOULD PRACTISE THRIFT.

CHAPTER VI.

SOME OF THE PRESENT CONDITIONS OF THE INDUSTRIAL CLASSES.

CHAPTER VII.

BIBLIOGRAPHY.

THROUGHOUT the text, the names of many books bearing upon this subject have been noted. The following may also be read:—'Hospitals, Infirmaries, and Dispensaries,' F. Oppert; 'Notes on Hospitals,' Florence Nightingale; 'Hospital Mortality,' Lawson Tait; '*Lancet* Commission on Workhouse Infirmaries,' vol. 1, 1880; '*Lancet* Sanitary Commission, 1865;' '*Lancet* Report on Out-patient Administration of Medical Charities,' October, 1869; 'Medical Charities,' Dr. J. P. Harris; 'Preventative Medicine,' Dr. W. Ogle; 'Metropolitan Medical Relief,' Sir C. Trevelyan; 'Sixteen Years of the Hospital Sunday Fund,' Sir S. Waterlow; 'Annual Reports of the Hospitals Association, London;' 'Breakdown of the Present Hospital System,' Dr. Sutherland; 'Hospitals and the Working Classes,' Robert Frewer; 'Notes on Hospitals, on a Cruise in the Baltic,' F. C. C. Gomm; 'The Organization of Charity,' W. Rathbone, M.P.; 'International Health Exhibition, 1884,' Sir J. Paget's speech; 'Pay Hospitals of the World,' H. C. Burdett; 'Cottage Hospitals,' ditto; 'Hospitals, Dispensaries, and Convalescent Homes,' ditto; 'Hospitals and the State,' ditto; 'Hospital Annual,' ditto; 'Dictionary of the Metropolitan Medical Charities,' Howe; 'London Charities,' Fry; 'Charities Register and Digest,' C. O. S., London; 'Petition to the House of Lords from C. O. S. for a Royal Commission on Medical Charities;' 'Medical History of England,' Dr. B. W. Richardson, *Medical Times and Gazette*, vol. 1, 1865; 'Medical Charity, its Abuses,' Dr. J. Chapman; 'Report of Commission of Inquiry into the Three Endowed Hospitals of London, 1836;' 'Vital Statistics of Hospitals and Infirmaries of England and Wales, 1863;' 'The Mortality of Hospitals, General and Special, in

the United Kingdom,' Dr. Steele; 'Hospital Management, Trans. Soc. Sc. Congress, 1883;' 'Taxation of Charities,' *Philanthropist*, January, 1889; 'Memorial from the President and Committee of the British Medical Association, praying for an Inquiry into Hospital Management, 1875;' 'Address to the British Association,' Hart, 1866; 'Charity Reform Papers,' Dr. Wilkinson; 'Hospitals, their History, Construction, and Hygiene,' Sutherland; 'Hospitals of Paris,' *Lancet*, 1869; 'Out-patients at County Lunatic Asylums,' *British Medical Journal*, January, 1890; 'Report to the Government on the Hospitals of the United Kingdom, Sixth Report of the Medical Officer of the Privy Council;' 'Some Proposals for Contributions by Patients to Hospitals,' Dr. N. Hardy; 'Liverpool Charities, their Objects, Ways, and Means,' C. O. Society; 'The Pay System in Hospitals,' Burdett-Coutts, M.P.; 'Report on the Elberfeld Poor Law System and German Workmen's Colonies, 1888,' Blue Book C. 5341; 'Elberfeld System of Poor Relief,' A. F. Hauewinkel; 'Poor Relief in Foreign Countries,' Louisa Twining; 'National Provident Insurance,' Blue Books 270, 208, etc.; 'Prevention of Pauperism,' Canon Blackley; 'The Poor Law Medical Service,' Dr. Dolan; 'Pauperism, its Causes and Remedies,' Hon. H. Fawcett; 'Six Centuries of Work and Wages,' J. Rogers; 'The Economics of Charity,' S. Smith, M.P.; 'Intoxicating Liquors (Workhouses), 1887,' Blue Book 333; 'The Poor Law,' Rev. Fowle; 'The Charitable Trusts Acts, 1853;' 'Reports of the Annual Central Poor Law Conferences;' 'Provident Medical Clubs,' F. Townsend, M.P.; 'The Health of Nations,' Dr. B. W. Richardson; 'Artificial Obstacles to Thrift,' Bland-Garland; 'Valuations of the Order of Oddfellows,' R. Watson; 'Foresters' Directory;' 'Rates of Mortality and Sickness of the Order of Foresters;' 'First and Second Report of the Select Committee on Metropolitan Hospitals, 1890 and 1891;' 'Life in One Room,' Dr. Russell; 'Vital Statistics of the Hospitals and Infirmaries of England and Wales, 1863,' Dr. F. Buckle.

TABLE 1. *Some Statistics of the LIVERPOOL VOLUNTARY MEDICAL CHARITIES, for the year ending 1888.*

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	
No.	Name of Charity.	Established.	Total No. of In-Patients.	Total No. of Out and Home-Patients.	Total No. of Attendances.	Sums Paid by Patients.	Cost of Drugs and Instruments.	Salaries to Medical Staff.	Total Wages and Salaries.	No. of Medical Staff. C. V. R. D.*	Total Income.	Total Expenditure.	Credit Balances.	In Debt.	Interest from Invested Funds.	No. of Nurses.	No. of Beds.	No.
						£	£	£	£		£	£	£	£	£			
1	Infirmary and Lock	1745	1661	7241	26670	10	711	D 0	1216	4 : 14 : 3 : 0	9387	9205	—	2282	1972	23	117	1
2	Northern	1834	1736	5120	—	56	947	250	1467	3 : 5 : 3 : 1	6211	7054	—	2514	1417	28	154	2
3	Southern	1842	1956	7821	—	211	823	E 290	1801	2 : 7 : 3 : 1	7089	7247	—	325	2202	35	180	3
4	Consumption	1864	193	1822	22700	744	450	70	525	1 : 7 : 1 : 0	6016	1746	A 299	—	169	5	50	4
5	St. Paul's Eye and Ear	1872	481	3492	19156	322	157	—	134	0 : 3 : 0 : 0	915	1003	—	691	25	2	23	5
6	Dental	1860	0	25044	—	101	61	110	53	6 : 0 : 0 :17	446	747	—	27	—	—	—	6
7	Cancer and Skin	1862	126	6194	20946	285	342	—	259	0 : 6 : 0 : 0	1773	1923	—	150	409	2	30	7
8	Eye and Ear, Myrtle Street	1820	658	8467	30480	749	231	89	347	3 : 5 : 1 : 0	2452	2150	—	61	—	2	45	8
9	Infirmary for Children	1851	1168	11469	34873	149	402	80	857	2 : 6 : 2 : 1	3126	3527	—	400	629	18	88	9
10	Diseases of the Skin, Granville Street ...	1863	0	1802	7000	42	96	0	52	0 : 4 : 0 : 0	154	266	—	131	—	0	1	10
11	Ladies' Charity and Lying-in	1796	157	2301	—	8	51	C 149	744	4 : 13 : 0 : 0	3624	1924	—	B 104	263	20	12	11
12	Hospital for Women	1882	354	3371	13222	383	338	—	262	1 : 6 : 0 : 0	1612	1703	—	90	—	10	33	12
13	Homœopathic, & Dispen. Roscommon St..	1843	220	22734	67982	427	252	400	925	2 : 14 : 1 : 2	1831	2341	—	510	189	8	52	13
14	Stanley	1867	702	12408	41107	242	237	150	710	3 : 8 : 1 : 1	2312	5979	—	3657	461	8	70	14
15	Dispensaries (3), North, South, East ...	1778	0	61545	198968	920	760	1080	1948	6 : 0 : 9 : 0	4415	5008	—	892	1021	—	0	15
16	Bootle Borough	1846	766	4219	—	28	317	80	495	3 : 6 : 1 : 1	2216	2367	—	151	244	13	103	16
17	Medical Mission, N. and S. Branches ...	1866	0	35493	—	135	124	561	757	1 : 0 : 2 : 0	1077	1043	34	—	44	2	0	17
18	Home for Incurables...	1870	53	0	0	991	145	0	433	0 : 1 : 0 : 1	2155	2102	52	—	35	8	56	18
19	Wavertree Medical Relief	1802	0	364	0	18	36	66	66	0 : 3 : 0 : 0	112	93	21	0	0	0	0	19
20	Liverpool Foundling	1886	14	0	—	66	3	—	54	0 : 1 : 0 : 0	311	364	—	52	—	2	20	20
21	Seamen's Dispensary...	1877	0	590	2509	129	40	50	—	1 : 1 : 0 : 0	129	171	—	—	—	0	0	21
22	Hyslop St. Mission, Canning St. Church...	—	0	1832	4995	27	11	120	130	0 : 1 : 0 : 0	224	144	80	—	—	0	0	22
	Totals ...	—	10245	223329	490608	6043	6534	3545	13235	42 :111 :27 :25	57587	58107	486	12037	9080	186	1034	

I have been unable to obtain Statistics of the following Medical Charities, viz:—1 Newsham Dispensary. 2 Hospital for Women, Hope Street. 3. Tumour Hospital, Rodney Street. 4 Throat Hospital, Mount Pleasant. 5 Hospital for Women and Children, Upper Parliament Street. 6 Fistula and Pile Hospital Daulby Street. 7 Epileptic Hospital, Maghull. 8 Home for Male Incurables, Dingle. 9 Bootle Maternity Hospital. 10 Vergmont Sanitorium. 11 Throat Hospital, Ashton Street. 12 Jewish Board of G'dans. 13 Seaforth H'pital & Dispensary; all of which grant free Medical Relief.

A. Invested £3970, leaving balance to credit of £299, as above shown.
B. Invested £1699, leaving the Charity £104 in debt.
C. Fees for Lecturing to Nurses.
D. Annual Fees from about 110 Medical Students, at about £12 each, not included, and Tutors' Fees.
E. Exclusive of Fees from Medical Students.

1	Woolton Convalescent Home	1873	1133	—	—	1054	45	50	465	1 : 1 : 0 : 0	5099	5384	—	285	852	2	120	

MUNICIPAL FEVER HOSPITALS.

1	City Hospital, North	—	302	The Annual Health Officer's Reports do not give particulars.												6	80	
2	City Hospital, South...	—	66	—	—	—	—	—	—	—	—	—	—	—	—	6	70	
3	City Hospital, Park Hill	—	320	—	—	—	—	—	—	—	—	—	—	—	—	12	100	
4	Toxteth Park Local Bd. Infectious Hosp.	—	2	—	—	—	—	—	—	—	—	—	—	—	—	2	4	
5	Corporation H. for Infectious Dise's, Bootle	—	45	—	—	—	—	—	—	—	—	—	—	—	—	1	46	
	Totals ...		735	—	—	—	—	—	—	—	—	—	—	—	—	27	300	

During 1888 the District Nurses visited 3,046 persons on 83,018 occasions.

* C. Consulting; V. Visiting; R. Resident,; and D. Dental; Medical Staff.

An advance proof has been forwarded to the Hon. Sec. of each of the above Charities for revision. Owing to the fact that the Annual Reports and Balance Sheets are so differently drawn up, and the information given is so meagre, it has been found impossible to work out the average cost of beds, or of in, or out-patients.

PREFACE.

To point out defects which are injuring our system of Voluntary Medical Charity relief is not a pleasant task. Each charity has generally been established as a semi-private undertaking, is someone's pet, and has been nursed through trying vicissitudes. Consequently, when attention is called to means by which abuses may be removed, the action is likely to be misunderstood.

In the following pages criticism of individuals is avoided—no good results being arrived at when personalities and principles are confounded. To do so would be worse than useless, because either reform must take place, or else Medical Charities must disappear. Grave administrative defects will be noticed, in the hope that the work carried on by our Voluntary Charities may not be overclouded by actions which must force the public to withdraw support from institutions intended, by their founders, to supply relief to the sick poor only.

The securing of financial help for charities is becoming more difficult each year. Evidently the public are beginning to arrive at the conclusion that charity is an evil, that if possible it should be done without: that each honest worker should receive an honest wage, and that if he does not make provision for himself, his wife and children, he should be made to, or supply a reasonable excuse for his gross and criminal neglect.

At present cinderellas, charity sermons, raffles, bazaars, street collections, and the selling of charity tickets, are all put into operation so as to supply more medical charity to the well-to-do. At one time the cry, 'a good cause and a bad balance sheet,' brought in contributions. At present a constant importuning for money goes

on—this being spoken of as 'the voluntary system'! Previously the statement, 'We treated 900 more patients this year than last,' was trusted to catch the eye. Now, however, the thinking portion of the public ask: 'Why is there so great an increase in the number of those who say they are unable to provide themselves with medical aid, when at the same time the wages and conditions of the industrial classes are improved by at least 50 per cent., and when provident societies offer facilities?' Thus the 'record breaker' charity is being 'chaffed' out of existence. Four classes are bringing discredit on the charities. First, Medical Charity committees, who sell charity almost to anyone who will purchase it; second, the well-to-do portion of the industrial classes, who accept charity as their right, looking upon it as relief in aid of wages; third, those who buy 'tickets of recommendation,' with the view of receiving cheap medical aid for their families, relatives and employés; and, fourth, medical practitioners who use the charity for the purpose of self-advertising, and to such an extent that it has lately been asked: 'Do our Medical Charities exist for the benefit of the doctors, or for the poor?' Is not Medical 'Charity' now almost a trade? Unfortunately, as at present administered, Medical Charities offer one of the greatest obstacles to thrift. No movement has been established by which the working classes might, by self-help, provide themselves with medical aid, without Medical Charity managers doing their utmost to destroy it. This is a very serious statement. It is true. What has been the action of Medical Charities towards Provident Dispensaries? If the Charities blindly continue this unnecessary course, the public will soon take as little interest in them as they now do in the Poor Law infirmaries. At present our Medical Charities form one of the greatest pauperizing institutions in the country. Medical Charities are now on their trial. A large number of the reasons for their existence has gradually disappeared. They have been founded for the sick poor only—yet the Poor Law gives relief to over 800,000 yearly, and provides useful infirmaries. At one time it was said: We must have Voluntary Medical Charities for the training of students. Yet for this purpose there are the Poor Law infirmaries and dispensaries, corporation fever hospitals; asylums, and best of all, the apprenticeship system, to which we must return if the country is to be supplied with safe, practical doctors.

The utter want of organization and supervision of Voluntary Medical Charities is alarming. Fancy any system which gives

relief to over three millions of persons yearly having neither supervision nor organization—doing just as it pleases! Thus one Charity competes against another for the greatest number of patients; 'Charities' spring up in all directions; annual reports and balance sheets give little or no information; the public are enticed to go for relief instead of providing for themselves, and to crown the many anomalies now taking place under the name of Charity, Charity is being sold for a few coppers to any well-to-do person mean enough to purchase. Now if the Poor Law guardians, or other Charitable Societies, conducted their affairs in this manner, distrust would develop quickly. Yet the theme of the Medical Charity manager is: 'Only give more money, and we shall treat many more patients.' After this there will not be sufficient room—a new wing must be built; next the beds will be empty, and lastly a piteous appeal will be sent to the papers, saying: 'There are thirty beds empty because there are no funds.' Can anyone say this is an exaggerated picture? Thus the cant of Medical Charity—which has even now made its way into the pulpit—goes on from year to year. No doubt this cant will continue until subscriptions are cut off. When the income fails, then a further appeal will be made to the cupidity of the well-to-do, who are offered medical aid by the Charity, and who will not fail to practically steal those funds which have been subscribed for the sick poor.

The question has been asked: Why does not the medical profession—a body which sings so loudly of its 'Charity'—take this question of reform up? Almost every doctor seeks an appointment at a Medical Charity, and feels that to bring himself into conflict with committees would mean disaster. No doubt resolutions and reports are adopted at Medical Societies, but experience shows that these are never meant to be put into force. Moreover, those who have used the charity appointment as a stepping-stone to more lucrative work, object to recognise faults in a system which they have encouraged. Perhaps the Committee of the House of Lords on Medical Charities will issue a Report, pointing out a way by which the present anomalies may be removed.

I have to thank those who have supplied statistics—more especially Messrs. Haggar, Moulding and Cleaver of the Poor Law; Mr. Nixon, House Governor of the London Hospital; to whom, and to the many others who have supplied information, I take this opportunity of expressing my gratitude.

Most of the figures quoted are taken from Charity Reports of 1889. Irregular hours of work with those in medical practice, and the fact that the opposing of a Bill introduced in the Commons took up much of my spare time, must be the excuse for delay. I would only hope the time will soon come when it will be considered as right and fair to advocate reform as it now is to misinterpret the action of those who are striving to purify our charities by eradicating abuses. If the statements made by me in the following pages are not true, let them be refuted: they cannot be sneered away, or be disposed of by a conspiracy of silence.

ROBERT REID RENTOUL.

LIVERPOOL, *October*, 1891.

THE REFORM OF OUR VOLUNTARY MEDICAL CHARITIES.

CHAPTER I.

IS THERE AN ABUSE OF OUR VOLUNTARY MEDICAL CHARITIES?

It is rather late in the day to ask: Is there an abuse of our Voluntary Medical Charities? Nearly all medical practitioners recognise it; statistics have proved it; requests have been made to the Governments of the day to grant a royal commission. In 1865 Drs. Buckle and Todd wrote on the subject.

Mr. T. Holmes said of the out-door department: 'It is a deception on the public and a fraud upon the poor.'

Sir E. Sieveking stated (in the *British Medical Journal* of Feb., 1889): 'No hospital physician who has attended for many years in the out-patient department, as I have done, can have failed to see over and over again cases of the abuse of charity, such as I have again and again brought before the notice of the secretary.'

Mr. T. Holmes has again said: 'In our over-crowded out-patient rooms a physician or surgeon can neither give the required attention to the patient, nor derive or impart, from the study of their cases, those lessons which it is one of the prime objects of a hospital to furnish.'

Mr. R. Harrison, when speaking at the Liverpool Town Hall, said 'that if something were not soon done in the way of reform, the hospitals in the city would soon be swamped.'

Mr. Burdett, in his book on 'Pay Hospitals,' says that the abuse of hospitals 'is becoming national in extent.'

Professor Gardiner, speaking at the 16th annual meeting of the Glasgow Charity Organization Society, said: 'It was notorious that

in the infirmaries a great deal of medical relief was given which might be considered as practically wasted, inasmuch as it was given to persons who ought to get medical assistance in other ways.'

Dr. James Erskine, in his pamphlet, 'Abuse of Medical Charities,' gives tables relating to Glasgow, and points out that 'about one in five of the people receive free medical relief.'

In the 'Sturge Prize Essay,' on the 'Financial depression in the London hospitals, with suggestions for improving their administration and finances,' 1886, I gave a table of statistics (*British Medical Journal*, Feb. 2, 1889), showing 130 Metropolitan medical charities gave medical relief to 1,230,596 persons. These do not include the large number of Poor Law and other charity cases. About one in two in the Metropolis receive free treatment.

The Right Hon. W. H. Smith, at a conference, called by the London C. O. S., stated he had 'undertaken to investigate the circumstances of out-patients at a large hospital, and found 20 per cent. had given false addresses.'

Dr. Sutherland, in the *Glasgow Medical Journal* of Nov., 1888, states that a Central Bureau for hospital administration is necessary. He states that in Liverpool and Birkenhead there are 19 hospitals with 1,197 beds, or 1 bed to 580 of the population; and that Dublin has 1 bed to 140 persons.

Having referred to a few statements made *by individuals*, I shall call attention to what has been said by the *medical papers* :—

The *Lancet* has said: 'Thus, in less than twenty-five years, an enormous department has grown up, and when it is considered that the medical officers of the Poor Law were appointed in 1835, and that they commenced a system of medical relief equal, if not greater, in extent in some districts in which the operations of Guy's and St. Thomas's Hospitals were also carried on, we are irresistibly led to the conclusion that the growth of gratuitous medical advice was fostered by the opportunities and temptations held out by these institutions, and that many persons were induced to seek gratuitous advice who had previously been accustomed to pay for all they required.' Again, it says: 'But it can scarcely be doubted that charity is grossly abused. The great complaint against the whole of this class is the utter want of thrift and forethought. They all regard the hospital as their refuge. The existence of a free out-patient system has, in fact, destroyed all necessity for thrift. . . . Our reckless flinging abroad of gratuitous assistance has created an amount of voluntary beggary' (*Lancet*, 1869).

The *Medical Times* has said: 'The amount of gratuitous work done by the profession in no way raises it in public estimation. It is well-known that it is not performed from motives of charity, but from the position which is gained by being attached to a hospital staff, and the hope of a good practice ultimately accruing therefrom. One of the by-laws of the Royal College of Physicians of London is—"No fellow or member of the college shall officiously, or under colour of a benevolent purpose, offer medical aid to or prescribe for any patient whom he knows to be under the care of another legally-qualified practitioner." The spirit of this by-law is being constantly broken, for medical aid and advice are often given by the best physicians and surgeons to patients whom *they* think cannot pay *their* fees, but could easily pay the fees of a general practitioner; and while acting as they believe benevolently to one, they are depriving the other of his dues, and thereby lowering the status of the profession.'

The *British Medical Journal* said: 'Hospitals compete with each other as to the number of patients, without regard to the fitness of the cases or the position of applicants. Physicians and assistant physicians take no note of the public injury inflicted by indiscriminate charity, and hoist themselves into public notice upon the shoulders of a recognised abuse, which they feebly denounce, while they are aiding to foster it.'

Let us give some attention to what *individual investigations* have shown.

At Manchester.—The following figures, taken from the 15th Annual Report of the Manchester and Salford District Provident Dispensaries (E. Jones, Sec., 9, Queen Street, Manchester), give the percentage, at five medical charities, of those found ineligible.

In 1875, of every 100 who applied, and whose cases were investigated, 42·32 were ineligible.

In 1885, 13·59 „ „

In 1889, 6·89 „ „

Royal Free Hospital, London.—An inquiry was made by the C. O. S., in 1875 (see paper by Sir C. Trevelyan, 1879), into the circumstances of 641 out-patients. The following table is instructive:

12 patients were able to pay a practitioner.
231 „ could subscribe to a provident society.
169 „ were suitable applicants.
103 „ gave false addresses.
69 „ gave insufficient information.

Of these, 231 were making between £1 and £2 per week, while 169 were making under £1, making a rate of abuse of 61½ per cent.

THE CHILDREN'S HOSPITAL, LONDON. — An arrangement was made with the C. O. S. that the inspectors of the latter should inquire into the social conditions of applicants. No patients whose parents were making under 30s. per week were to be excluded from treatment. No first treatment was refused, but second treatment was if the inspector had not stamped the card. Each parent had to answer the following questions: Name and address, date, employment, name of employer, married or single, number and age of family, weekly earnings of father and mother, income from clubs and other sources, in receipt of parochial relief. The hospital authorities sent 8,798 card cases for inquiry, but only 4,574 of these went to the C. O. S., about half shirking investigation. Of the 4,574 who went, only 43 per cent. were eligible for relief. Thus there was an abuse rate of 57 per cent. Unfortunately this arrangement fell through.

THE LONDON HOSPITAL.—A notice is fixed on the hospital gates and in the waiting-halls, on which it is stated that on and after a certain date a waiting-hall inspector would be employed, to ascertain if *out*-patients were proper persons for the receipt of relief. It is stated that the charity is for the sick poor. The inspector is paid £145 yearly. He asks a few leading questions of those whom he thinks are improper cases, and, if not satisfied, asks for a reference—generally that of the employer. If the inquiry is unsatisfactory, the patient is advised accordingly, and told not to come again. If the patient is dissatisfied at the inspector's ruling, he or she has the power to appeal to the House Governor, or to the Committee. No one is refused first treatment. In 1884, when the inspector was appointed, the number of *out*-patients was 20,905; in 1888, 21,464. Previous to 1884 'there had been a serious tendency to increase in this class of cases,' that is, out-patients. A very large number were prevented from even paying a first visit, knowing they would, if ineligible, be refused second treatment. Even in 1883 — the year before inspection began — the number of *out*-patients was 28,236! In twelve months the plan brought a reduction of 7,311 patients. This may seem a small sum, but each *out*-patient costs, on an average, 4s. This number, therefore, gives a saving of over £1,466 in one year to the charity. At this hospital the 'abuse rate' was about 50 per cent.

ST. BARTHOLOMEW'S HOSPITAL.—There is an inquiry officer, paid £156 yearly. The secretary says: 'He draws the patient's atten-

tion to the fact that the hospital is a charitable institution, designed for the relief only of the necessitous poor.' In 1882, the year previous to the appointment of an inspector, the number of casualty and out-patients was 170,030, while last year the total number was 144,681 : a falling off of 25,349.

Royal Albert Hospital, Devonport.—In 1867 the committee reported : 'They had come to the conclusion that, while the system is not so beneficial as it might be to the deserving poor, it by no means does justice to the medical profession, and is financially injurious to the charity.' The honorary secretary, Mr. Shapcote, says : 'I beg leave to say that the out-patient department of this hospital was converted into a provident dispensary in 1868, because we found that the hospital was being crippled by the large amount spent on out-patients. The scheme has worked remarkably well.'

Leicester Dispensary.—This opened in 1833 as a charity, and was converted into a provident dispensary in 1866.

These examples show that wherever investigation has taken place, abuses have existed. To adduce further proof, I shall call attention *to the finding of various committees which have been appointed to consider this subject.*

In 1870, the C. O. S. of London appointed a committee, composed of medical practitioners, with Sir William Fergusson as chairman, to report upon the subject of Out-patient Administration, and they reported :

1. 'This meeting is of opinion that there exists a great and increasing abuse of out-door relief at the various hospitals and dispensaries of the Metropolis which urgently requires a remedy,' etc.

The 'Lancet' Investigation into the administration of the out-patient department of the London Hospitals (*Lancet*, Oct., 1869), reporting upon the Royal Free Hospital, stated :

'But it can scarcely be doubted, that the charity is grossly imposed upon, in many cases. . . . The great complaint against the whole of this class is their want of thrift and forethought. . . . They all regard the hospital as their refuge. . . . The existence of a free out-patient system, has, in fact, destroyed the necessity for thrift.'

Speaking of St. Thomas's Hospital, in 1869, the same journal said : 'The patients, particularly those with governors' letters, are a most respectable class. It is not uncommon to find them dressed in silk, and many are reported to lounge about the hospital grounds as if that were their chief employment.'

Report of the British Medical Association.

At the annual meeting of 1889, seven notices were referred to the branches, while a Medical Charities Committee was appointed to receive and digest their replies, and to present a report to the next annual meeting, 1890.

*Report of Medical Charities Committee.**

Your Committee report that replies have been received from twenty-two branches, of which a digest is published in the Appendix.

In respect of the proposed medical service, constituting proposal number 2 of Dr. Rentoul's report, the replies received from the branches are to the following effect: Three branches numbering 426 members approve; two branches numbering 318 members are neutral; and sixteen branches numbering 4,497 members disapprove.

The majority of the Committee entertain also an opinion adverse to this proposal; they see no reason, however, why the branches which believe it to be practicable should not endeavour to carry out the proposition in their own districts.

In respect to proposal 1, which ran as follows:

'Recognising the fact that there is an abuse of the out-patient department of our medical charities, this meeting of the British Medical Association resolves: That medical practitioners and the managers of our medical charities in the various towns and cities meet together and decide who are eligible for out-patient medical aid. This meeting suggests that the following "wage limit" be adopted: When a man and wife make 25s. per week and over, or a single person 20s. per week and over, that these shall be ineligible for out-patient treatment at the medical charities—except in cases of accident—and that those earning a similar rate of wage be ineligible for "home visits;" that is, visits paid by the staff of the medical charities to sick persons at the patient's home. Further, that either the Manchester system of checking abuse, or that used at the London and St. Bartholomew's Hospitals be put into force, but that preference be given to the plan used in Manchester'—

The Committee recommend an immediate reform of the out-patient departments of medical charities as an urgent necessity, and would especially emphasize the fact that it is difficult for provident or thrift movements to compete successfully against medical charities which

* *Brit. Med. Journal*, July 26th, 1890.

bestow relief on all applicants without any inquiry, or against those which, by charging a fee from one to two pence, try to undersell any provident system.

They would also add that the reform of provident dispensaries and sick clubs is necessary.

To carry out these proposals, the Committee consider that a reform of the abuses of the out-patient departments would be best obtained by some modification of the Manchester system, which is set out in the Appendix.

To this end they would recommend that the following wage limit should be adopted:

Single man or woman	- - -	14s. per week.
Man and wife	- - - -	18s. ,,

and an allowance of 1s. 6d. opposite each child under twelve years.

The above wage limit is one that cannot be adopted universally.

They regard it as most important that *all* the medical charities in each city or town adopt a uniform 'wage limit,' else the destructive system of charity competition will, with its many evils, be perpetuated; while ineligible applicants refused at one hospital would be accepted by another. By strict co-operation the performing of the work of one charity by several will be prevented.

On this basis they recommend that the following cases should be considered *ineligible* for *out-patient* hospital relief, otherwise than as accident and urgency cases.

1. All those earning over the wage limit.

Letters of recommendation from subscribers to medical charities, Hospital Saturday and Sunday Funds, ought to carry no weight, unless the person so recommended for relief conform to the 'wage limit' clause. No subscriber should be permitted to receive any benefits for himself or his household. Each subscriber who recommends an ineligible patient should have forwarded to him by the hospital clerk or secretary a form similar to that now used by the Salford Royal Hospital (Appendix, p. 9).

2. 'That all those who are in receipt of Poor Law relief, and those who are members of friendly societies possessing a surgeon, shall be ineligible for out-patient relief, except with a recommendation from the surgeon in attendance to show it is a case requiring consultation.'

To inquire into the social circumstances of applicants for relief, an

inquiry officer should be appointed at each hospital with a view to prevent the abuse of charity by improper objects, and a notice to this effect, similar to that in use at the London Hospital, should be placed in the waiting halls. This will act as a deterrent to those who try to impose on charity, and will therefore lessen the work of the inspector (Appendix, p. 8).

The Committee suggest that the hospital clerks and inspectors who inquire into the social circumstances of applicants for medical charity relief be instructed to inform such as they find ineligible, that they can receive *immediate* treatment either from a private practitioner, or under suitable circumstances from the staff of a Provident Dispensary—supplying them at the same time with a leaflet on which is printed the names and addresses of the medical staff, and a few of the rules bearing on the scale of fees.

The Committee further wish to reaffirm the following resolutions passed by Sir William Fergusson's Committee of 1871, which was appointed 'to inquire into the subject of out-patient hospital administration,' viz. :

'That the practice of receiving payments for medicine or medical advice is untenable, it being impossible to dissociate the feeling of payment and right.

'That the number of out-patients treated should not exceed twenty-five per hour.

'That all hospital authorities make a complete and full annual statement regarding income and expenditure on a uniform system.'

J. SPENCER WELLS,
Chairman of Committee.

BIRMINGHAM HOSPITAL REFORM COMMITTEE.

In 1889, a Sub-Committee of the Medical Profession was appointed, among the chief workers being Drs. Cheshire and Marsh. This Sub-Committee showed :

(*a*) That the original purpose of our medical charities has been widely departed from.

(*b*) That as a result of this departure the demands made upon them are greater than they can adequately meet, and are increasing from year to year.

(*c*) That a constantly increasing proportion of the community depends upon charitable medical relief in times of sickness, rather than on providence and self-help, and that this is unjust to the

subscribing public, injurious to the recipients themselves, and an imposition upon the medical profession.

(*d*) That in order to bring about a better state of things the voluntary hospital system needs to be reorganized, so that, on the one hand, it may work harmoniously with and supplement the Poor-Law system, and, on the other hand, it may encourage, and not hinder as it now does, the development of provident institutions for the medical treatment of the industrial classes.

They pointed out that 1 in every 2·6 received free relief, and that while the rate of increase of the population was 35·3 per cent., the rate of increase of applicants for relief was 147 per cent.

As a result of this report, a Committee (with County Court Judge Chambers as Chairman, and the Mayor, Mr. F. C. Clayton, as one of its members) was appointed, and a valuable report was drawn up by them (Cornish Bros., New Street, Birmingham). This Committee recommend :

1. The formation of a General Council representative of all the public medical institutions of the City.

2. The formation of an Inquiry Agency to investigate the circumstances of applicants for treatment at the Hospitals.

3. That apart from first aid, and urgent cases, regulations should be framed by the Hospitals to exclude trivial cases, and cases where either the patients are in a position to pay for such treatment as they may require, or which could be more properly dealt with under the Poor-Law.

4. That facilities should be given for cases so excluded being dealt with by Dispensaries or Provident Associations.

5. That any person recommended by an approved Provident Association or by a qualified medical practitioner should, as a rule, be admitted to the out-patient departments of the Hospitals without further formality.

(*Signed*) M. D. Chalmers.
G. B. Lloyd.
C. T. Saunders.
Edwin Rickards.
Richard H. Taunton.
Priestley Smith.
J. C. Blissard.
Herbert Ball.
Alfred Harvey.

In 1883 an effort was made by the Queen's Hospital and the Charity Organisation Society, Birmingham. They formulated recommendations very similar to the above, but the General Hospital succeeded in thwarting these good efforts, by refusing to join in carrying out the much-needed reform.

Memorandum on the Medical Charities of the Metropolis.

This was issued in 1889 by the C. O. S., of London, with reference to the petition to the House of Lords, that a Select Committee might be appointed to inquire into the administration of Metropolitan Medical Charities.

Liverpool Medical Institution Committee, 1877.

In 1877 the members of the Medical Institution appointed a Sub-Committee to report as to the abuse of medical charities. That Committee was composed of such well-known men as Drs. Carter, Oxley, Campbell, Finegan, Shearer, Bernard, Cormack, Reginald Harrison, Mitchell Banks, E. Browne, and R. Parker. The following were the findings of the Sub-Committee:—

1. 'The Committee are of opinion that the relief at present (1877) afforded to *in*-patients of the various hospitals and institutions of the town is warranted by the severity and urgency of the cases admitted, and does not call for further comment. These remarks do not apply to gratuitous advice and attendance afforded to *out*-patients either at hospitals or dispensaries, or at their own homes.'

2. 'They consider that in this latter respect *public charity is greatly abused by persons receiving it who are quite in a position to contribute* something towards obtaining medical attendance; that the multiplying of charitable institutions, by producing separate interests, and requiring separate buildings and staffs, involves waste of public money which might be better applied to maintaining the leading medical charities in a highly effective condition; that with the present diffuse mode of administering medical charity no systematic inquiry into the circumstances of persons applying for it is made: that its indiscriminate distribution tends to destroy the self-reliance of the working classes, and to encourage improvidence and pauperism; that in consequence of the number of unsuitable cases applying for treatment, the medical officers are unable to devote sufficient time to really serious cases, while it greatly hinders the scientific study and treatment of diseases.'

Public Meeting in Liverpool.—In January, 1886, a public meeting was held in the Town Hall, presided over by Sir W. B. Forwood. Canon Lefroy, Mr. R. Harrison, Dr. Hamilton, and others, called attention to the grave state of affairs. Attempts have also been made by Drs. Maunsell, Alexander, Clark, Irvine, and others to bring about a reform.

Report of the Committee to the Medical Institution on Hospital Abuse.

In February, 1890, I read a paper on the Reform of the Out-patient Department of our Medical Charities (see *Liverpool Medico-Chirurgical Journal*, July, 1890), before the members of the Institution, and gave notice of the following motion. I withdrew this motion in favour of those which appear in the following report; I having drawn them up, with the aid of Drs. R. Jones, Barr, Logan, and others:

> 'Recognising the fact that medical charity as given at the hospitals is open to abuse unless an inquiry into the social circumstances of applicants is made, this meeting of the Medical Institution instructs its Council to write to the hospital committees asking them each to appoint one of their number so as to form a Central Committee, and that such Committee decide what classes are eligible for out-patient hospital relief. That such Committee have power to add to their number.'

At a subsequent meeting, May, 1890, fearing the Managers of the Charities might accuse us of working at this question without their knowledge and help, I moved the following:

> 'That a copy of the Resolutions relating to the Reform of the Voluntary Medical Charities, passed by the members of the Medical Institution at their last meeting, on March 13th, 1890, be forwarded by the General Secretary to the Committees of the Medical Charities, and also to the various Medical Journals.'

Also—

> 'The members of the Institution beg to suggest to the various Medical Charity Committees that they meet together to discuss the above resolutions, so that when the time for conjoint

deliberation between the Committee appointed by the Medical Institution and that of the Medical Charities arrives, practical effect will be given to their united conclusions. That a copy of this resolution be forwarded by the General Secretary to the Committees of the twenty-two Medical Charities.'

Owing to the opposition of a member, the above were not carried. This I regret, and I fear the injudicious advice given to reject the above will delay the Reform in Liverpool.

The following is the Report:

At the Eleventh Ordinary Meeting of the LIVERPOOL MEDICAL INSTITUTION, held on the 13th March, 1890, it was resolved:

That this meeting appoint a Committee of Medical Practitioners, with power to add to their number, which shall not exceed forty, to draw up a report on the following points:

(*a*) To decide on the best means of checking the abuse of Public Medical Charities.
(*b*) To consider what classes shall be eligible for Charitable Relief.
(*c*) To consider by what means such classes as are ineligible shall be provided with efficient medical treatment.
(*d*) To make suggestions regarding the general working of the Medical Charities.

I. Under the head of means for checking abuse of Medical Charities, they suggest that all voluntary Medical Charities adopt some uniform system of inquiry into the pecuniary circumstances of all patients seeking or receiving relief, and that each Medical Charity appoint an officer to make such inquiry. Further, that a notice be placed in one or more conspicuous places, to the following effect, namely, that the institution is for the benefit of the sick poor only, and that inquiry will be made into the pecuniary circumstances of those applying for relief, but that urgent cases and accidents may receive first treatment before inquiry is made. They further suggest that the Central Relief Society be requested to co-operate with the Medical Charities, and that the names and addresses of all new applicants be sent daily to that Society in order that the pecuniary circumstances of those marked doubtful may be inquired into, and that the Society may mark all such additional cases as it may consider ineligible for Charitable Relief.

II. Under the second head of what classes shall be eligible, the Committee suggest that all patients whose income exceeds the following be considered ineligible as out-patients, namely :

20s. a week for a single man or woman.
25s. a week for man and wife, plus 1s. per week for each child under fourteen years of age.

III. The circumstances of in and out-patient treatment being so different, the Committee decide not to recommend an in-patient wage limit, but recommend that no patient receive indoor treatment who, on investigation, is considered able to pay for treatment, suitable to his particular case, at his own home, except in case of accident or other emergency.

IV. The Committee further recommend that a charge be made for hospital treatment in urgent cases where the pecuniary circumstances are found to exceed the limits for out-patients, and where it is considered that in-patients could have proper home treatment provided.

V. With regard to the provision of medical treatment for those who are ineligible for Charitable Relief, the Committee decide not to recommend the interposition of a new institution between hospitals and medical practitioners, because it is found that qualified practitioners give their services at rates within the reach of such classes.

VI. Under the head of suggestions as to the working of Medical Charities, the Committee, believing that such institutions have been founded for the benefit of the Sick Poor, earnestly request that the practice of receiving payment from such patients be discontinued.

VII. They recommend that all Medical Charities, when publishing their Annual Reports and Balance Sheets, adopt a uniform system of statement and accounts.

VIII. They also recommend that a Central Committee be formed, whose objects shall be to deliberate and advise on the administration and management of Medical Charities ; that this Central Committee include representatives of the Medical Charities desiring representation, the Medical Institution, the Central Relief Society, the Hospital Sunday Fund Committee, and the Hospital Saturday Fund Committee.

IX. That before the end of the year the President of the Medical Institution shall, in the name of the Institution, request the Mayor to call a Public Meeting for the purpose of considering the foregoing

proposals for a Central Hospital Committee, and for taking action thereon.

X. That a small Committee be appointed by the Council to assist the President in carrying out Clause IX. to a successful issue.

XI. That a copy of this Report be sent to the Medical Journals, and the Committees of the various Medical Charities in and about Liverpool.

LIVERPOOL HOSPITAL SUNDAY FUND, Annual Meeting 1891: 'The Committee desired most respectfully to suggest to those who had the management of the Medical Charities of Liverpool, to consider whether the time has not come for dealing in some careful way with the alleged abuses of Hospital Charity.'

MANCHESTER INFIRMARY REPORT for year ending 1888 (p. 8): 'But your Board cannot but think that it is a grave fact, and one requiring careful investigation, that in an industrial community so large a proportion of the working class population should presumably be unable, or unwilling, to pay for medicine and medical advice when attacked by those ordinary forms of disease which constitute the majority of cases treated in the out-patient departments of our hospitals.'

MEDICAL SOCIETY OF VICTORIA, AUSTRALIA.—Lately the above society at a meeting in Melbourne unanimously adopted the following resolutions:—

This Society is of opinion that—

(*a*) Great imposition on the part of well-to-do people is practised at the public hospitals, which is contrary to the principle on which these institutions were founded, and on which they should be conducted.

(*b*) All Hospitals receiving Government aid annually should be devoted solely to the treatment of the destitute and poor.

(*c*) Paying patients should not be admitted into hospitals receiving Government aid granted for the benefit of the destitute and poor.

(*d*) A wage limit should be fixed for all hospital patients (*i.e.*, all those earning more than a certain amount should be excluded).

That the circumstances of each applicant for admission should be investigated by an officer of the hospital appointed for the purpose, who should use wide discretionary power in special cases.

GLASGOW MEDICAL CHARITY REFORM COMMITTEE.—This Committee has not yet issued any report. It is to be feared the death of the Hon. Sec., Dr. Robb, will seriously affect the work of the Committee.

AMOUNT OF MEDICAL RELIEF IN ENGLAND IN 1888.—The following figures show approximately how many persons said they were unable to provide themselves with medical treatment:

Number treated at 759 hospitals and dispensaries ...	2,828,296*
„ „ 118 „ „ ...	(no returns)
Number receiving Poor-Law medical relief, medicine included	831,353
Number treated in Metropolitan fever hospitals ...	6,537
Number treated in provincial cities and towns fever hospitals	(no returns)
Number receiving free private medical aid from doctors	338,600
Total receiving free medical relief	4,004,786

These figures do not include 457,301 persons who received free State vaccination, nor those who received free treatment from the many non-medical charitable institutions.

Taking the population of England and Wales in 1888 at 28,000,000, these figures show that *at least* one in every six depended upon free medical relief. If all were included, the debasing fact would be brought out that about one in three are, medically, paupers.

Thus the preceding figures prove—and no one has shown them to be untrue—that

In London about 1 in every 2 persons receive free medical relief.
In Liverpool „ 2·6 „ „
In Birmingham „ 2·6 „ „
In Glasgow „ 4 „ „
In Manchester 42·32 of every 100 were found ineligible!
At the Royal Free Hospital, 61½ per cent.
At the Children's Hospital 57 „
At the London Hospital 50 „

This is very discouraging. In 1888 at least 1 in every 35 persons was a State pauper: *i.e.* received relief through the Poor Law!

As showing the great amount of swindling at present in force and

* Of the above 208,768 were *in*-, and 2,619,530 were *out*-patients.

the large numbers of professional mendicants, the following figures are instructive.

Of 19,530 who applied in twelve months to the Liverpool Charity Organization Society 3,188 were dismissed as ineligible!

Of those who applied to the Glasgow Sick Poor Nursing Association about *one-third* were ineligible!

The fact that so many efforts have been made to recognise and correct the present state of affairs, proves the presence of abuses. I am aware that if we go to a particular charity and ask if there is an abuse, this will be denied. Such denials must be taken for what they are worth, for, unless *they give us their* ideas as to *what constitutes an abuse of charity;* what class of the community *they* hold should be eligible for relief, what practical system of inquiry *they* have made, then *their* statements must be of little value.

CHAPTER II.

MEDICAL RELIEF IN LIVERPOOL.—ITS EXTENT IN 1888.

FEW have any idea of the amount of relief given in Liverpool. To bring this home, I shall refer, *first*, to the relief given by the Poor Law; *second*, by the Corporation in their fever hospitals; *third*, by non-medical benevolent institutions; *fourth*, by private benevolence; and, *fifth*, by the voluntary medical charities. I do not include provident societies and clubs, although when we consider the well-to-do persons who enter, and the small contributions demanded, it will be seen that their rate of payment is in reality on a charity scale.

POOR LAW MEDICAL RELIEF.

The parish of Liverpool is included in, but forms only part of the city. As the parish and city take in a small area only, I include in the scope of this inquiry not only Liverpool city, but also the West Derby Union, and the township of Toxteth Park. This district includes an area beginning at the north end, and embracing Everton, Kirkdale, Bootle, West Derby, Walton, Waterloo, Kirkby, Seaforth, Crosby, Litherland, Wavertree, and round to Garston on the south. Its population in 1881 was 686,461, and in 1888 I have estimated it at 717,569. It comprised a total area of 43,547 acres. Of its population in 1881, 333,795 were males and 352,670 females; and 231,249 were married; 389,862 were between the ages of 15 and 55. In 1881, 1 in every 36 of this population *was a pauper*.

In order further to show I do not exaggerate regarding the number who receive free aid from our local charities, I call attention to the area of the *City of Liverpool*. It is bounded by a line passing by Canada Street, Beatrice Street, Roxburgh Street, Spellow Lane, Walton Lane, Rockfield Road, Garfield Road, Bel-

mont Road, Whitfield Road, Boundary Lane, Lister Road, Spofforth Road, Smithdown Road, Lodge Lane, Ullet Road, and Dingle Lane. In 1886 the population of the city was 599,738, and in the last census returns (1891) 517,951. It is a much smaller area than that included in the three unions. The parish is bounded on the west by a line passing down the centre of the river; on the south by a line passing through the Queen's Dock, Parliament and Upper Parliament Streets; on the east by Crown Street, Boundary Place, Moss Street, Calver Street, Canterbury Street, William Henry Street, Soho Street; and on the north by Great Homer Street, Boundary Street, and across Wellington Dock.

Within these unions there are four Poor Law infirmaries—at Brownlow Hill, Walton, Mill Road, and Smithdown Road. During 1888, 14,818 persons (approximately) received *in*-patient treatment (see Table II.), and there were 3,948 beds, 151 nurses, 8 resident and 5 visiting medical officers.

Besides these infirmaries, there are the Poor Law dispensaries, with district medical officers giving treatment either at the homes or at the dispensaries. The parish is divided into 12 districts, held by 7 district medical officers; West Derby has 15, with 14 medical officers; while Toxteth has 2, with 2 medical officers.

During 1888, the number of paupers receiving *out-door* medical relief was 23,937 (see Table II.). One district medical officer may have charge of two districts. This should not be encouraged, as it leads to a 'rushing' of duties. If the salary for one district is not sufficient it should be increased.

In connection with granting of medical relief, the relieving officer is chiefly responsible. He receives all applications for relief, and forthwith examines into the circumstances of every case by visiting at the house of the applicant, making inquiries regarding the health, ability to work, number and condition of family, sources of income, and reports *in the prescribed form* to the Guardians. He must visit from *time to time* and report on all cases receiving relief. In cases of 'sudden and urgent necessity' he can grant immediate relief without waiting for an order from the Guardians; but if he grant unnecessary relief, the auditor can call upon him to repay the amount. Further, he must give all reasonable aid and assistance when requested by any other relieving officer.

Thus, in the case of medical relief, the applicant applies to the relieving officer and obtains a ticket, with which he goes to the

district medical officer. A ticket holds good for the one illness only, unless the pauper is upon the 'permanent list.' If the medical officer thinks right, he advises the patient's removal to the infirmary.

There is another method by which the State supplies relief. I refer to public vaccination. Table II., col. 4, shows the three unions gave *free* vaccination to 11,372 persons in one year. Some are vaccinated in the infirmaries and others at the vaccination stations.

The Liverpool parish has 3 stations, West Derby 12, and Toxteth 2, with a total of 13 medical vaccination officers. Generally these officers hold other Poor Law appointments. The payment for vaccinating is made up by grants from the local poor rate and from Parliament. The Government Inspector of Vaccination calls at a station whenever he wishes, and has the right to withhold the Government grant. Vaccination at the expense of the poor rate does not make the person or relative a pauper. If an *out-door* become an in-door pauper, he is not counted as two persons in the total number. Any union can give the total number of paupers who obtained relief on any given day throughout the year. But as far as Local Government Board statistics are concerned, the number of paupers stated as having received relief throughout the year is *the mean* between the number returned as having received relief on the 1st of January and on the 1st of July.

The figures quoted relate to the number who received *medical relief* only, and not to the total number of paupers. But all who receive relief can also obtain medical relief. That is, the entire Poor Law population is provided with medical relief if required. I only include those who were *sick* paupers, and not those who were vaccinated.

By the Act of Geo. III., c. 59, 1819, and also by the 58th and 59th sections of the Poor Law Act, 1834, Guardians are given the *right to grant relief on loan*, and to attach subsequent wages in repayment. They have also the power to grant *medical* relief on loan. Mr. Bland Garland, of Bradfield (Berks), has, in a paper read before the Central Poor Law Conference, called attention to this; and in his union—a rural one with a population of about 18,000—the results given by carrying out the principle of relief on loan have been very encouraging They also make relatives contribute towards the support of aged parents in sickness and infirmity.

Formerly the receipt of relief made the recipient a pauper, and deprived him of his municipal and imperial votes. The Medical

Relief Disqualification Act, 1885, now provides that 'Where any person has in any part of the United Kingdom received for himself, or for any member of his family, any medical or surgical assistance or any medicine at the expense of any poor rate, such person shall not by reason thereof be deprived of any right to be registered, or to vote either as a Parliamentary voter, or at any municipal election, or as a burgess, or as a voter at any election to an office under the provisions of the Statute.' The Guardians however, possess power to refuse relief under this Act, and in some cases the receipt of relief does still disfranchise the recipient. This measure should have had for its title, 'The Nursing and Cultivation of Votes Act.' At present Poor Law infirmaries are not used for the education of medical students. The Metropolitan Poor Act, 1867, lays it down, section 29, that the asylums provided for the reception of the sick or insane *may* be used for the purposes of medical instruction, and for the training of nurses subject to the Local Government Board. Then came the Metropolitan Poor (Amendment) Act of 1869, which by section 20 says: 'So much of the 29th Section of the Metropolitan Poor Act, 1867, as authorizes the use of any asylum for the sick or insane for the purposes of a medical *school is hereby repealed.*'

These two Acts relate to the Metropolis only. The Boards of Guardians in England and Ireland and the Poor House Committee, under the Board of Supervision of Scotland, have power to throw open their infirmaries for the training of medical students; the general consolidated order of the Local Government Board placing these under the control of the Guardians.

Of late years, efforts have been made by the Royal College of Physicians and other bodies that the Poor Law infirmaries should be opened for instruction of students, and at last, by the Poor Law Act, 1889, section 4, it is enacted that: 'the Asylum Managers may, if they think fit, allow the asylums provided *by them for fever*, small-pox, and diphtheria, to be used for purposes of medical instruction.' There are now seven fever hospitals under the Metropolitan Asylums Board. A great stimulus was given to the passing of the above section by medical officers of health reporting that the education of young medical practitioners in the recognition of cases of fever was very deficient. This is a most important matter, as very grave results would follow if persons were removed to fever hospitals when they were *not* suffering from any such disease, chiefly owing to their exposure to infection in the wards in which they were placed.

It is not too much to hope our large workhouse infirmaries will soon be opened for the instruction of students. Patients who attend the Poor Law dispensaries might be used for instruction. In Liverpool there is a rich mine of teaching material, with the 3,948 beds, and 14,818 in-patients. The power which unions possess of building infirmaries for the use of sick persons, and the action of such unions as those of Birmingham, West Derby, and Toxteth, in establishing infirmaries replete with every modern requirement, must soon lead the public to demand that such places shall be open for the teaching of students. The constant cry of our Voluntary Medical Charity managers is that their hospitals must be kept up, else students could not be properly educated. A more hollow cry has never been raised. With a return of the system of pupilage or apprenticeship, and with a use of the Poor Law and Corporation hospitals, the necessity of the Voluntary Medical Charities is gradually becoming less and less.

I wish to add, the Poor Law Act of 1889, by section 3 (2), gives the managers of the Metropolitan Asylum District the power to admit persons *who are not paupers;* and the expenses incurred for the maintenance of patients are to be paid by the Guardians, who, again, can recover from the person liable by law to maintain the patient.

Unfortunately the English Poor Law returns do not give the total number who were found to be ineligible for relief. It is to be hoped such an annual return will soon be given.

In Scotland, in 1890, 92,824 were in receipt of relief on May 14th; 3,362 were refused relief throughout the year; and 6,883 were offered the poorhouse, but declined.

In England and Wales there are about 4,300 Poor Law medical officers, and the sum spent, including salaries, drugs, etc., was £325,516 in the years 1886 and 1887. There are also 1,407 medical officers of health, exclusive of poor and county medical officers.

II. Medical Relief given in the Corporation Fever Hospitals.

A reference to Table I. shows that during the year 737 cases of fever received treatment at the City, Bootle and Toxteth Park fever hospitals.

These are situated in Netherfield Road, N.; Grafton Street, Parkfield; and Smithdown Road.

The Public Health Act, 1875, section 131, gives Urban and Rural Sanitary Authorities power to provide hospitals for the reception of infectious diseases. Section 132 gives them power also to sue a patient, who is not a pauper, for expenses connected with his treatment while in such hospital.

In cases where fever occurs in common lodging-houses, etc., the patients may, on a practitioner's certificate, and on an order from a magistrate, be removed to the hospital.

The Infectious Diseases (Notification) Act, 1889, has given a great stimulus to the building of fever hospitals, for, by section 3 of that Act, the head of the family or other person, *and* the medical practitioner called in to treat or visit any person suffering from an infectious disease, mentioned under this Act, must forthwith notify to the medical officer of health the fact, or, in default, be fined forty shillings. Under this Act, each Sanitary Authority may order that the Act shall apply to any infectious diseases, other than those mentioned in the Act. The Act is a most valuable adjunct to the Registration of Deaths Act. The latter tells how many persons *have died* from fevers, etc., while the former will tell the number of persons who have suffered through illness from fevers. Previously only the army and navy reports gave data relating to the *amount of sickness*, but now this Act will give figures relating to the entire population. The resident and visiting medical staffs of these fever hospitals are paid for their services; but at a very unremunerative scale, considering the risks. The Infectious Diseases Prevention Act, 1890, which can be adopted by any urban or rural sanitary district, by section 7 provides that every person who shall cease to occupy any house or room, in which any person has within six weeks previous been suffering from any infectious disease, and has not had the house disinfected, may be fined £10. The same penalty is fixed if a house is let in which a person has within six weeks suffered from an infectious disease.

The 13th section also provides that a person casting any infectious rubbish into an ashpit shall be guilty of an offence under the Act.

III.—Medical Relief given by Non-Medical Charitable Institutions.

By these are meant institutions which give relief, such as the Blue-coat School, boys', female and infant orphan asylums, widows' homes, etc.

Each of these, as a rule, possesses a medical officer, and consequently the inmates are provided, *when necessary*, with free relief. Such appointments are, I regret to say, honorary. There are over 70 non-medical charitable institutions in and about Liverpool. Calculating that each contains at least 40 inmates, this gives a total of 2,800 persons eligible for free treatment.

IV.—Free Medical Relief given privately by Medical Practitioners.

In 1888 there were about 415 medical practitioners in active work in the area comprised in the three Unions, and of this number about 274 resided in the city of Liverpool, exclusive of 27 resident medical officers at the hospitals.

I am well under the mark in stating that each of these 415 practitioners gave free relief to at least 25 persons, or a total of 10,375. Look at the amount of gratuitous work done.

Practitioners give free treatment to nurses, matrons, midwives, medical students, relatives, many of the clergy, their wives, children and servants, and to fellow practitioners. Nor do I include people who do not, and never mean to, pay their bills—a fearful number if we ask the various collectors and trades' protection societies. A visit to the County Court shows what a large number insist on having free treatment, who drive home the truth of the old couplet :

> 'God and the doctor we alike adore when in the hour of danger, not before.
> The danger passed, both are alike requited ; God is forgotten and the doctor slighted.'

Indeed, a visit to the County Court shakes one's faith in the inherent honesty of people more than any other experience. Nor do the above figures include those who insist on pushing a poor relative on the charity of the practitioner—instead of combining among themselves to defray the expense—those who meet one in the street and extract advice ; those who come 'to pay a bill,' and on going out turn back and say, 'Oh, doctor, I just wanted to ask you !' nor those

who want a doctor to treat three or four patients in the same house, and charge one fee—'taking a number at a reduction.'

To the poor the practitioner gives his charity quietly and unostentatiously, the kindly deed being neither sung at annual meetings nor recorded in annual reports. This is the true charity which avoids the braying in the market-place.

V.—Medical Relief as given by the Voluntary Medical Charities.

A reference to Table I. shows that at 22 voluntary medical charities, 10,245 *in*, and 223,322 *out*, *home*, and *casualty* patients, received treatment during the year. Sixteen of these charities had 186 nurses, and 1,034 beds, and 22 had 111 visiting, 27 resident medical officers, and 25 dental practitioners.

There were 13 other medical charities from which I could not obtain information; each gave relief to about 500 persons, or a total of 6,500 patients.

As regards the figures in Table I., they are all taken from the official reports. To reduce inaccuracies to a minimum I forwarded a proof of the table to the various secretaries for correction. In so far as official reports are correct, the tables are correct, and any person who denies their accuracy must be able to adduce proof that these official reports have been 'cooked.' I use the expression 'cooked' because I once heard a surgeon connected with one of our largest charities say at a public meeting, that not only were the statistics 'cooked,' but that he himself had taken part in cooking them!

There are sources by which errors may creep in. It has been said one patient may be counted twice; that an *out* may become an *in*-patient, and *vice versa;* that a Poor Law case may obtain relief from the voluntary charity; that the patient may apply twice, or even three times in a year, or be attending two or more charities at the same time. We all recognise this evil of 'overlapping' and the gross want of management which permits the other conditions to exist. Investigation and inspection should prevent 'overlapping': patients should not be registered as 'new' cases when they obtain a 'renewal form'; while a 'census' might be taken weekly and monthly on one pre-arranged date. Another error which might creep in is that of confounding the number of '*attendances*' with the number of *patients*.

The Birmingham Committee sent questions to the charities asking (*a*) 'What number of *in*-patients were registered *more than once* during the year as fresh cases?' Answer—about 10 per cent. (*b*) 'What number of *out*-patients were registered more than once during the year as fresh cases?' About 10½ per cent. (*c*) 'In answer to the foregoing questions have you included transfers from *out*- to *in*-patients' departments, or *vice versâ*, and if so, what were the numbers transferred?' About 2½ per cent.

I shall use these answers and apply them to Liverpool.

SUMMARY.

The following statistics arranged in tabular form give a graphic picture of the enormous extent of free medical relief:

	Persons.
Free medical relief given by three Poor Law unions to	38,755
Free vaccination given by three Poor Law unions to	11,372
Free medical relief given by five municipal fever hospitals to	735
Free medical relief given by 415 medical practitioners to	10,375
Number treated at 22 voluntary medical charities (per annual official reports)	233,574
Number treated at 13 voluntary medical charities (estimated).	6,500
Exclusive of 1,133 persons at Woolton Convalescent Institution.	
Exclusive of 2,400 persons, 60 non-medical charities.	
Exclusive of 3,046 persons visited by District Nurses' Association.	
Total number who received free medical relief .	301,311

To correct the above number treated at the voluntary medical charities, deduct 10 per cent. from 223,329 *out*-patients registered more than once as 'fresh cases' = 22,332. Again, deduct 10 per cent. from the 10,245 *in*-patients registered as 'fresh cases' more than once = 1,024. Again, deduct 2½ per cent. from the *out*-patients who have been transferred to the *in*-patient department = 5,583. This gives a total of 28,939 to be deducted from the total of patients, leaving 272,372 *as the corrected total.*

As the estimated population of the area included in the *three* Unions is placed by me (for 1888) at 717,569 (the population in 1891 was 725,300), it follows that about 1 in every 2·6 persons received free medical relief. It would not be fair to say 1 in every 2·6 of the population of *the city* received relief in that year, as no doubt a large proportion of patients came from beyond *the city* boundary. For this reason I have taken the much larger area.

I am aware that taking the average for the large area will not be acceptable to a few, as these hold that some patients come from a greater distance. This may be granted, but to a very small extent. It must be noticed that Birkenhead amply supplies its own poor. It has 10 voluntary medical charities with 18,454 patients, a Poor Law with 1,212 patients, a Corporation fever hospital and convalescent home (see Table III.). Then Wallasey, Chester, Southport, St. Helens, Warrington, Preston, and Rochdale have each their medical charities and Poor Law. Therefore the three Unions must supply the bulk of the cases.

The following figures are instructive:

Number of Beds to Inhabitants.

Number of beds at 16 voluntary medical charities . .	1,034
,, ,, 5 fever hospitals	300
,, ,, 3 Poor Law Unions . . .	3,948
Total	5,282

to population of 717,569; or 1 bed to every 135 persons.

Number of Nurses to Patients.

Number of nurses at 16 voluntary medical charities = 186, or 1 nurse to every 50 *in*-patients.
Number of nurses at 5 fever hospitals . . = 27, or 1 nurse to every 27 patients.
Number of nurses at 3 Poor Law Unions . . = 151, or 1 nurse to every 98 *in*-patients.
19 district nurses and midwives . . . = 38

Total number of nurses . . . 402

Number of Medical Staff to Patients.

163 medical officers to 233,574 voluntary medical charities' patients, or 1 doctor to every 1,432.

37 medical officers to 38,755 Poor Law patients, or 1 to 1,047.

One practitioner may hold two or three charity appointments.

Number of deaths at the workhouse infirmaries and medical charities in 1888 = 2,071.

CHAPTER III.

WHY ARE OUR VOLUNTARY MEDICAL CHARITIES ABUSED?

To give a clear view of the causes which combine to create and establish the abuse of charity, I shall discuss the subject under the following heads, dividing the chapters into several sub-chapters :

SUB-CHAPTER.

I.

BECAUSE THERE IS NOT A CENTRAL BOARD WITH LOCAL AUTHORITIES EMPOWERED BY ACT OF PARLIAMENT TO SUPERVISE VOLUNTARY MEDICAL CHARITIES.

There is a well-grounded feeling that, unless a Central Authority is formed, all the work done with the view of bringing about a reform will be wasted. Experience bears this out, for, although earnest men have been labouring, little progress has been made. Even in Manchester only five of the sixteen charities agree to combine in checking abuse. The rock on which managers stumble is—they will not recognise that, while other charities require careful supervision, their particular form of granting relief is more open to abuses, and so demands more careful management than others. Some are opposed to supervision because their isolated condition allows them to carry on a guerilla warfare which would be stopped if they were under supervision. Hence their violent screamings when any person proposes proper control.

Granting the necessity for a Central Board, how is this to be constituted? The Local Government Board would be the best authority. It has inspectors and auditors. The auditors could supervise the finances, and the medical inspectors report upon the administration and construction of charities. Regulations for the guidance of each Local Medical Charity Board, and a specified uniform plan on which to draw up annual reports and balance-sheets could be authorized.

Those interested should read the Consolidated Orders of the Poor Law Commissioners, 1847, containing instructions to Boards of Guardians. If the Central Board published a Blue Book, containing full information regarding all voluntary charities—some 750 in number—valuable data would be collected, public confidence restored, while fewer subscriptions would be withheld. Another useful power might be given, viz., the regulating of the number of medical charities, and preventing the formation of new undertakings, unless with the approval of the Board.

A Central Board would be given power to recommend the amalgamation of several charities. In this age of specialism the work of at least four or five could be easily performed by one charity. Thus large sums of money—now swallowed by management—would be saved. When, under the Poor Law Act, each parish agreed to combine with other parishes to form a union with a central infirmary, a great saving was effected. The expenses would have been enormous had each parish insisted on having its own infirmary. What would be said if a union proposed to have *special* hospitals? Let us hope the 'special' mania will not infect the Poor Law.

Further, a Central Board would advise as to the persons eligible for relief, the Board having power to enforce its recommendations, and to surcharge any committee or official who granted relief to ineligible persons.

Some will say the Local Government Board has now sufficient work, and that the duty should fall upon the County Councils. The best results will be given if we obtain an impartial central authority, uninfluenced by local petty considerations. It may be no Government has a right to interfere with voluntary medical charities! Supervision should be accepted as a boon. Why should committees fear it? Would it not remove many grave abuses? Does anyone suggest the various Poor Law infirmaries do not benefit by supervision? Do not Board Schools benefit largely by the visits paid by her Majesty's inspectors? and do not the voluntary schools prize such?

There are many other examples where supervision by a central body is secured. At one period, the Government took over the control of charities and hospices, and appointed, in 1834, the Poor Law Commissioners, who afterwards became the Poor Law Board, and, later, the Local Government Board. This Board now supervises vaccination stations, and sanitary authorities.

Other examples are—the appointing of inspectors of coal mines,

canal boats, factories and workshops, bakehouses, railways, and the power given to the Board of Trade to inspect ships; the inspection of local loans and local Acts; of boarded-out children, and alkali works. If we come to supervision exercised by corporate bodies, and Urban and Rural Sanitary Authorities, under the Public Health Act, we find these have power to inspect houses, sewers, dairies, weights and measures, theatres, and public buildings.

Taking these as examples, it will be granted that those who advocate disunion have no valid objections. In fact, no honestly-conducted charity has anything to fear from supervision.

How can we expect, say, 156 voluntary charities in the Metropolis to work in harmony and to cease their petty rivalries if there is not a central authority? What would we think of a rivalry between different Poor Law unions or charity organization societies? Even if only 25 charities, of a total of 30, combine to check abuses, will not the remaining 5 open their doors to those who have been refused aid, and so bring discredit on the system? Yet the public tolerate such irregularities. Why? Is it because they secure cheap medicine, and so patronize the charity as they do the store?

I shall next refer to medical charities which are supervised. The Board of Charity Commissioners has power to make endowed medical charities — that is, those which hold landed and other property — furnish copies of accounts. This Board has not such power over charities without endowments, and only over these to the extent of inquiring into that portion of income drawn from endowments. Some hold both results would have accrued had the commissioners been given power over endowed and voluntary charities. It is to be hoped the duties of the commissioners will be taken over by the Local Government Board.

If reference be made to 'an Act for the better regulation of the Houses of Industry Hospitals and other hospitals in Dublin,' 1856, it will be seen the Lord-Lieutenant is given power to appoint a 'Board of Superintendence.' The duties are thus defined: (*a*) To inquire into the rules and management of the hospitals; (*b*) to prepare general rules for the government of all hospitals supported wholly or in part by Government grants, provided such general rules shall not be inconsistent with the acts, charters and testamentary bequests at present regulating such hospitals respectively, such rules to be approved by the Lord-Lieutenant; (*c*) to present a yearly report regarding the accommodation of patients, management

of hospitals, conduct of officers and servants, care of patients, and whatever observations they may think necessary in relation to hospitals; and (*d*) to present such report to both Houses of Parliament. The 31st Annual Report, 1889, gives a large amount of valuable information.

As further illustrations of the utility of a Central Board, we may refer to the powers given by the Local Government Board to direct that the accounts of the receipts and expenditure of County Councils be drawn up after a prescribed manner; and also that of the Lunacy Commissioners, who are given similar powers. Anyone interested in this matter should refer to the Local Boards' Accounts Order, of April, 1884; and the Local Boards Act, 1880, issued under the Public Health Act, which provides 'that all the accounts of the receipts and expenditure under this Act, of *every* local authority, shall be made up in such form and to such day in every year as they may appoint.

Speaking on the subject of want of harmony, Sir John Simon has said: 'Among the most flagrant illustrations of the general cases' (abuses of medical charity) 'are the facts regarding the very numerous medical charities of London: all of them more or less mendicant or expectant as to charitable gifts from the public, and most of them loud in professing financial difficulties, yet none of them under any sort of exterior audit or control: all of them independent of each other: all of them free from any relation to the admirable system of asylums, infirmaries, and dispensaries which the Poor Law has worked in the same area: all, or nearly all of them—except so far as subscribers' tickets may be required, and the individual subscribers may choose to investigate—ready to give medical treatment without any sort of inquiry whether the recipient is really so poor as to need that form of alms; and the chief of them giving out-patient treatment in this indiscriminate way, on so immense a scale as to raise doubts against the value of what they give.'

On March 4, 1863, the Right Hon. W. E. Gladstone said: 'One of the great evils of the present system is, that while you bestow public money on these establishments you dispense with all public control over them, and thus annul all effective motives of economy. Endowed institutions laugh at public opinion; the Press knows nothing of their expenditure; Parliament knows nothing. It is too much to say that the hospitals are managed by angels and archangels, and do not, like the rest of humanity, stand in need of criticism, supervision, and rebuke. Therefore, even in the case of

St. Bartholomew's, I object to an exemption which by its very nature at once removes the principal motive of economical management. When the managers tell me that the exaction of £820 will compel them to dismiss 500 patients, I am entitled to ask: Why, then, do you spend £220 in a feast? What right have you, in one hour, to eat up 150 beds?'

These examples show there is nothing 'unconstitutional,' 'tyrannical,' 'revolutionary,' or 'socialistic' in this proposal, nor is it 'contrary to the genius of the English nation'! Some try to frighten the timid by trotting out the bogey of 'Government interference,' or centralization. Supervision has been the means of working good, and very few should allow personal and private interests to stand in the way of an imperatively called for reform.

I emphasize the fact, I neither advocate the levying of municipal or imperial taxes, nor the granting of State support in aid of voluntary charities. I do not suggest they be taken over or administered by the State. All I recommend is, State supervision. The glory of these institutions is, that they are voluntary, that they are free, and that they should be for the benefit of the sick poor only.

Leaving now the proposed Central Board, and coming to Local Administration, I suggest that each city and town have a Local Medical Charity Board, consisting of members elected for two years by the committees of the charities, Charity Organization Society, Hospital Sunday and Hospital Saturday Funds, representatives of the medical profession, of the different religious denominations, the different Boards of Guardians, of the Municipal Fever Hospitals, the Nursing Association, and School Board; the inspector of the Central Board having the right to attend all meetings of committee, but not the right to vote. Such a board would exercise local supervision and frame by-laws; these, as well as the rules of each charity, being approved by the Central Board, made in the way the Chief Registrar of Friendly Societies approves and puts his official stamp on the rules, and inspects the annual reports of friendly societies. In this way there would be a registration of charities. The Board would leave each charity committee to administer its own funds, appoint and elect its committee and medical staff, and discharge officials. It might take over the duties of the Hospital Sunday and Saturday Funds, appointing sub-committees to administer. The Press should be admitted to the meetings of the Medical Charity Board. I would suggest that *each* charity need not publish an annual

report, nor hold separate public meetings. The former plan would lead to economy, and the latter effect a great saving in the time of the mayors, who have now to preside at each individual meeting. The Medical Charity Board should, instead, hold one public annual meeting of the combined charities, and publish an annual report containing information regarding each charity, and suggested improvements and alterations. To show such a plan may be carried out, I would refer to the Dublin Hospital Sunday Fund Report of 1889, and which contains not only a full report relating to the income and expenditure of sixteen medical charities, cost of beds, number of patients, and a summary of the report of the Visiting Committees of the Sunday Fund on the state of each charity, but suggestions regarding administration.

I advocate the placing of our charities under central and local supervision; every city to group its charities under one board, and each charity to be managed by its committee.

The fact that over 3,000,000 persons receive free aid from voluntary charities, points to a grave condition of affairs, while large sums of money are being collected and expended with little or no public control. It is to be hoped an Act will be passed, giving the Local Government Board power to supervise the charities. Such an Act might be made renewable at the end of ten years, supposing the advantages gained in the interim proved the desirability of its continuance. None should give a warmer welcome to a well considered Bill than those engaged in medical charity administration and organization.

SUB-CHAPTER.

II.

One Medical Charity competes against the Other for the Greatest Number of Patients.

The manner in which charities tout for patients is humiliating. Not one of the charities in and about Liverpool take the trouble to state in their Reports what system of inquiry is adopted to check impo sition; nor do they give figures showing what numbers have been refused. Each charity vies with the other in quoting the highest number of patients treated! The presence of something like the following in an annual report is not unusual: 'We are glad the numbers are greatly in excess of those who received treatment last year, thus proving the necessity for, and the increased usefulness of,

this institution ; but we deeply regret that, owing to the want of funds, we are unable to extend the sphere of our usefulness !' Then follows an appeal for more funds, 'so that some twenty more beds may not be kept idle !' A very good illustration of this is to be found in the Report of the Stanley Hospital, Liverpool, for 1890, where it is said : 'The Committee would draw the attention of the public to the fact that this hospital treated in 1889 no fewer than 14,491 patients, and that this is a larger number than were (*sic*) treated in any other Liverpool hospital during the same period.'

Such reports have given rise to much 'chaff' in some of the medical journals. Paragraphs like these have been given the particular title of 'This Year's Record Breaker ;' or, 'The Charity which offers "Special Inducements !"'

The sooner managers are made aware that the public are sick of this kind of advertising the better. What would be said if the Poor Law issued such a report ? The public, or at least the thinking portion of the public, prefer to read the Poor Law Report when it states : 'We are glad to say there is a marked decrease in the number of applicants for relief.' It cannot be too forcibly driven home that many persons are now asking, Why do so many of the industrial and middle classes say they are unable to provide themselves with efficient medical treatment, while at the same time they are better housed and fed, and better clothed ; when wages are greatly on the increase ; when they are not weighed down by taxation ; when the ordinary commodities of living are cheaper ; when hours of labour are shorter ; and when so many luxuries can be indulged in ? This is a momentous question which must soon be answered, else there will be a further falling off in subscriptions. Mr. Burdett Coutts, M.P., has shown that the incomes of the general hospitals of the Metropolis have fallen off during six years at the rate of £60,000 per annum.

This contemptible system of charity competition would cease if a well conducted Medical Charity Board were established, especially if such board had the granting of sums of money to the charities, in a manner similar to that adopted by the Metropolitan Hospital Sunday Fund (see p. 44).

SUB-CHAPTER.

III.

There is no Uniform System of Inquiry into the Circumstances of Applicants for Relief.

The Right Hon. G. J. Goschen, in 1869, issued a circular letter to the Metropolitan relief authorities with the view of bringing the Poor Law and those who administer other charitable funds more in touch with each other, and 'to mark out the separate limits of the Poor Law and of charity.' A copy of this letter and the replies will be found in the 22nd annual report of the then Poor Law Board. A result of this circular was the formation of the London Charity Organization Society.

The organization of medical charity relief is a supposed difficult task. Great diversity of opinion prevails. Individuals of the 'cock-sure' school, and those who have but a superficial knowledge of the subject, bring forth panaceas which are no sooner tried than they fail.

In some cases, the practice of medical charity is, that the poorer the person, the higher the medical skill given. This charity should be bestowed so that the recipient may be demoralized in as small an extent as possible, for all grant that relief in any shape is likely to demoralize. No practical person will argue, because one person out of twenty who obtains relief is unworthy, the other genuine cases should be refused relief. The indiscriminate giving to all applicants is working great evil, and this can alone be rectified by a thoroughly-worked system of inquiry. All other charitable agencies put it in the front rank that a close inquiry is made before relief is granted. Why should our voluntary charities be an exception? If an investigation proved there was no abuse, what a splendid opportunity would be given to appeal to the public and say: 'There is no abuse.' Some go so far as to say the medical charities should be 'free to all;' that a system of investigation would be cruel, and that the liberty of the subject must not be hampered! They refer to the case of the good Samaritan, and ask what would have happened had any system of investigation been necessary prior to the granting of aid in such a case? But this is about the worst illustration. Such a person would now be classified as an 'urgent' case; the telephone would be sounded: the ambulance rush to the rescue, with the eternal whistle going; the man would be taken to the charity,

whether he wished to be taken there or not; and, if the modern Samaritan were a fairly well off 'case,' a paragraph would be sent to the local papers, while the 'case' would be invited to give a donation to the ambulance fund!

The next question is: What kind of inquiry or investigation should be adopted? This point can be answered by referring, firstly, to systems which have been fairly successful; and, secondly, to systems which have failed.

(*a*) *First, as to systems which have been fairly successful.*

I shall refer to the system in force at Manchester. In 1875, the Manchester and Salford Provident Society—a body similar to a charity organization society—asked the various voluntary medical charity authorities each to appoint a representative; these to meet as a committee and decide, What are the circumstances which qualify for the receipt of out- or home-patient treatment? and, further, to arrive at the best practical means by which the congested state of the charities would be relieved. Mr. O'Hanlon, an employer of labour, took an active part in this work. The committee agreed that a 'wage limit' would afford a fairly accurate basis to work upon. They fixed the following 'wage limit,' and ruled that applicants making over should be refused treatment:

Single man, or woman . . .	12s. per week.
Man and wife	18s. ,,

And an allowance of 1s. 6d. opposite each child under 14 years.

The granting of a margin of 1s. 6d. per week opposite each child below 14 years shows the Committee recognised that a man and wife with, say, eight children, although in receipt of a combined weekly wage of 30s., were more in need of relief than a man and wife without a family.

Next, five of the charities agreed to furnish complete lists of applicants for treatment to the District Provident Society, while this society undertook to supply inspectors to inquire into the pecuniary circumstances of applicants.

System of Inquiry.—The system at the infirmary for out, home, and dispensary patients is as follows: Every morning *all new applicants* take their place on forms in the entrance hall, and are called

up to the inquiry office window by the clerk, who takes their names and addresses and interrogates them as to their circumstances—filling up the following form :

MANCHESTER INFIRMARY.

NO.	NAME.	RESIDENCE.	RENT OF HOUSE.	NO. OF FAMILY.	STATED WEEKLY EARNINGS OF					REMARKS.	WILL PAY PER WEEK —*in*-PATIENT.
					Patient.	Father.	Mother.	Children.	Total.		

Next, the applicants are admitted to the out-patient room and are passed to the medical staff. All receive treatment on the first occasion, and so seeming severity is avoided.

Accident and urgency cases are admitted at all hours and without inquiry—nor is a list of such furnished to the inspectors.

Twice weekly a list of all applicants who reside within the provident dispensaries' districts—comprising a radius of about four miles from the centre of the city—is forwarded by the infirmary to the Provident Society, as per table. The inspectors of the society investigate the circumstances of each applicant, either at his home or at his employer's. If the inspector finds the patient's wage is over the limit he withdraws the charity card, or stamps it, tells the applicant he is ineligible for relief, and that he should join the provident dispensary. He also gives the following :

MANCHESTER INFIRMARY.

'It having been decided to confine the granting of free medical attendance and medicine to out-patients whose weekly earnings do not exceed the following scale, viz. :

Single Man or Woman . .	12s. 0d.
Married Couple . . .	18s. 0d.
For each Child . . .	1s. 6d.

and your weekly earnings being in excess of this scale, the visitor of

the District Provident Society bringing this circular is authorized to withdraw out-patient's card, and will furnish you with all particulars for joining the provident dispensary of the district in which you reside.

W. L. SAUNDER,
Secretary, Manchester Royal Infirmary.
JAMES SMITH,
Agent, Manchester and Salford District Provident Society.

'N.B.—Above will be found a list of the provident dispensaries, with particulars of the advantages of membership.

'Should your earnings be but slightly in excess of the limit entitling you to free medical treatment, the officer enrolling you a member of the provident dispensary is authorized to accept a reduced entrance fee.'

Having visited all, and entered remarks on the Table, he returns it to the infirmary.

The out-patients who reside outside the four-mile area are not visited at their homes, but inquiry is made when these apply for treatment.

The society has seven inspectors, four employed exclusively in making inquiries regarding medical cases, three others being used for similar duties if the number of cases is excessive. The inspectors are paid each from 27s. to 40s. per week, and an extra allowance for train fares when inquiries are made regarding distant *in*-patients. The cost of inspectors is defrayed partly by contributions from the medical charities and partly by the society. The infirmary gives £50 per annum: Children's £30, Clinical £10, Ancoats £5, and the Royal Salford £25. The infirmary pays an extra £13 for the inquiry into the circumstances of *in*-patients. During 1889 (*see* Annual Report of the Manchester and Salford Provident Society) the salaries chargeable to this society for investigating 60,322 cases for the different charitable agencies—the above medical charities included—were £869, and towards this the medical charities paid £155 15s. 6d. The society investigated 19,101 cases for the infirmary, 9,374 for the Salford, 8,262 for the Children's, 8,007 for the Clinical, and 4,538 for the Ancoats charity.

The five charities had inquiries made into 49,182 applications for treatment, at the cost of 1¼d. each to the medical charity. It cost

the society, on an average, 3¼d. for investigating their total of 60,322 cases, and so each medical charity case cost the society 2d. If an extra 1¾d. be allowed for other expenses, such as rent, clerks, stationary, etc., the sum of 5d. per case covers the entire cost.

At the Salford charity the system is modified. The inspector does not withdraw the patient's card, but the following notice is forwarded to the subscriber:

[Note to Subscriber who recommends Improper Applicant.]

SALFORD ROYAL HOSPITAL.

.....189

Name,.....

Residence,.....

The circumstances of the above-named person, recommended by you, have been carefully inquired into, and it is found that he is not a proper case to be admitted as a Patient of this Charity. (See Rule 27, printed at foot.)

Full particulars may be obtained at the Hospital.

By Order of the Board,
(Signed) GEO. H. LARMUTH,
Secretary.

To Mr..... ..

....

Rule 27.—'All persons who are unable to pay for medicines, and are not in receipt of parochial relief . . . . shall be considered proper objects of this Charity.'

The following note is given to the patient:

[Note to Improper Applicant.]

SALFORD ROYAL HOSPITAL.

.....189

To.....

Your attention is hereby directed to the following extract from the Rules of the Hospital:

> 'All persons who are UNABLE to pay for medicines, and are not in receipt of parochial relief . . . shall be considered proper objects of this Charity.

You are respectfully informed, after careful inquiry into the circumstances of yourself and family, that, in the opinion of the Board of this Institution, you are capable of providing yourself with efficient medical attendance in the ordinary way, or through the Provident Dispensaries.

You are, therefore, deemed not to be a proper person to be admitted as a Patient.

By Order of the Board,

GEO. H. LARMUTH,
Secretary.

At this charity the wage limit begins at 15s., and an allowance of 1s. 6d. opposite each child.

As regards the system of investigation into the circumstances of *in-patients* at the infirmary and Salford hospital, this is practically similar to that made into the out-patients'. There is no 'wage limit;' as those who apply as *in*-patients are generally known to the inspectors, a further inquiry is not so much required. Mr. A. Hay, Secretary to the Salford Hospital, informs me that no letters of recommendation for in-patients are issued to subscribers. A table similar to that for out-patients at the infirmary is used for the *in*-patients, and it is sent to the Provident Society, the inspectors filling it in and entering in the column 'able to pay weekly' the sum agreed upon. These charities do not try to make in-patients a source of revenue, for the Salford Hospital in 1889 had 1,083 in-patients, giving a total of £106.

Having described the system of inquiry in force, the next question is: *Has the system been a success?*

In so far as it has been given a fair opportunity the system is one of the best yet devised, and it has succeeded fairly well. I refer to results relating to the number of *ineligible* applicants who now apply for relief. The fact that this number has been reduced from 42·32 per cent. to 6·89 speaks for itself.

Mr. A. Hay, Secretary of the Salford Hospital, says: 'The plan as a whole works well. Of course there are cases where subscribers grumble on account of cases, where they have given a "recommend," being discharged. I have no doubt but that it is a saving to the charity. The fact of its being known that an investigation is made into the circumstances of all applicants for relief, prevents many, who would otherwise, from presenting themselves.' Mr. Forrest, Hon. Sec. Ancoats charity, says: 'It is most undoubtedly a saving to the charities.' Only five of the 16 medical charities co-operate in carrying out this system. Some of those which do not co-operate say they have a system of their own. I am dubious of these.

Thus the 23rd Annual Report of the Southern Charity says, page 7: 'No *paying* patients are admitted, and the position of those seeking relief is carefully investigated, yet *out of their poverty* they and their friends have shown their appreciation of the services rendered by contributing £207 15s. 6d. during the year.' This is a strange statement! What is their 'wage limit?' What 'careful' system of investigation is in force?

Again, the St. Mary's Charity, in the 1889 Report, page 13, says: 'To protect the hospital against abuse by the admission of undeserving applicants, an inspector is employed to inquire into the position and deserts of those seeking admission.' Yet, at page 5, there is a notice stating patients can be admitted without a recommendation *on payment of a fee of* 5*s*. 'Private forms of admission for a period not exceeding four weeks may be purchased singly by patients for their own use, on application to the house surgeon, at the following scale of charges: Pregnant women residing within the boundary, 5s., and up to 40s.'

This is one of the chief faults of the Manchester system—viz., that there is a want of uniformity—much to the delight, no doubt, of dishonest patients.

I shall next notice *some other flaws* in the Manchester system which might be remedied.

1st. If a person apply at the infirmary and is found to be making

over the 'wage limit,' such person obtains free relief *for one month on giving a guarantee that he is about to join a provident dispensary.* As the 'entrance fee' to the provident dispensary is 6d., and the weekly subscription 1d., such patient secures a month's treatment at the charity on making a payment of 7d. to the Provident Dispensary! Such a rule is absurd, and its presence disfigures this system. Its existence is due to the fact that a person cannot obtain treatment at the provident dispensaries until he has been a member for one month. This objection can be readily removed by the provident dispensaries giving aid for a small *immediate* or cash fee, as well as working out its provident department.

2nd. If a member of the provident dispensaries is sent by one of its medical staff to the infirmary, the authorities have neither the right to inquire about such a patient, nor to refuse treatment. Such a rule opens a door for gross abuses. It, in fact, gives the provident dispensary member the power of insuring for treatment at both the dispensary and the charity, and allows him to go to the charity if he is displeased with the former. It also permits the medical staff of the dispensary to rid themselves of an obnoxious patient.

3rd. *All* who apply for out-patient treatment receive *first aid.* First treatment should be given to two classes of out-patients only: viz., cases of serious accident and urgency, and those making under the 'wage limit.' If *all* receive first treatment and are refused on a second occasion only, this means that a patient could go round, in succession, about 22 charities, and still receive only *first* treatment from all! I would suggest that the condition of 'serious accident and urgency' should be decided by the resident medical staff, or by the visiting staff on duty, and that the clerk or other person employed be given power to refuse first aid to those non-urgent cases making over the 'wage limit.' Such a plan would not mean any hardship if it be remembered that all severe accident cases are admitted without any inquiry, and also because out- and dispensary patients are 'walking cases of illness,' in contra-distinction to 'bed-fast illnesses.' Cut fingers or scalp wounds should not go to the charity for aid if over the wage limit. A very large proportion of *out*-patients are trivial cases. Sir W. Fergusson's committee found that from three-fourths to nine-tenths of the out-patients were *trivial.*

As showing the trivial nature of many, I have compiled the following from the Liverpool Medical Charities' reports:

Burns and scalds treated at	5	Medical Charities	. .	712
Contusions and sprains treated at	4	Medical Charities	.	4,163
Cuts and wounds	4	„	.	8,699
Dislocations	4	„	.	175
Injuries treated at the	3	Dispensaries	. . . .	12,274

4th. All cases of serious accident and urgency which receive immediate treatment, *but who are found to be making over the 'wage limit,'* should be made pay a fee, equal to that charged by practitioners to such a patient. In other words, while *no* serious accident or urgent case should be refused *first,* or immediate treatment, I would apply the 'wage limit' to such cases also. I would, however, in *no case give continuous* treatment to any *out-patient making over the* 'wage limit.' The fee charged should be such as to discourage any attempt to return for treatment. As before stated, the Poor Law is given power to recover expenses either from the person relieved, or from a relative. Under the Public Health Act the different sanitary authorities have similar powers. An Act of Parliament might be necessary to enforce such claims for treatment. A knotty question arises, as to whether such fees should go to the funds of the charity or to the medical staff? They should go to the charity, always provided *no continuous treatment* be given to this hyper 'wage limit' patient.

5th. The wage limit is too high. That of Preston infirmary should be substituted. The following is theirs for *out-patients*:

Single person . .	7s. weekly wage.
Two members . .	12s. „ „
Three members . .	16s. „ „
Four members . .	19s., and an additional 1s. for each member.

The numbers refer to the total in the family. The height of the wage limit depends on the alternatives offered. The better these alternatives to charity the lower the charity's wage limit. If fees are such that wage earners cannot pay, and if there is no provident dispensary, then the wage limit must be higher.

6th. As a means of giving more complete information it would be well if additional columns in the table were made, viz.: for occupation, in or out of work, sick-pay from clubs.

7th. The Manchester system, in that it does not contain a wage limit for *in-patients*, falls short. Some object to fix such, but as great difficulties were foretold when the limit for *out-* and home-patients

was discussed. In all schemes a certain elasticity must be allowed, if not, the system fails. I would propose the adoption of the following rules for *in-patients :*

(*a.*) *Single persons.*—When a single person has been for the one month immediately preceding the application for relief, and continues to be during sickness, in receipt of an income not exceeding 15s. per week from all sources, such applicant only shall be eligible for *in-patient* treatment.

(*b.*) *Families.*—When the combined income of a family does not exceed 25s. per week for one month preceding the application for relief, and continues so during sickness, any member of such family may be eligible for *in-patient* treatment. Provided that when an illness has existed for three weeks, and where the relatives refuse to support the patient, the above limit may be subject to some modifications.

(*c.*) Whenever any out-, in-, home-, or accident-patients in receipt of a weekly wage *over* the above-mentioned limits are treated, such shall be made to pay the charity a sum of money equal to that charged by practitioners to such class of patients. But patients making *over* the wage limits shall receive continuous treatment at the charity *only* until they can be removed with safety.

(*d.*) Voluntary medical charities shall possess the power of recovering expenses from patients, or persons responsible for them.

The above rules are in no sense narrow. The wage limits may be considered too low or too high, according to practitioners' fees, the presence of provident dispensaries, and the existence of home hospitals.

Any single wage earner having under 15s. per week will be eligible for indoor relief. If he continues to have over this sum, when ill, he will be ineligible. Often when 'bed-fast sickness' comes on, such income ceases. His club money may not exceed 8s. to 12s. per week. It would also give much better results if local medical charity boards had power to receive and distribute charitable funds. It should possess the right to refuse grants to charities not conforming with the rules laid down. The Metropolitan Hospital Sunday Fund has the two following rules :

Rule 4. 'Those hospitals and dispensaries only which are *managed by a committee* duly appointed, and which produce *printed reports with balance sheets duly audited* for *three years*, shall be allowed to participate in the fund.

Rule 5. 'The awards to the hospitals, etc., shall be previously based on an average total expenditure of each institution for the last *three years*, after deducting therefrom—1, a sum equal to the income derived from endowments and realized property; 2, the amount received in legacies exceeding £100 each, unless such legacies have been necessarily spent to meet the current expenditure of the institution; 3, the amount of expenses of management: *but in every case* the merits and pecuniary needs of the institution concerned shall be fully inquired into and considered by the Distribution Committee, and the award made shall be determined in accordance with the judgment of the Distribution Committee upon such merits and needs, provided that in no case shall the grant be further reduced, or withheld, until a conference shall have been sought with the Managing Committee of the said hospital.'

This fund has also drawn up a definite form by which the statement of accounts *must* be furnished.

A perfect understanding should be arrived at as to how long a patient shall receive treatment before a further inquiry is made into his circumstances. Generally a letter of recommendation lasts for six weeks. Under the Poor Law the relieving officer must visit, and report from time to time, those in receipt of relief. The inspector should inquire at least once a week, to see if patients are still ineligible. It would also give a feeling of greater security to the public if a cross-visitor were appointed. The system of surprise visits shows that charity is imposed upon. The Poor Law and friendly societies frequently employ cross-visitors.

Other Systems, Partially Successful.

Having described the Manchester system, and suggested alterations and additions, I shall refer to systems in force at other charities.

London Hospital.—A reference to page 4, and to the Annual Hospital Report, 1884, shows that the plan has been useful. Mr. Nixon, the House Governor, says the system works well, as applicants know inquiry is made in good faith. The following is a copy of the most important portion of the placard placed on the gates and in the waiting-rooms of the charity:

'LONDON HOSPITAL.

'NOTICE TO GOVERNORS AND PATIENTS.

'On and after the 1st January, 1884, the following arrangements, which are in accordance with the terms of a Report from the House Committee, adopted by the Special General Court of Governors, held on Wednesday, 6th of June last, will come into operation—

'1. With a view to prevent the abuse of Charity by improper objects, a Waiting Hall Inspector will be employed to ascertain whether any Patients presenting Governors' Letters are able to pay the fees of Consulting Physicians or Surgeons, or (not being urgent Cases) of Local Practitioners; or should be referred to recognised Provident Institutions (wherever existing); or, being in receipt of Parish Relief, should be required to attend Poor Law Dispensaries.

'4. The object of these arrangements is to bring the numbers of Patients in attendance within manageable limits, thus, at the same time, rendering the Tickets a more valuable possession to the Governors or Subscribers who may issue them, and to those Patients who may be recognised as requiring and deserving skilled Hospital treatment.

'By Order of the House Committee.

'28th November, 1883.

'N.B.—Incorrect information in reply to inquiries will lead to forfeiture of Tickets.'

St. George's Hospital, Hyde Park, London.—In 1868 the whole out-patient department was made free, thus enabling the executive to exercise much more control over the admission of applicants; as, when these brought Governors' letters, it was difficult under the circumstances to refuse relief to any. On the ordinary four out-patient days, 15 *new* out-patients are admitted to each of the two medical and two surgical officers. The resident medical officer takes their names, addresses, occupations, and any information that may be required as to their social position. The cases admitted are therefore limited to the number which can be effectually dealt with, and are selected with due reference to their means, urgency of their

disease, and to their usefulness as means for the teaching of medical students.

The secretary freely avails himself of the assistance of the inspectors of the Charity Organization Society, if he has any doubt as to the applicants for relief being unsuitable objects of charity. In 1873 twenty new cases were admitted to each medical officer, but in 1878 the number was reduced to 15.

The Secretary, C. L. Todd, Esq., adds:—'There is of course a saving to the hospital, because if we had more out-patients we should have to dispense more medicines, employ more porters, etc., etc.'

The Hospital for Sick Children, London.—Regulations for out-patients, March, 1876:

'5th.—No patient whose parent is in receipt of more than 30s. per week shall, as a rule, be considered eligible for permanent treatment as an out-patient of the hospital.

'6th.—No patient shall be entitled to attend a second time as an out-patient, unless the letter with which the parent has been furnished shall—

'1.—Be accompanied with a note from the governor or subscriber who gave the original letter of admission for such out-patient, stating that the case is, to the knowledge of the Governor or subscriber, within the last preceding rule; or

'2.—Shall have been submitted to the secretary or other officer of the Charity Organization Society for the district in which the patient dwells, and bear the stamp of the society, verifying the statement contained in such letter.

'7th.—In cases where the weekly earnings of the head of the family exceed 30s., the Charity Organization Society shall be at liberty, notwithstanding the fifth regulation, to stamp the letter (adding a note) if any exceptional circumstances are found to exist which render it advisable that the case in question shall receive charitable assistance.'

The following rules were also passed:

'That in all cases the applicant sign a statement in accordance with the terms of the accompanying form.'

'That a notice be set up in the hospital, stating the terms of admission, etc.'

FORM OF APPLICATION.

No.....

Statement to be signed by all applicants for Medical Relief.

Name in full.....

Present Address .....

The weekly income of my husband is.....; of myself.....; from my children and other sources we receive.....weekly. I have.....children; and am.....in receipt of Parish Relief.

I hereby declare that the foregoing statements are strictly true.

Signature of applicant for relief.....

Address .. ..

Date.....

At present the 'wage limit' is 40s. per week, and if any doubts exist as to the social circumstances of the applicant, the letter E is stamped on his recommendation form; while this applicant is given a card and is referred to the branch of the Charity Organization Society. Until the result of the inquiry is known, such doubtful applicant is precluded from coming again.

With such excellent arrangements, it is a pity these should have their practical value rendered almost worthless by the high 'wage limit,' as it is absurd to suppose that a parent making 40s. per week is unable to pay a small fee, or 2d. per week to a provident dispensary. A charity should have nothing to offer to such a well-to-do class, otherwise the spread of pauperism is encouraged, while habits of self-reliance and forethought are discouraged.

Royal Albert Hospital, Devonport.—This medical charity found that its income was being squandered on *out*-patients, and it was determined to do away altogether with the out-patient department, and to convert it into a provident dispensary, retaining only a casualty department for accident cases, and those discharged in-patients who still required a little looking to.

The Report by their Managing Committee of September 10, 1867, among other points, stated: 'The Committee have had under their serious consideration the inconveniences and evils arising from the present plan of out-patient relief. They have come to the conclusion that while the system is not so beneficial as it might be to the

deserving poor, it by no means does justice to the medical profession, and is financially injurious to the charity.

'It will be obvious that if the present system be continued, and the number of out-patients increase in the same ratio as they have hitherto done, the whole of the subscribed income will be absorbed in the out-patient department.'

In 1867 there were 3,000 out-patients, costing 3s. per case. Here was a saving of £450 in one year; for in 1875 2,908 persons had joined the provident dispensary department.

Mr. Sharpcote, R.N., the Hon. Sec., says: 'The scheme has worked remarkably well.'

Preston Infirmary.—The following is the scale of present weekly incomes sanctioned by the Board of Management. (*The numbers refer to the total number in each family, including parents.*)

If 1 only	. . .	7s.	Present Weekly Income.
„ 2 members	. .	12s.	„ „
„ 3 „	. .	16s.	„ „
„ 4 „	. .	19s.	„ „
„ 5 „	. .	21s.	„ „
„ 6 „	. .	22s.	„ „
„ 7 „	. .	23s.	„ „
„ 8 or more	. .	24s.	„ „

It is understood that this scale admits of exceptions in special cases.

OUT-PATIENT'S RECOMMENDATION FORM.

Preston.....18

TO THE HON. MEDICAL OFFICERS OF THE PRESTON AND COUNTY OF LANCASTER ROYAL INFIRMARY.

Gentlemen,

I have inquired into the condition of.....
and believe that he is poor, and unable to pay for medicine.
Age.....Occupation (If a Child name the occupation of the Parents) .....Residence No. .....
How long Sick .....
Total Number of Family (including Parents).....
Usual Weekly Income of the Family .....
Present Weekly Income.....Special Remarks.....
Signed.....

Mr. R. F. Easterly states, 'the plan has been in force for twenty years, and answers well as regards home-patients; *out*-patients are not so easily dealt with. The results have been fairly satisfactory.'

Oldham Infirmary.—Persons where the income of the household exceeds the following scale are ineligible for relief:

WAGE LIMIT AT OLDHAM INFIRMARY.

One person	18s. a week.
Two persons	24s. ,,
Three ,, ...	29s. ,,
Four ,, ...	33s. ,,
Five ,, ...	36s. ,,

and 3s. per week per head for every additional member of the family.

Rule 43: 'Cases of *severe* accident, or of *great emergency*, shall be eligible for immediate admission by any member of the medical staff, but such cases must be furnished with in-patient's recommendation as soon after as possible.'

STANDING ORDERS.

To be observed by the Visiting and Admission Committee.

OUT-PATIENTS.

(1) Patients shall appear before this committee and give evidence that they are fit persons to participate in the benefits of this infirmary before being attended to by the medical officers.

(2) This committee shall be furnished with particulars as to age, employment, number of family or household, income from all sources, and (if required) the applicant shall name some person or persons who can verify such particulars.

(3) This committee shall adopt means for testing the accuracy of the statements made by the patients, and should such statements be proved to be false, notice shall be sent to the patient, that no further medical treatment will be allowed to his or her case.—See Rule 39.

(4) Should any patient passed by this committee appear to the medical officer not a fit subject for treatment as a patient the recommendation shall be brought back to this committee, endorsed by the medical officer, so that the reason for non-admission may be stated to the applicant.

Warrington Infirmary and Dispensary.—Out-patient recommendation to the Warrington Infirmary and Dispensary:

Patient's Name .....Age.....
Residence ....
Occupation.....No. of Family.....

Persons earning, when well, the following income cannot be admitted as patients, except in cases of protracted illness:

One person in the family	. .	15s. per week.
Two persons in the family	. .	18s. „
Three persons in the family	. .	21s. „

And so on, 3s. for each additional member of the family.

Date.....18

Extracts from Rules.

Rule 98. 'No person shall be admitted as an out-patient (except in case of accident and emergency) unless a recommendation, fully and properly filled up, be provided.'

Rule 99. 'No member of a benefit society, having its medical officer, shall be admitted as an out-patient.'

Mr. A. Ure, the Hon. Sec., says the system has been in force for about 19 years, and 'imposition is minimised.'

Liverpool Ladies' Charity and Lying-in Hospital.—Extract from Rules. Mode of administering relief:

'No Patient shall be entitled to relief unless she shall have been visited, and the particulars of her case inquired into, either by one of the Visitors of the *Central Relief and Charity Organization Society*, or by some other Visitor on behalf of the Charity or by a Subscriber. Such inquiries shall be directed to the applicant's moral character, and to her own and her husband's inability to provide for her or to obtain relief from other sources. The Visitor shall have power to grant or withhold relief, but he may refer any doubtful case to the Ladies' Committee or the Executive Committee, who shall decide the matter.'

The help of the Charity Organization Society was agreed upon in 1874. The charity pays the society 6d. per case investigated, and in 1886 paid £64. If particular inquiry puts the society to greater expense, a higher charge is made.

Leeds General Infirmary.—The general manager sees all applicants for medical relief who are supposed to be in a position to pay even a small fee to a medical practitioner outside of the hospital. If the general manager is not satisfied with the answers given by the applicant he either sends him away or requests the Leeds Charity Organization Society to investigate. The plan works well, and it is said that the abuse rate is kept down to the lowest point. The system has been in force for fourteen years, and the infirmary gives a yearly donation to the society.

Coventry and Warwickshire Hospital.—The committee in 1877 drew up the following regulations:

'All new out-patient tickets must be presented at the *out-patient* department, accompanied by a certificate from the house surgeon, or some other medical practitioner, that the case is a proper one for hospital treatment, between the hours of 9 and 11 a.m., when inquiries will be made into the circumstances of the person desiring medical treatment.

'Patients whose average earnings exceed, when in work, the amount stated below, will be considered ineligible, viz.:

	PER WEEK. £ s. d.
Foremen, Tradesmen, unmarried persons and others	1 0 0
Married persons	1 3 0
Ditto, with 2 children	1 6 0
Ditto, with 4 children.	1 12 0

And members of any family where the joint earnings exceed 30s. per week.'

Huddersfield Infirmary.—Instituted for the relief of those ONLY who are absolutely Poor and Needy, and incapable of purchasing Medical Assistance.

NOTICE.—There having been *numerous instances* of *gross* impositions upon the funds of this charity by individuals obtaining medical and surgical relief who are well able to pay for it, NOTICE IS HEREBY GIVEN, that should any such case come to the knowledge of the board in future (except under most special circumstances), a charge will be made for the services rendered, and if payment be refused, it will be enforced.

In consequence of improper applicants having frequently obtained medical relief from the infirmary, the governors are particularly

requested to obtain answers to ALL THE QUESTIONS when giving a recommendation.

I recommend as an Out-patient—
Name and Age of Patient.....Age.....
Name of Parents, if a Child; or of a Husband if a Married Female.....Trade.....
Residence.....Number of Family.....
Weekly Income of Family.....Name of Employer.....
Whether Party is in Receipt of Parochial Relief.....
.....18 Signed... .....*Governor.*

Hull Royal Infirmary.—At this medical charity, on a certain number of days each week, a list of the new *out-patients* is sent to the Charity Organization Society, and an inquiry is made into their social circumstances.

All working people making over £1 5s. per week, for man and wife, are ineligible for relief. An allowance of 2s. 6d. opposite each child is made.

The above plan was discontinued about four years ago, but last year it was re-introduced. It is deeply to be regretted that the other medical charities at Hull do not fix a 'wage limit,' and so put a stop to a degrading system of competition.

Royal Albert Edward Infirmary and Dispensary, Wigan.

OUT-PATIENT'S RECOMMENDATION.

.....18

I recommend.....
(full address important) of .....as an Out-patient
Age ..... How long ill .....
Number of Household or Family .....
Earnings or other Income of the Household or Family.....
Where Employed .....
Does any of the Family now receive Parochial Relief .....
Signed by.....
On account of the annual subscription,
contributed by.....

Rule 141.—'No person shall be admitted as an Out-patient whose weekly income exceeds the following scale:

One person in the family	15s.	per week.
Two persons „	18s.	„
Three persons „	21s.	„

and so on, 3s. for each additional member of the family.'

Rule 146.—'Accidents or cases of Sudden Emergency, *in the first instance*, shall be considered as proper objects for assistance, without a recommendation, on application to the House Surgeon, but not afterwards, unless the case comes within these rules.'

Wallasey Dispensary, Cheshire.—Rule 24.—'The proper objects of the Dispensary are the Sick Poor, and, as a general rule, no subscriber shall give a recommendation when the head of a family has been in the receipt of TWENTY-FOUR SHILLINGS a week or upwards for the last three months. On *Emergency*, however, patients may be visited, prescribed for, and receive medicines at first; but afterwards, regular recommendations are to be obtained.'

Rule 28.—'Domestic Servants shall not be attended at the residence of their employers; neither shall they receive relief at the Dispensary unless their employers are Subscribers to the Charity.'

The Southport Infirmary.—The following wage limit has been lately adopted. Any person making over the undermentioned wages is ineligible:

For one person . . . . . 15s. per week.
„ two persons . . . . . 21s. „
and 2s. for each child.

Glasgow Sick-poor and Nursing Association.—As Liverpool and other towns supply nurses to the wage-earning classes—and this being a part of charity work—it is well to call attention to the above. Mr. Watson, the secretary, states: 'The nurse is sent to the patient, and reports this fact to her superintendent. The latter forwards this report to the C. O. S., whose officer makes the necessary inquiries—the nurse continuing her services until the officer's report has been received. About one-third of the cases handed by us for investigation to the C. O. S. are found to be ineligible, either because they are well-to-do, or are Poor Law cases. Others withdraw at once when they understand that an investigation is to take place.'

An inquiry into the above-mentioned systems shows they are not so good as that in Manchester. They all start with the true principle—that an investigation is necessary: and that the adoption of a 'wage limit,' as a guide, gives the best results. No matter how good a system may appear *on* paper, or how skilfully drafted an Act of Parliament may be, all recognise the success of a scheme lies in the manner *in which it is administered.*

I shall here call attention to plans which exist abroad—in Boston, in Paris, and in Berlin. They contain valuable information for those who work for the organization of charity.

The Associated Charities of Boston.—This society was established in 1877. A pamphlet with the title 'Its Constitution' may be obtained from Messrs. Ware, 41, Charity Buildings, Chardon Street, Boston.

Its chief objects are:

'To secure the concurrent and harmonious action of the different charities of Boston.

'To raise the needy above the need of relief; prevent begging and imposition, diminish pauperism.

'To provide that the case of every applicant for relief shall be thoroughly investigated.

'To make all relief either by alms or charitable work conditional upon good conduct and *progress*.'

There is a Central Bureau at which official work is transacted, while the city is divided into districts. A great portion of the work is performed by voluntary agents. Among the directions given to district visitors are: '1. Give immediate attention to every applicant, and regard each applicant as deserving charity until a careful examination proves the contrary. 2. Never take squalidness as an evidence of want, or neatness as an evidence of plenty. 3. Application for relief should be made at the central office by the head of the family, when there is one. 4. As a large proportion of the destitution is the result of individual improvidence, a little hardship will often prove a salutary lesson and stimulate them to effort.'

In the Report for the year 1884 it is stated that out of a total of 4,959 *families*, whose circumstances were investigated, intemperance was one of the causes of poverty in 1,206 families. In the Report for 1885 it is stated that 30 per cent. of the poverty of families investigated was due to drink. There are over thirty-six similar associated charities in the chief towns in America.

The Assistance Publique, Paris.—This is a Government service under the control of a superior authority. The French system, as Mr. A. Doyle* has put it, is a happy combination of private benevolence with official guarantees: both the public and the Government working together in the cause of charity. A director is appointed, who is under the control of the Board, and he is subordinate

* Poor Law in Foreign Countries, 'Blue Book.'

to the Minister of the Interior and the Prefect of the Seine. This Assistance Publique administers the hospitals, asylums, lying-in homes, infants' homes, almshouses, and other institutions, and also the entire *outdoor* relief service through another department—the Bureau de Bienfaisance. Part of its revenue is obtained from Government grants, and a commission of 10 per cent. on all tickets sold for theatres, concerts, public entertainments, from public burial-grounds, pawn-tickets, and lotteries.

As regards Paris, there are twenty Bureaux de Bienfaisance—one for each Municipal District—each being managed by a council composed of the mayor, twelve administrators, stewards, sisters of charity, and a treasurer-secretary. Each district again is subdivided into twelve zones, each zone being given to one of the twelve administrators, who decides on the nature of the relief to be given. Each one who applies for relief has his or her name inscribed in a register. The applicant is then visited, and a detailed report presented to the council, who give a yellow or green card, according as the relief is to be temporary, or for the year. Each bureau has one or more houses of succour attached, and here relief is granted. Medical practitioners are present to give treatment, and from here patients are drafted to the hospitals. It will be noticed each bureau grants *outdoor* relief, and refers others for in-patient relief. In 1889, of 61,080 who applied, 17,855 were ineligible for relief.

Relatives are made to pay for their sick friends when in hospital. The 'child' must contribute to the support of father, mother, grandfather, and also to the great grandparents. Sons-in-law must support their fathers, or mothers-in-law in proportion to their power of paying.

The Night Medical Service of Paris.—The Municipal Council of the City of Paris directed that some practitioners should be constantly at the service of those requiring help *during the night.* Every person has a right to use the service. It was established in 1876, and is administered by the Prefecture of Police. About 300 practitioners and 200 chemists placed themselves at its disposal.

When an individual requires a doctor at night he sends to the police-station in his district. The officer accompanies the applicant to the doctor's house, giving him a note for 10fr. if for a single visit, or for 20fr. if for a surgical operation, or confinement. The officer takes the prescription written on a special form, and accompanies

the person to the chemist, and at the same time delivers a note for the value of the drugs. The officer then returns to his station. Both doctor and chemist are paid at the Prefecture of Police. The police have power to recover the expenses from the person using the service.

In 1890 the service entailed an expenditure of 75,000fr., and this sum is increasing as people know more about it. Similar services exist in other large towns. The nights last from 10 p.m. to 7 a.m. from October 1 to March 31, and from 11 p.m. to 6 a.m. from August 1 to September 30. The chemists' night-service is identical with the medical. Their charges are fixed at 1½fr. If the patient cannot repay the cost of medicines the Bureau de Bienfaisance pays, and according to the tariff of the Chamber of Apothecaries. At present 520 practitioners and 536 chemists act under the service.

Similar services are in force in New York, and other American cities, also in Berlin.

Surely it would be much better if such gave its services to the poor only, to some accident cases, and not to the entire community. I am indebted to Mr. Loch, of the London C. O. S., and to the *Medical Press*, for the above information.

The Berlin Night Medical Aid Stations.—This service supplies only night aid. At first a porter resided at the station, so as to direct those requiring aid, but now a doctor resides in the station *during the night*, so that urgent cases can receive first aid immediately. In 1888 nine stations had doctors residing on the premises at night; three had assistants only, while three had porters only. The stations are supported by voluntary aid, by house collections, and a grant of 10,000 marks yearly from the Municipality. About 40 per cent. of those treated did not pay any fee. Fifteen stations cost about 50,000 marks yearly; 43½ per cent. received treatment at their homes. The average number treated in one year was 8,429. If well-to-do persons use the aid they must pay. The doctor is paid only for first visits to persons taken suddenly ill during the night. The following form is distributed to every police-station, and to night-watchmen. The police accompany the person requiring the doctor. The doctor living nearest to the patient is chosen.

'The Sanitary Commission, 28 of Berlin.'

'The pay-office of the Sanitary Commission, 28 of Berlin, pays, on return of the notice on the other side, filled up, 6 marks.

(*On reverse side of form.*)

'Receipt for a night visit on the.....of.....187 . At .....o'clock to.....(name).....(address)..... (occupation).....(name of disease or accident).
In your opinion is the patient able to pay?
Have remedies been prescribed?
Remarks..... .....

'Received 6 marks (5s. 10d.).

'Signature..... Berlin.....date.....'

Those interested should read 'The Berlin Sanitary Watches; their Creation, Organization, and Work.'—Springer.

I have to thank Dr. Oscar Lasser of Berlin for the above information.

'SYSTEMS' WHICH HAVE FAILED.

There has been a large amount of 'tinkering' in connection with reform. Most of the plans put into force show the originators have not been acquainted with even the elementary features of organization and administration.

I shall notice a few of the so-styled 'systems' which have and were made to fail.

1. *The payment of a 'registration' fee*, varying from one shilling to sixpence. This has failed because it overlooked the fundamental fact that no notice whatever was taken of the social or pecuniary circumstances of applicants, thus differing from the general rules which guide practitioners when charging private patients. It supplies funds to the charity; but leads to the exclusion of those genuine sick-poor who cannot pay.

2. *The payment of one penny for each article supplied.* This encourages the applicant to suppose that payment is made for what has been received, and that it is a purely business transaction. It also leads to the over-dosing of patients, so that money may be made.

3. *The payment of one penny per week.* It is encouraged by some Hospital Saturday funds. It is looked upon by the working classes as a kind of insurance, and encourages them to think they can *demand* treatment *as their right.* Subscribing, unfortunately, is almost compulsory with some firms, who say, 'Oh, there is no compulsion—only you must.'

A very gross example of this 'penny-a-week' plan is in force at

the Royal Hospital, Belfast. There, there is a 'wage limit,' but it is practically non-existent, as the following notice, which is placed in the waiting-hall, shows :

'*Notice.*

'The medical and surgical service of the exterior department of this hospital is only intended for weekly subscribers, and for those who are unable to pay for medical and surgical advice.

'All persons are ineligible for its benefits whose wages exceed the following limits :

£	s.	d.	
1	0	0	weekly for single persons.
1	5	0	„ „ married persons.

'N.B.—Weekly subscribers are exempted from the operation of this rule.'

During 1890, the 'weekly subscribers' paid £1,864 15s. 4d. So that practically the above 'wage limit' system is inoperative, as any person who wishes to shirk an inquiry, but who desires to use up charitable funds, can do so by paying one penny! Is not such a 'system' enough to bring discredit on any charity? It says, in fact—'if you wish to avoid any inquiry—down with your penny.' Do the medical staff give their approval to this 'system?'

4. *Closing the doors of the charity at a certain hour.* Tried in London, and failed.

5. *Giving precedence to those who pay a 'priority fee.'* This makes the treatment of *the sick-poor* a matter of secondary consideration only, and prostitutes the charity ; a sort of cheap boarding-house.

6. *Increasing the number of medical charities.* This takes no notice of the real wants of a locality. While the demand is based on the bad principle—that the more charity given, the more will be asked. The more charities, the more paupers.

7. *Opening the charities during the evening hours.* Evidently for the benefit of those who are in active employment. The plan is in force in London and in Birmingham. It leads to an increase in the number of patients.

8. *Pay beds, and pay wards.* In all cases this plan has been a marked failure. (See pp. 70 and 75.)

9. *Selling 'recommendation forms.'* This is practically the same scheme as the penny-a-week ; and establishes the *quid pro quo*

principle. It says, give me one guinea, and I shall give you four forms.

10. *Allowing the medical staff to select a certain number of 'interesting cases,'* no matter what their social circumstances may be. Such a plan is very unsuitable to a charity.

Other 'systems' are in force, and are to the superficial observer misleading. Take, for instance, the following:

At the Great Northern, London, there is a system; but it seems to exist *in order to find out how much the patient can be made to pay!* An inspector is paid £1 per week, and among his duties are the following:

(1.) To attend to the out-patient department during the hours of admission of patients, and to be responsible for the giving out of letters and cards.

(2.) To *make* an application to each patient for some *voluntary* contribution while the letter is being filled up, marking the letter and the amount given.

(3.) If patients state they are unable to give, to make certain that such is the case.

(4.) When you have reason to think patients are ineligible for treatment at the hospital in view of their social position, to make proper inquiry, and if found to be so, to refuse them further treatment.

The second instruction appears to be the most important.

The refusals average 6 per month, the amount collected £7 10s. per week.

Royal Portsmouth Hospital.—This charity advertises its scale of prices as follows:

Annual Subscribers

Are entitled to recommend during the current year the number of patients in the following scale, viz.:

Subscribers of	5s.	and under	10s.	to recommend	1 Out-patient.
,,	10s.	,,	£1	,,	2 Out-patients.
,,	£1	,,	£2	,,	1 In or 4 Out.
,,	£2	,,	£3	,,	1 In and 4 Out.
,,	£3	,,	£5	,,	1 In and 8 Out.
,,	£5	and upwards		,,	2 In and 8 Out.

This ticket entitles an out-patient to two months' treatment, and is available for one year from issue to subscribers.

Four of these tickets will admit an in-patient.

Rules.

No person receiving parochial assistance (such having medical aid provided for them by the union), nor any person in the receipt of £1 per week, who has less than three children, can obtain relief, but on payment of 2s. per day as an in-patient, or 6d. per week as an out-patient, subject to the approval of the committee of management.

Bristol Hospital for Sick Children and Women.—The Committee appoint a Superintendent of the waiting-room, who is authorised to refuse out-patient admission to any person where the united earnings of family exceed 30s. per week, and when there are not more than five of a family; or if there are more than five whose *united* earnings exceed 6s. per head per week. If any question arises as to the fitness of any person, such will be prescribed for on the first visit, but previous to the second visit inquiries will be made, and if found not suitable, treatment will be refused.

Special Features of the Hospital.

Women paying 1s. 6d. on admission and 3d. on each subsequent visit, or 6d. for the week.

Girls of 12 and under 15 years, paying 1s. on admission and 3d. on each subsequent visit, or 6d. for the week.

Children paying 6d. on admission and 1½d. on each subsequent visit, or 3d. for the week.

Attendance between the hours of 10 and 11 every morning, excepting Sunday.

It is little wonder the secretary, Mr. Jones, writes: 'I . . . . beg to say that having tested the "special features" and rules for many years do find that they have failed.'

Before closing this sub-chapter a reference will be made to the proposal that a municipal or imperial tax be levied for the support of voluntary charities.

In France a tax is levied, that on theatres giving £80,000 a year. In St. Petersburg a municipal tax is imposed; artisans, workmen, domestic servants, and the poor generally, are required to pay annually one rouble and twenty kopecks (about 2s. 6d.). The payment is entered in the passport which every Russian resident is required to possess. In Stockholm there is a poll-tax of fifty ore (about 6¾d.) on every person over fifteen years of age. In Dublin the medical charities are supported partly by imperial and municipal and county

grants, and partly by voluntary contributions. The grants by the city of Dublin are voted by the Corporation; the county infirmary grants are given to two charities because they are county infirmaries; while the parliamentary grants are given under the Medical Charities (Ireland) Act, 14 & 15 Vic.

Previous to the passing of this Act some of the Dublin charities received grants from the Irish Parliament under the Act of 5 George III., chap. 20.

The system of these parliamentary grants, however, is not approved of, and a recommendation has been made that they be commuted for a lump sum, and that a central board be appointed to invest and manage it (see Report of the Dublin Hospitals Commission, 1887, Blue Book).

In the United States up until 1884 there was collected from every vessel belonging to the United States the sum of forty cents per month from each seaman employed on such vessel. This was a hospital tax. This law was repealed in 1884. It gave each seaman the right of free medical treatment in the hospital.

In Norway and at Christiana there is a large State hospital. It is under Government supervision, but it is largely supported by the payments made by patients. In it three classes of patients are treated—first, the Poor Law cases, and for whom 3s. per diem is paid; second, the second class, who pay 3s. 8d. per diem; and the third class, who pay 6s. 8d. per diem. Children are charged for at the rate of 1s. 5d. per diem.

If a system of taxation were introduced it would almost put an end to voluntary charity. The already over-burdened taxpayers would resent it, unless they were offered a very large 'pennyworth' of free medical treatment, and would pay it with as bad a grace and with as little charitable feelings as we now pay the poor-rate. *Compulsory* charity is not charity, and such an enforced system would be an enormous obstacle to thrift and individual action.

The following table shows the systems of admission of in- and out-patients to the various Liverpool medical charities, and the amount of money taken by the sale of medical treatment and medicines, etc.:

HOMŒOPATHIC.—*In-patients*, 10s. weekly; those recommended by subscribers, 5s.; private rooms, 1 to 3 guineas weekly. *Out-patients*, 2d. per 'registration card' and 4d. for 'home-patient's card.' 1d. per attendance. By sales to patients in one year, £427 8s. 5d.

HOME FOR INCURABLES.—*In-patients*, 7s. 6d. weekly. By sales to patients, £991 11s. 6d.

CANCER AND SKIN.—*In-patients*, one guinea a week, others free. *Out-patients*, 'absolutely free to all poor,' except 1d. is charged for each ticket, so as 'to prevent abuse of charity.' A priority fee of 6d. to those who 'might otherwise lose part of a day's wages.' By sales to patients, £286 8s. 8d.

MEDICAL MISSION.—*Out-patients*. All out- and home- patients to pay if fit. By sales to patients, £135 7s. 7d.

WOMEN'S HOSPITAL.—*In-patients* free, or pay what they can. Private room at 2 to 3 guineas per week. *Out- and home-patients* free, but charged 4d. By sales to patients, £383 11s.

EYE AND EAR, MYRTLE STREET.—*In-patients* from City, free; others, 8s. 6d. per week. *Out-patients*, 1d for each article supplied. By sales, £723 19s.

ST. PAUL'S EYE AND EAR.—*In-patients* free; all who can pay must do so. *Out-patients* free; 1d. per visit. By sales to patients, £321 18s.

STANLEY HOSPITAL.—*In-patients* by subscriber's letter. *Out-patients*, 1d. By sales, £237 8s.

DISPENSARIES.—*Out-patients*, 1d. each. By sales, £920.

DENTAL.—Free; 1s. 3d. for gold filling, or subscriber's letter. By sales, £101 13s.

ST. GEORGE'S.—*Out-patients*. By sales, £42 11s.

LADIES' CHARITY.—*In-patients* free, or pay as they are able. *Out-patients* free. By sales, £8 13s.

BOOTLE.—*In-patients* free, but patients can be treated at their own expense. *Out-patients*, if able, pay 2d. each. By sales to patients, £28 17s.

CHILDREN'S INFIRMARY.—*In-patients* by written recommendation. By sales, £149 9s.

INFIRMARY.—*In and out* free.

SOUTHERN.—*In-patients* by letter from trustee. Pay wards abolished. By sales to patients, £211 9s. 6d.

NORTHERN.—*In-patients* by trustee's letter. By sales, £56 2s. (Board of foreign seamen.)

CONSUMPTION.—*In-patients*, 7s. per week; those recommended by subscribers, 2s. 6d. 'All payments in advance,' and no admission for less than two weeks. By total sales, £744 8s. *Out-patients* paid £541.

SEAMEN'S DISPENSARY.—1s. per visit.

SUB-CHAPTER.

IV.

Medical Charities are used by Medical Practitioners as a Mode of Advertising and Personal Advancement.

Some one has asked—Do our medical charities exist for the benefit of doctors, or for the sick poor? The question is a pertinent one. A large proportion of charities have either been organized by practitioners or founded by money left by them. No doubt a hospital appointment is a fair and legitimate mode of advertising. It is not too much to say the hospital is to the medical practitioner what the pulpit is to the clergyman, the House of Commons to the politician, and the Law Court to the barrister. This is denied by a few—it is a sort of hereditary denial, the person making it scarcely knowing why he does so. Such persons say they 'really lose by the appointment'! I fail to see why a practitioner spends £300 or so in canvassing for an appointment unless he intends to benefit himself. Were it otherwise he would do more good in making the money a gift to charity. In some cases this would be a better plan, and for many reasons. I know of a practitioner who offered £300 to another for his appointment, but he would not accept it. Why? Is not the value of an appointment emphasized by the unseemly touting which takes place? It is shown by the manner in which 'charities' spring up everywhere, and where hospital after hospital—for the eye, or ear, throat, nose, spine, skin, feet, chest, nerves, etc., etc.—appear. A young practitioner starts in practice; all at once he is consumed with the idea—a delirium in fact—that the poor 'creatures' have not *skilled* medical treatment. He mentions this to a few lady friends, and so he and they call a meeting and start their 'charity'—probably in a locality which has not the slightest need for it. Thus, the well-to-do are pauperized, for they do not care to refuse the tickets of recommendation almost forced upon them! It is little wonder the medical has been nicknamed—'the Christ-like profession.'

This question of mock charity has been before the profession for many years. One of the by-laws of the College of Physicians, London, is—'No fellow or member of the college shall officiously, or under colour of a benevolent purpose, offer medical aid to, or prescribe for any patient whom he knows to be under the care of another legally-qualified practitioner.'

In some cases, when a practitioner is appointed he gives a guarantee he will practise only one branch, such as medicine, or surgery. This, *when fulfilled*, entails a loss the holder hopes will be made good. It is the sprat thrown to catch the mackerel, and he casts his bread upon the waters, in the hope that it will return to him and not take many days in doing so!

Sometimes a practitioner when appointed must resign his sick clubs. Such a loss must be balanced by a *quid pro quo*—unless the clubs are given to the assistant—being virtually held by the principal. The above rule is a good one *when fulfilled.*

Some practitioners who charge a fee of from one to one and a-half guineas, advise their clients to send their coachmen, nurses, governesses, and poor relatives—and, in fact, every one who cannot pay *their* fee, to the charity. They divide patients into two great classes, first, those who can and will pay; second, those who cannot pay a half guinea fee. Those who can pay should on *no account* go to the charity. All who cannot pay this should *certainly* go to the charity! This sounds very charitable. It is, however, based on the lowest of trade trickery. It means that all who take a lower fee than 10s. 6d. should be starved out, by encouraging persons who can pay smaller fees to depend on charity. It may be said, this is fair. But when done under the sacred name of charity it is a foul and unnatural procedure. Naturally those who secure free treatment for relatives able to pay a 5s. fee, and who are mean enough to practically steal funds subscribed for the benefit of the poor, applaud the conduct of such a practitioner.

I am acquainted with one who charged half a guinea fee, but who insisted on a servant being sent to the charity because, as he confessed, if she were not sent away the employer would call in a practitioner who would charge a 5s. fee, and who might probably displace him. This is business, however, not charity. It is *fool*-anthropy—not philanthropy.

To a certain extent the tabooing of fair fees from wage earners is ceasing. The opposition to it was meant to keep new-comers out of the field. The established practitioner felt, if all who can only pay a fee of 2s. 6d. are given relief, then the young doctor cannot make a livelihood and so must be starved out; hence one great reason of the charity cry 'free to all,' *i.e.*, free to all who cannot pay the higher fee; but let the 10s. 6d. patient go to the charity and soon a storm will be raised. Is it not amusing that some practitioners who 'shudder at

the idea of taking a small fee,' have no objection to accept a salary—no, an honorarium! from the medical charity, or give their advice for threepence at the charity? In other words, to treat the patient at even a cheaper rate than he who charges a small fee. To show that this knavish cry of 'free to all' is based on very low motives, take the case of the '1d. hospital' and the '6d. dispensary' doctors. The '6d. doctor' has been scoffed at for years, yet now his companion at the charity tries to run him off by offering treatment for one or two coppers. These are serious statements. Let them be disproved.

Another reason why charities are abused by practitioners is that someone has a fancy for some disease: it is his 'specialty.' He therefore wishes to take every 'special' case into the charity—no matter whether the 'case' is, or is not, a poor person. This same rage is noted when a surgeon wishes to publish his 'second hundred of cases'—of, say, removal of some 'appendage' of the body. In this case the patients represent so much 'operating material,' either for the practice of the surgeon or the teaching of students. Lately a philanthropic journal, commenting on the evidence given before the House of Lords' Committee on Hospitals, calls attention to the laments of witnesses regarding the dearth of 'material' at the charities, and states that a sickly smile went round the Committee.

Speaking of the value of a hospital appointment, Sir Andrew Clark, M.D., lately said, at a meeting at the Mansion House: 'I can only say of it (the out-patient department) that it would have been simply impossible for me to have practised my profession in the way in which I am engaged in it, with anything like a pretension to efficiency, unless I had had that work at the hospital.' Is not the average appointment taken in the hope that it may be the stepping-stone to practice, society, and wealth—always provided the said appointment is *not* to a Poor Law infirmary! So says *modern* Christian charity. I do not blame any practitioner for bowing to the above condition of affairs. I only wish an honest and open recognition of the system in force.

Speaking of the value of an appointment, Dr. Croley, President of the Royal College of Surgeons, Ireland, said, in evidence on oath, before the Dublin Hospitals Commission: 'I certainly would not give up the advantages of my hospital, say for £10,000.' Mr. W. Thompson, F.R.C.S., in answer to the question (4,095): 'Don't you think that a hospital position has a distinct pecuniary advantage to the holder?' said: 'Oh, a distinct advantage, certainly.' He

further stated he would not accept from £10,000 to £15,000 for his appointment at the hospital. Referring to this same question, and more particularly against the appointing of a goodly number of practitioners to hospitals, he said that such increase in the number of the medical staff was injurious to those already appointed, 'Because I need not say that were fifty or sixty holding hospital appointments, instead of only twenty, the eminence that these men can attain is not likely to be so great.' This, I fear, is an advocacy of the 'dog-in-the-manger' policy. It teaches the public that the appointments should be to the few, instead of the many. To question 4,073—the Chairman: 'In fact, half the Dublin hospitals have been started by the medical men as advertisements for themselves—is that not so?' Answer: 'Well, I don't know about the advertisements; it may have been *for the good of the country!*' Why blame lawyers for framing laws to suit their own ends, when the 'most charitable profession' starts 'charities' for its pecuniary benefit!

As regards the pecuniary value of an appointment, this is occasionally increased by the fees received for the teaching of medical students and nurses. It has been stated that over £40,000 per annum is made by Metropolitan practitioners who teach students.

I mention these facts to show that members of the medical profession have to be watched in these matters of 'charity' just like other mortals. There is a world of sad sarcasm in the statement made, 'that it would recompense a doctor to pay people to go to the hospital.' Next to the Poor Law, the medical profession is the greatest pauperizing agency in this country. We have started our hospitals. The public never asked us to do so. We offer gratuitous aid to all, yet the public have never asked us for it, but good-naturedly smile and accept it. And to-day, if they hesitated to oblige us by accepting our 'charity,' we would—as 'the most charitable profession'—quote a text of Scripture, and complain bitterly that, although we had piped the seductive song of 'medical charity,' the public had not danced to it.

I trust the time is not far distant when each medical practitioner will receive his appointment after passing an examination, and for a limited number of years only. The System of *Concours*, as at present in force at the Paris Medical Charities, works admirably. Such a system of competitive examination is in force in the Army and Navy Medical Service, and the Civil Service. In this way profes-

sional worth, for once, would outweigh political and social influences, and the whole medical profession would touch a higher standard of education; *every person* would benefit.

The *Medical Times and Gazette*, as far back as 1859, said: 'However, in the meantime, let us not fear to speak the truth, and the truth in this matter seems to be this: that the self-interest of the individual originally inaugurated the custom, and the self-interest of the individual still fosters and keeps it alive. Their services were never claimed by the public in the first instance; they were voluntarily offered by the professional aspirant, who thought thereby to arrive rapidly at some culminating dignity in his profession, that for him *sic itur ad astra*. Yes, and then after a time the honour of performing these unpaid duties was not only accepted, but was sought and petitioned for by the aspirant. The public had no occasion to look for an honorary officer. The honorary office was begged for, entreated for, often paid for. They who sought it often went down, and go down, on their very knees for it. The public, no doubt, was at first astonished at this extraordinary phenomenon, but it soon began to understand the meaning of it, and soon, therefore, learnt to set down these services at what they considered to be their true, real, and legitimate worth.'

SUB-CHAPTER.

V.

The Wages-paid Classes accept Medical Charity as Relief 'in Aid of Wages,' and as their Right.

A large proportion of the wage-earners hold, or profess to hold, they have *a right* to demand and to receive relief from the charities. That a great number believe—or affect to believe—they have a right to be supported by the Poor Law is evident; some 830,000, at least, making this demand yearly!

The existence of this condition is not to be wondered at. Almost every plan has been tried in England to pauperize the wage-earners; to make them depend less and less on their own prudence and forethought, and more and more on the charity of others. This has been the traditional policy of our country. The Poor Law Commissioners, in 1834, found the guardians gave relief in aid of wages. If the average wage was then lower than that agreed upon by the

local authority, a grant was made out of the poor rate, so as to bring up the total weekly income to a certain standard! This was neither an encouragement for men to work, nor to ask a reasonable wage.

The above condition is in force to-day. An employer of labour 'subscribes to a charity.' He receives a number of 'letters of recommendation,' and distributes these among his employés. Instead of giving a proper wage, such as will allow employés to provide efficient medical treatment for themselves, the minimum is paid, and with the result the workman looks for *free* medical aid. The same thing happens with other than wage-earners. A fund is formed by which poor clergymen may be provided with an annual holiday. Now, why should this class of men be compelled to depend upon charitable relief? Why not pay such salary as will allow them to take holidays? And the same with the wage-earning classes. Why not give such wages as will allow them to provide *by their own efforts for their own wants?* No doubt this condition is being slowly arrived at, but the progress is exceedingly slow, unless the statistics relating to pauperism and charity mislead us. Lately a merchant said to me: 'You see it is essential my workmen are not absent from work. They tell me it is my duty to provide them with treatment. I do this in the cheapest way, namely, by giving donations to some charities. If practitioners choose to attend men as charity cases, that is not my business, but theirs. I deal in the cheapest market.' Fully one fourth of 'medical charity' is carried out on this system. If the wage-paid classes obtain wages which allow them to be independent of charity, and if they are discouraged from joining self-help movements, then charity to such is a farce, and the sooner the public withdraw their money from these questionable undertakings the better will it be for the community. And if medical 'charity' is given in aid of wages, then this too should cease as a duty falling upon the public, while the provision should rest between the employer and the employed only.

In Ireland the Poor Law, through their dispensaries, grant medical relief and medicines to a very large proportion of the population. Many of the members of the dispensary committees grant white and red tickets to their domestic servants, labourers, friends, and families. In some cases, where the member of committee has a shop, trade is encouraged by giving an occasional ticket, else business becomes slack. This is 'charity'!

In 1889 there were 1,139 dispensaries; 405,840 persons were treated at the dispensaries, and 164,396 at their homes.

I call attention to this system because its extension to England has been suggested.

SUB-CHAPTER.

VI.

Charity is Publicly Sold at Medical Charities.

Few will doubt but that those who founded benevolent institutions for the benefit of the sick poor hoped those who continued to administer them would do so in the same philanthropic spirit as actuated the founders. This pious trust has been betrayed. Day by day the charity administrator introduces the commercial, or *quid pro quo*, element. Men have endeavoured to establish provident societies, and the charity managers run it off by offering treatment to all who come for a fee of one or two pence. Others try to form pay hospitals, and immediately word is sent round by the charity administrator—the 'corner' charity monger—that the pay home must be 'choked off'! In order to do this the pay bed, the pay ward, and the pay patient plans are introduced! No one can point to any instance where either a provident dispensary or a pay home has successfully competed against the pauperizing influences of indiscriminate charity. Yet, because a few of the clergy give their blessing to the charity—without thinking for one moment of the other side of the question—one of the most gigantic obstacles to thrift is allowed to go on.

If I were asked—When did managers of charities take their first downward step in charity-administration? I would answer—When they began to sell charity and to barter with it as an ordinary saleable commodity. *Charity cannot be sold.* Medical charities were founded for the benefit of the sick poor. The intentions of the founders should be perpetuated. To-day charity is asked to cover a multitude of administrative sins which she was never intended to cloak. Whenever a great charitable gift has been bargained away for a few pieces of silver, nothing but evil has resulted. True philanthropy is an excellent custom, but when the charity manager tries to make a 10 per cent. dividend out of the recipients his efforts must fail. Scarcely one Medical Charity Report can be taken up without finding—under the heading 'Privileges of Subscribers'—that so many 'forms of recommendation' are given *if so much is*

paid. If subscribers would inquire into the social circumstances of those to whom they give forms, then harm would be reduced to a minimum. But when they purchase these forms for their own use, for their clerks, relatives, and servants, their 'charity' must be taken at its true value.

As a rule, the lowest subscription sold is one guinea. The dental hospital, however, gives a donor of 10s. 6d. 'the privilege' of recommending patients. If such a price is fixed as the minimum amount at which forms can be purchased, then some end might be looked for. But lately efforts have been made to introduce a new hospital-tax, in the form of weekly penny payments. Here, also, it follows that the donor of such a charitable gift has asked—'How many forms of recommendation am I to receive for this gift?' If the 'donor' of 10s. 6d. can purchase *the right* to four forms, surely the 'donor' of 4s. 6d. has a right to two for his 'poor' relatives. Such illustrations thoroughly exemplify the baneful effects of bartering in charity. As well might a Board of Guardians grant a number of relief orders to those who pay their poor-rate. The paying of poor-rate does not confer on the person who pays any right to receive aid. The providing of a charitable gift to a charity should not, and cannot, carry with it any pecuniary advantages to the giver.

In Birmingham, at the General Hospital, charity is sold at the following prices:

'Every subscriber of 10s. 6d. or upwards shall be entitled to recommend patients according to the following scale:

	£	s.	d.		In-Patients.		Out-Patients.
For	0	10	6	to recommend	0	.	3
,,	1	1	0	,,	0	.	6
,,	1	5	0	,,	0	.	7
,,	1	11	6	,,	0	.	9
,,	2	2	0	,,	1	.	0
,,	2	12	6	,,	1	.	3
,,	3	3	0	,,	1	.	6
,,	4	4	0	,,	2	.	0

and so on, in proportion to the sum subscribed.

'Any governor or subscriber may purchase additional in-patient tickets at £2 2s. each, and additional out-patient tickets at 3s. 6d. each.

'*N.B.—All Tickets issued by the Hospital entitle the Patients to treatment for* SIX WEEKS, *should the case need it; but at the end of Six Weeks another ticket is required should further treatment be necessary.*'

'Any person may purchase a ticket, and as there is no investigation into the social circumstances of applicants, the plan is a very favourable one for those who wish to secure cheap medical aid. However, even as a trade venture, this effort has proved a failure.'

The selling of 'privileges' leads to unpleasant complications. A subscriber sends a person to the charity who is in no sense entitled to draw on the funds, and who consequently may be refused relief. The subscriber resents this, and indignantly refuses to make further contributions! The Liverpool Ladies' Charity surmounts this difficulty by stating (Annual Report, 1889, p. 11): 'Unless the applicant bring a letter of recommendation from a subscriber as a guarantee that she is eligible for the charity, inquiry must be made in the usual way.' This rule establishes *the right* of the subscriber to send any person.

A more objectionable method of selling charity is by charging, not the subscriber, but the patient. A reference to page 70 shows to what an extent this deplorable system is in force. This 'plan' is given out as the 'pay patient,' 'pay bed,' or 'pay ward' system. It is like the 'systems' in force in gambling—bound to end in disaster. It may be stated, for every 'pay patient' treated, at least one poor person has been excluded. How can the poor find money, and how can charity managers say, 'Yes, we shall treat you, if you give us so much for our *charitable* treatment'? Such a plan prostitutes the very well-spring of charity. Apologists have brought forward as an excuse for this 'pay system' that it checks abuse. Why do they not prove it? Can one case be produced where it has done so? We must not take it for granted that because a 'charity' patient has paid one or two guineas he has proved his inability to pay more, or that he has proved his right to a full use of the funds subscribed for charitable purposes.

Even this paying of a sum of money, in some cases, gives the patient a right *to prior* treatment. Take the case of the Cancer and Skin Hospital, Liverpool, where it is stated (Annual Report, 1888, p. 7): 'It has been found advantageous to allow a priority fee to be paid by those who, through the claims of business, cannot well attend except during the dinner hour, and who might otherwise lose

part of a day's wages. The priority fee is sixpence.' Also: 'The hospital is *absolutely* free to all poor out-door patients, *except* that one penny for each ticket is charged *to prevent abuse of charity*.' What is 'the dinner hour' at this charity, if 'priority' patients are treated *only* during this hour, and how does the paying of a penny prevent abuse? This 'system' encourages well-to-do people to the charity. It will prove to be a Frankenstein, as, sooner or later, the pay patient will object to be used as 'material' for the instruction of medical students, or to sit with the charity cases. In this way the chief use of a medical charity will disappear, unless a private room is provided for paying *out*-patients!

A reference to Table I., column 7, shows that twenty-two charities obtained £6,043 from the 'sick poor' during the year. Column 8 shows that the cost of drugs and instruments alone was £6,534. Yet although patients were made to pay the 'system' failed. Only more patients were attracted, while these were led to believe their relief was in no sense a charitable one. Just now, charity-going patients inquire as to the prices charged in the same way as they ask the price of treacle or bacon. People know the prices charged by charities. At one dispensary 'they charge you twopence for a bottle of medicine'! 'At ——— Hospital they sell you four or five things, and charge a penny for each'! 'If you go to the ——— Hospital they sell you an instrument for your womb, and charge you for a syringe as well!' Is this 'charity'? The people are offered charity at a certain fixed price, and take it. As a 'system,' however, it is bad. If it continues there is little use in forming a 'Charity Rating Exemption Society.' For charities cannot be exempt from taxation if they sell charity, and do not treat the sick poor.

Another reason given for selling charity is, that by so doing '*funds are obtained by which to treat those also who cannot pay*.' I think Mr. Burdett and Mr. Burdett-Coutts, M.P., are the chief apostles of this new teaching. I should like to hear from any secretary who has been able to work out this 'system,' and by so doing to add to the income of his charity. Perhaps it might be worth while to answer the question: By what right do the managers of charities set aside a number of beds for the well-to-do? It is beyond their rights, and I am glad to see the managers of the Southern Hospital have ceased to favour pay beds. Regret must be expressed at the action of the infirmary in supplying pay beds for the benefit of a public who have never asked for them.

Why should efforts be made to 'run' charities after the fashion of hydropathics, or medical homes? How can medical homes compete with charities subsidized by charitable gifts? Anyone who wishes to look into this new business as undertaken by charity managers should read the pamphlet, 'The Pay System in Hospitals,' by Mr. Burdett-Coutts, M.P. His idea is to make every patient pay, and to make up the deficiency 'from the income of the hospital.' He adds: 'It has been found a very great convenience to clergymen, officers of the army and navy, clerks, etc.' Has it been found satisfactory to the sick poor? His 'system' is 'mixed,' and reminds one of the writing on the sign-board over the entrance to a small shop:

'We sell Bibles, bacon, and beer,
New Testaments, treacle, and tar.'

He illustrates his remarks by a reference to the paywards at St. Thomas's, Guy's, and the German Hospital, London. At St. Thomas's the receipts amounted in three years to £15,999, and the expenditure to £14,073, thus leaving a balance of £642 on one year's business. In three years there were 1,114 pay patients, or, on an average, 371 per annum. These 371 cost £4,691, and the hospital received £5,333, thus making £642 out of the total. Each patient cost £12 12s. 10d., and paid £14 9s. 3d., giving the meagre profit of £1 17s. 5d. on each case. To make this they had to keep forty-five beds, charging from 8s. to £1 1s. per diem per bed. The resident medical officer is paid £500 a year, and is not allowed private practice.

At Guy's there are twenty pay beds at £1 1s. per week each, and twelve at £3 3s. each. These thirty-two beds give an income of £1,874 6s. 4d. for one year. The cost of each bed was £1 7s. 3½d. per week, and the income from each was £1 2s. 0½d. This transaction therefore entailed a loss of 5s. 3d. per bed per week.

The German Hospital had six pay beds. The average income per bed per week was £1 16s. 2d., and the cost £1 3s. 6d., leaving a balance of 12s. 8d. So that about three pay beds would be required to support one free bed. That is, supposing the charity had eighty beds, sixty would require to be hired out to the best paying persons, while only twenty would be free.

The British Lying-in Hospital, London, has what it terms a 'Home for Accouchements,' where patients are received at £2 2s. 0d.

per week. In 1890, four patients were admitted who paid £40 of fees, which sum was transferred to the charity.

There is little use in asking whether the well-to-do or the sick poor come off second best. I would call the attention of those charities which advertise 'pay beds' to the above figures.

It has been adduced as one of the excuses for the existence of hospitals that they are for the instruction of students. It is to be feared the 'pay patient' will resent this, and that he will look on the visits of the pious and benevolent as a gratuitous act of impertinence! It is to be hoped the philanthropic will resent these efforts to commercialize our charities, and to turn them into a kind of lodging-house. I would urge that managers do not take it upon themselves to provide medical treatment for a class of the community able—if need be—to provide for themselves and their relatives. It must follow, that if the charities tout for pay patients, the public will—in order to avoid wounding the feelings—accept their advances. But let us remember the public have never asked for such a 'system.' We must not look upon charity patients as a source of revenue. The idea is altogether foreign to the feelings prevalent in this country. It may appear 'old-fashioned' to recommend an adherence to the work of our predecessors; but it is true they did not experience the difficulties now felt, although it is probable there were as many poor to provide for then as now.

Perhaps the medical charity manager secretly feels that the average Britisher *cannot* afford to be honest, when he sees a good opportunity of securing medical treatment and medicine at a cheap price even from a charity. Consequently the bids for this patronage, and the offer of 'charity' for *one and elevenpence three farthings only* instead of two shillings!

SUB-CHAPTER.

VII.

Medical Charities treat Symptoms only, and not the Causes of Disease.

A thoughtful practitioner first seeks for the symptoms of the disease; then he will look for the causes of these symptoms, and lastly, he will, while treating the disease, remove the cause.

True charity consists in striving to remove those conditions which

cause sickness, in remembering that charity 'grows by what it feeds upon'; and in noting that the majority of diseases treated at charities are *preventible*. The chief end of a medical charity *is to prevent disease*, and to stamp out disease-producing conditions. It is the duty of all true practitioners to drive home these facts, and show that they can act as a moral, as well as a medical force.

One of the chief reasons why our charities are so abused and why they act as obstacles to thrift is, they content themselves with treating symptoms only. True charity consists in eradicating, not tinkering. Broadly speaking—disease is filth, and due to a breach of the Laws of Health. Some speak of 'fashionable diseases,' and a self-satisfied smile may steal over a patient's face if it is hinted he suffers from gout; while on the other hand, indignation will be shown if it is stated the complaint is *scabies*. Hence the fashionable names by which to hide obnoxious diseases. At one time a portion of the community said disease was 'sent from God.' During the epidemic of cholera, the late Canon Kingsley caused disquietude by telling the people to clean their sewers, and to throw less blame on the Almighty.

Some time ago Dr. Churton, of Leeds, had an inquiry made regarding the homes of those who became in-patients at the infirmary. He found about one-third of these in-patients had 'grossly insanitary homes.' He remarked upon the unwisdom and costliness of sending patients back to such homes. Dr. Churton would not confine the investigation into cases of infectious diseases alone, but would extend it to the homes of patients suffering from ordinary diseases. He adds: 'Houses can be shown which have formerly yielded a constant supply of hospital patients.'

Any person who wishes to note what a large mass of *preventible* disease occurs in Liverpool, should read the Annual Report of the Health of Liverpool for 1888, by Dr. J. Stopford Taylor, Medical Officer of Health. It may be noticed that the area included in this Report differs widely from that on which the Registrar General bases his returns. The latter refer to the parish of Liverpool only. Of a total number of 12,159 deaths in that year, there were 1,796 deaths due to zymotic diseases, viz.:

Small-pox	1
Measles	331
Scarlatina	187
Whooping-cough	113

Diarrhœa		66
Fever (typhoid, 125; typhus, 36)		161
Croup		108
Tubercular diseases	Phthisis	1613
	Scrofula	
	Tabes Mesenterica	
	Hydrocephalus	
Convulsions		472
Teething		102
Childbirth		109
Premature birth		225

In order to bring before the mind the loss of life, time, and money, due to these preventible diseases, and to enforce the fact that the true charity consists in not only treating the symptoms but *in removing the cause*, let us accept typhoid fever as an illustration. In all England and Wales, in 1888, 4,848 deaths from this fever were registered. In that same year in Liverpool, there were 125 deaths from typhoid. These figures mean first, that 125 persons lost their lives from one *preventible* disease. Supposing each of these persons had been a bread-winner, and estimating the value of each life at £159, here is a loss of £19,875 in one year. I do not refer to the loss through funeral expenses; or to the community by the wife and family going on the poor-rates.

The above figures refer to the loss *through death* from this one fever. It must be noticed that the *loss* of time and money *through sickness* is also very heavy. The death-rate from typhoid fever is about 15 per cent. Therefore, if 125 persons died, and there was a death-rate of 15 per cent., it follows that 833 persons must have *been attacked and suffered* from typhoid in that year.*

Having shown the number *who died*, and the number who suffered from this fever, two other important calculations can be made, viz., the amount of time and wages lost. As regards the time lost, Dr. Broadbent has stated the average duration of an illness from typhoid is ten weeks. If, therefore, 833 suffered, here is a loss in time of 8,330 weeks. As regards the money loss, supposing each of the 833 had been a bread-winner, and making £1 per week, there would be a loss of at least £8,330, owing to this one disease alone.

Is it little wonder Dr. Churton has striven to bring this question

* During 1888, the existence of 5,987 *cases of fever* came under the notice of the Medical Officer of Health.

of the *cause* of disease to the front, and to make it one of importance? It is to be hoped the time will soon come when each health authority will have control over all the house-drains and sewers, as the Corporations now have over the water and gas pipes.

It may be argued the Infectious Diseases (Notification) Act, 1889, makes it penal if infectious diseases are not notified. No doubt this Act—if administered—will be of great advantage; but for so far it does not make it compulsory for the practitioner and householder to notify cases of measles, mumps, whooping-cough, or chicken-pox. The Act gives local authorities power to add such diseases to the list, but for so far they have not, except in one or two instances.

The following figures show the necessity for making such additions: In 1888 the following *deaths* were registered in England and Wales:

Measles	9,784.
Whooping-cough	12,287.
Small-pox	1,026.
Scarlet Fever	6,378.
Typhus	160.
Diphtheria	4,815.

These figures show, while scarlet fever and diphtheria are notified, measles, and whooping-cough, with death-rates much above the former, are ignored. It is to be hoped so grave defects will be rectified.

If notification only be carried out, little good will result; but if the medical officers of health and the sanitary inspectors visit and report upon the conditions of the houses in which fevers exist, and insist on the house-owners remedying defects, good results will follow.

Further, if parents were prevented from sending their children to Board and other schools when infectious diseases are either developing, or when convalescence is progressing, benefit would accrue. It is no exaggeration to state that a great number of children are sent to school when recovering from infectious diseases. This should not be permitted. Parents say the School Board authorities insist on their sending their children. Possibly. But parents allow children to sit on the door-step and converse with large numbers of children who are returning from school, when they are convalescing from fever. The same evil is known to exist in the out-patient waiting-rooms of charities, where parents take children suffering from diphtheria, whoop-

ing-cough, measles, and scarlatina, in their early or late stages. This might be remedied. Section 126 of the Public Health Act of 1875 lays it down: 'Any person suffering from any dangerous infectious disorder wilfully exposes himself without proper precautions against spreading the said diseases in any street, public place, shop, or public conveyance, or enters any public conveyance without previous notifying to the owner, conductor, or driver thereof that he is so suffering, or who lends, sells, transmits or exposes without previous disinfection any bedding, rags, or other things which have been exposed to infection from any such disorder shall be liable to a penalty not exceeding £5.'

I would express the hope that all the Board and other schools may soon see it to be their duty to appoint a medical officer to each school, who will weekly examine the children, order those who are weak or suffering to return home, and by detecting cases of ringworm, skin diseases, mumps, and infectious or contagious diseases, or any conditions likely to prove fatal, to call the attention of parents to such. The Workshops and Factory Act, 1878, provides for inspection and rejection of children employed in factories.

Attention has been called to the duties of medical charities in seeking out *the causes* of disease, and for purposes of illustration reference has been made to typhoid fever. Anyone interested in this subject of vital statistics can apply the same process of reasoning to any other of the *unnecessary* fevers.

Beside fevers, there are a large number of diseases treated which might, in the immediate future, be prevented.

A reference to the Annual Report of the Registrar-General for 1888 shows the following:

Deaths from Diarrhœa and Dysentery	12,839
„ „ Thrush	539
„ „ Premature Birth	14,063
„ „ Dentition	4,235
„ „ Convulsions	20,764
„ „ Parturition	1,774
„ „ Accident and Negligence	14,908
„ „ Intemperance	1,451
„ „ Venereal Diseases	2,212
Starvation and want of Breast Milk	308
Running from the Ears	516

A glance at the Annual Report of the Liverpool Children's Infirmary shows that the children *suffered*, among other diseases, *from the following:* Cough and bronchitis, 1,704; dyspepsia, 565; improper feeding, 254; congenital syphilis, 118; diseases of the skin, 1,456; burns and scalds, 85; injuries, 252; fractures, 71. It is well-known a very large proportion of the diseases of children are due to improper feeding and clothing. How many of the cases of 'dyspepsia' and diseases of the skin are due to the fact the infant drew its milk from the breasts of a beer-soaked, or gin-drinking, mother? At the dispensaries in 1888, 10,077 persons were treated as suffering from diseases of the stomach and intestines!* Unfortunately the reports of the medical charities do not give any useful statistics relating to *the real cause of disease and of death.* Such a report would be most instructive. It might horrify the public for a time, but eventually good would follow.

Taken generally, the registration of deaths is performed in a loose manner. Our present way of filling up death certificates is becoming quite too 'scientific'! It is frequently filled up so as effectually to hide the real cause from which the person died. This is partly owing to the fact that the practitioner does not wish either to hurt the feelings of relatives, or to stop the payment of insurance money. The Registrar-General's returns for 1889 show that of a total of 518,353 deaths registered, only 474,174 were certified by registered medical practitioners; 29,079 were certified by coroners—and we know the usual style of coroner's juries—'Visitation of God,' 'Found dead,' etc.; while 25,466 deaths were registered under the heading 'Ill-defined, and not Specified Causes'; 3,175 letters had to be written concerning unsatisfactorily described deaths from the Registration Office.

The public do not seem to grasp the momentous fact that medical practitioners do not usually certify *that the person has died.* The death certificate only requires the practitioner to take the statement of the informant—that the patient is dead; to state he attended 'John Jones' in his last illness, and that 'to the best of his knowledge and belief' *the cause* of death is so-and-so. The practitioner,

* An excellent plan of putting the principle of prevention into action is that adopted by the Hospital for Sick Children, Manchester, where printed directions for the management and feeding of infants are given. The Annual Report of this charity all throughout is one which will repay careful perusal; while it might be accepted as a pattern by other charity managers when drawing up their Annual Report.

therefore, certifies only to *the cause* of death. It would be much better if the practitioner gave a certificate stating: 'I have *examined the dead body* of "John Jones," whom I attended *in his last illness*, and the cause of death is so-and-so.' It would be much more to the benefit of the public if all registrars of deaths were medical practitioners, as it is impossible for lay registrars to understand such serious subjects. Dr. Farr, in 1864, advocated an improvement. Dr. Newsholme, in his book, 'Vital Statistics,' says: 'As matters now stand, when there is no medical certificate of the cause of death, the registrar makes inquiries of the relatives of the deceased person, and if *he* is satisfied with *their* explanation of the cause of death, enters it according to their statements, adding that the death is not medically certified. If he does not care to undertake the responsibility, he refers the matter to the coroner, who generally gets his officer—a functionary as irresponsible as the local registrar—to make inquiries. If the coroner's officer reports favourably, the coroner writes to the registrar that an inquest is unnecessary. Such a system is obviously open to the grossest abuses. . . . The death certificate should never come into the hands of the relatives of the deceased, but be sent direct to the local registrar. This would insure much more accurate results, as the present family practitioners have great difficulty in returning the *true cause* of death in cases of alcoholism, syphilis, etc.'

I call attention to this subject because there is ground for believing there is laxity in the granting of death certificates by the authorities of the children's infirmary, and other children's hospitals. For instance, it has been stated that at the Liverpool Children's Infirmary, a child is taken to it, say, on the first of December, as an out-patient. The relatives may take the child once or twice to the charity, but in the month of January or February someone comes to the infirmary and states that the child is dead, and at the same time asks for a death certificate. The following 'death' certificate is then given:

CHILDREN'S INFIRMARY, LIVERPOOL.

.....18 .

This is to certify that.....
Aged.....attended this infirmary as an out-patient from.....
.....to.....suffering from..... .....and from.....
.... Signed .....
.... Qualification.....
..... Residence.....

This certificate is taken to the Registrar of Deaths, and accepted as part evidence *of the death* of the child. I have called on one of the District Registrars of Death regarding this matter. It is horrible to think what events may have happened to the child from the first of December to the beginning of February. It may have been maltreated, or poisoned; been buried alive; or it may not even have died—although the club money has been drawn. Coroner Braxton Hicks has, in his evidence before the select committee of the House of Commons, on the Friendly Societies Act, 1875, called attention to the Evelina children's hospital.*

From the preceding, two important lessons should be taken, that the granting of certificates of death should not be performed in a loose way, more especially in the case of children; and second, that a thoroughly honest classification of *the causes of death*, and of the causes of *diseases*, from which medical charity patients have suffered, appear in each Annual Report. I would suggest the Registrar-General's classification be adopted.

There are two other *preventible* diseases to which I shall call attention, viz., diseases due to intemperance, and venereal diseases. No exact figures are given by medical charities regarding the number of deaths or the number of *diseases due to intemperance*, but we know a large proportion of illnesses, such as diseases of children, scalds, wounds, delirium tremens, suffocation of infants, are due to excessive drinking. It would be well if the police report stated how many of the 15,628 cases of drunkenness taken up by the police in twelve months were taken to the medical charities. The following is taken from a local daily paper:

'Drunkenness and accidents in Toxteth.—The police who were on duty on Saturday and early on Sunday morning had a good deal of their time taken up in quelling numerous street-fights, and conveying the injured to the Southern hospital. From six o'clock on Saturday evening until Sunday morning about forty cases were removed to the hospital, and fifteen were suffering from cuts on the head and face. About half the number were women in the various stages of intoxication.'

A similar condition exists at the three dispensaries. It may be said fully one quarter of the cases admitted both as in, out, and casualty patients, are due to drink. Lately it was stated in a daily

* His pamphlet, 'Hints to Medical Men concerning the Granting of Certificates of Death' (Clowes and Sons), should be extensively read.

paper, when a request was made for a license for an hotel at Bootle, that the opponents to the granting of a license were in possession of medical evidence which would show that nearly all the accidents at the docks were caused either through the drunkenness of the person who sustained the injury, or by some other person being drunk. It has been suggested a tax be placed on public-houses, but I do not think it would be right or suitable to support charities with the funds obtained by such a tax. It would show too closely how the patients found their way to the charity. The Annual Report of the Registrar-General for 1888 states that 1,451 deaths were registered during the year as due to intemperance. It has, however, been calculated that about 50,000 lives are lost yearly from this one cause (Ransome).

As regards venereal diseases and deaths due to them, the reports of the medical charities are almost silent. Why? During 1888 at least 267 cases were treated at five charities, and 894 by two Poor-Law authorities. What number was treated at the other charities the authorities do not tell, and a large porportion are entered under the misleading heading—'diseases of the genito-urinary organs.' No less than 1,650 of these were registered under this heading in twelve months at the dispensaries—a large business being carried on there.*

The Annual Report of the Registrar-General states that 2,212 persons died from venereal diseases in 1888. That this figure is much below the number few will doubt. Of the above number 1,452 deaths occurred in infants under one year, thereby showing the far-reaching and devastating results of this preventible disease, and how the innocent suffer by the sins of the guilty.† If the reader wish to obtain information relating to the extent of venereal disease, he should refer to the Report of the Health of the Army. The Home Army, in 1886, numbered 92,601 men. In that year the number *admitted to hospital*—not the total number who suffered, not the number who died—was as follows :

* In 1875, 395 prostitutes were admitted into the Liverpool Workhouse ; and in 1885, 716.

† Is it too much to suppose that a very large proportion of the 6,120 deaths due to 'premature birth,' as recorded in the Registrar-General's Returns for 1888, were due to syphilis? Indeed, the figures make one take to heart the statement made by Oliver Wendell Holmes, when he said, 'The patient may almost always be saved if the doctor is called in in time—but he should be called in 200 or 300 years before the patient is born.'

Suffering from primary syphilis	8,236
„ „ secondary „	3,079
„ „ gonorrhœa	10,632
Other venereal diseases	2,766
Total admitted	24,713

The number of men *constantly* sick from venereal disease was 1,785·84.

If again, reference is made to the Annual Report of the Health of the Navy for 1887, it will be seen that of a total force of 48,410, the number of admissions to hospital was as follows:

Suffering from primary syphilis	2,924
„ „ secondary „	934
„ „ gonorrhœa	3,598
Total admitted	7,456

In the foregoing statements the following facts must not be overlooked; first, the figures relate to the number *admitted to hospital*, and second, that cases of tertiary syphilis are not included.

If a guarantee could be given that these diseases would not be handed on to others, then the above number would be a mere flea-bite on the face of debauched nature. Unfortunately no such guarantee can be given. Each infected person acts as a centre of malignant contagion. Women, children, and unborn infants suffer, and so one of the most devastating and far-reaching* diseases is handed on to posterity. The fact that in one year *at least* 32,169 men in the army and navy acted as so many forces of contagion is a matter of national moment. But as grave conditions affect the mercantile marine and our large towns; there is little doubt but that venereal diseases are slowly but surely undermining the health of the population. There is a feeling among a number of medical practitioners that diseases such as leprosy, consumption, water on the brain, rickets, lupus, and syphilis are all members of the same family—no doubt modified by time, climate and constitution—with their parent, Syphilis. Under the Mosaic law such disorders were dealt with with great stringency (Leviticus xv.). But so long as a

* *Far-reaching effects.*—It has been given in evidence that 30 per cent. of the *total* blindness affecting persons in this country is due to *ophthalmia neonatorum*—inflammation of the eyelids of infants. This eye disease is often due to gonorrhœa.

maudlin sentimentality says 'Hush!' whenever any person endeavours to inform the big jury—the public—on this question, we shall make little headway. If the public understood the malignant character of this disorder—that it is worse than a cancer—they would seriously endeavour to obtain useful information and act upon it; not in an hysterical and spasmodic fashion, but with slow, sure, deliberate and determined action. To show how this disease penetrates almost everywhere, and how innocent persons may suffer by the conduct of others, I shall call attention to some *authenticated* cases.

Unclean towel.—A man infected was in the habit of rubbing his gums with a towel which was used in common by a companion. The latter contracted syphilis.

Infected thread.—Three workmen contracted syphilis on their lips by drawing through their mouths pieces of thread from a ball of thread used in common by a fourth syphilitic workman.

Licking cigars.—Two cases contracted the disease by smoking cigars whose broken leaves had been stuck down by the seller's tongue when he was suffering from syphilis.

Tattooing.—A professional tattooer inoculated fourteen persons with syphilis through moistening his instruments in his mouth.

Vaccination.—Undoubtedly cases have been reported where syphilis has been caused by dirty instruments and poisonous lymph. Clean instruments and calf lymph should absolutely hinder the propagation of this disease.

From Parent to Offspring.—The poison leads to abortions, miscarriages, the birth of dead children, and of those who live but a few hours or days. A table has been given showing the mortality among syphilitic infants, infected by their parents. Of 119 families with 330 births, 127 of the children were prematurely born; 111 were born dead; 80 lived under 6 months; or 191 died from syphilis. Ricord, who practised in Paris, has stated that of every 1,000 men 800 have had gonorrhœa; and more important still, 90 per cent. of these go uncured. Of every 100 women married to men who have formerly suffered from gonorrhœa, scarcely 10 remain healthy. Noegerath has called attention also to the same fact. Of 81 married women, 5 had miscarriages, and 23 were prematurely delivered.

During Confinement.—A midwife who contracted syphilis in her finger, and who continued her vocation, gave this disease to her husband, and to about 100 other persons. In 1883 the medical

officer of health for Sheffield (Dr. Hime) called the attention of the health authorities to the case of a midwife who had syphilis, and who gave this disease to 30 married women, the latter giving it to 9 husbands and 2 infants. She continued her work, although told by a medical practitioner she should not do so.

Wet-nurses.—A syphilitic wet-nurse infected an infant. The infant then gave the disease to its mother, to its grandmother, to two servants, and finally the mother infected the husband.

In two cases ladies were infected on their lips by their lovers when kissing them.

I have seen two cases where children contracted this disease by putting their trumpets to their lips; evidently these instruments were bought by the parent and given to the children before being thoroughly washed and disinfected.

The above mentioned cases may, perhaps, help to awaken some interest in this preventible disease. I hope our medical charity authorities will not fail to order that no cases of venereal disease be admitted into the wards or out-patient departments.

In 1867 the Harveian Society issued a report upon the prevalence of venereal disease. At Guy's Hospital, 43 per cent. of the whole number of out-patients suffered from venereal diseases. In the Eleventh Report of the Medical Officer to the Privy Council, 1871, it is stated that $7\frac{1}{2}$ per cent. of the 'sick poor' treated at these institutions suffer from venereal disease of some kind. The Surgeon-General of the United States Army showed that of applicants for enlistment during 1879, 20 per 1,000 were rejected for venereal diseases, although *the applicants were all under seventeen years of age;* while at the Educational School not one in five escaped a venereal affection.

Recognising the existence of such a deplorable disease, how can its spread be checked? The Contagious Diseases Act of 1866 was a gigantic failure. How could it have been otherwise, when it gave the police power to arrest *women* suffering, *but not men?* It is difficult to understand how the British House of Commons brought themselves to pass such a piece of legislation. Happily the Act is now repealed. Under it, no doubt, some *towns*, *thoroughfares*, may have been *apparently* more orderly; but the devastating disease continued in its virulence all the same.

In Liverpool, in 1890, 2,677 prostitutes were proceeded against by the police. It is not too much to suppose that each of these infected,

at least, twenty persons, and that the latter gave the disorder to ten more, and so spread this plague. Those interested in the question should read the pamphlet by Dr. F. W. Lowndes: 'Prostitution and Venereal Diseases in Liverpool,' and the evidence of Dr. J. B. Nevins, given before the Select Committee of the Commons, when inquiring into this subject.

I would express the opinion that no cases of gonorrhœa, or of primary or secondary syphilis, or venereal sore, be treated at one of our voluntary medical charities. Tertiary and congenital syphilis might be admitted; but even here it would be unfair to put a child so suffering into a ward with a number of other children. None of us would wish our children to be so exposed. Much better results would be given if an infirmary—such as the Lock Hospital of London—were built. It should also be supported out of the local rates, just as the hospitals for infectious diseases are. The law should be amended, so that all cases of venereal disease should be notified to the health authorities, as is now the case with many infectious diseases. All those unable or unwilling to undergo proper treatment privately, should be compelled to enter the hospital. It is no exaggeration to say that each person suffering from venereal disease is a public danger, and threatens the public health. We are accustomed to talk largely of the benefits of compulsory vaccination, yet I question if syphilis would make the cruel inroads on the public health, if it were strictly controlled after the manner of infectious diseases. There is no good in ranting about leprosy when there is a greater leprosy in our midst—a cancer kept from public knowledge, because the Medical and the Public Press will not speak out, and because society at large has been gulled by the cry, 'Necessary evil.'

Further, the law should give hospital authorities power to detain such patients until they are cured, or, at least, harmless to their neighbours. The Public Health Act gives this power in reference to dangerous infectious diseases, and the Contagious Diseases (*Animals*) Act, 1878, provides for the notification of certain infectious *and contagious* diseases.

It is not an exaggeration when it is stated that *no real cure* is effected in one out of every fifty cases of venereal disease admitted. Most practitioners agree that it takes from two to eight years to cure a case of syphilis. The majority of male and female prostitutes remain in hospital only until the more repulsive symptoms of their

disease have been removed. This should not be allowed. One has only to refer to the vast number of diseases of the genito-urinary organs treated at medical charities to understand that in many cases these affections had their origin in a venereal disease, and in one which obtained very imperfect attention.

I have somewhat fully called attention to the *prevention* of disease; to the affections known as fevers; and to the diseases due to intemperance and prostitution. There is not much excuse for those who contract venereal disease, and charity is wasted upon them. The sufferers are not usually the poor, but those who can pay for the 'pleasures' of alcohol and other accompaniments which attach themselves to those who deliberately expose themselves to infection. Cool, deliberate exposure to infection it is, for I do not fancy Liverpool contains the individual who will adduce any evidence to show there is a male or female prostitute in it free from the taint of venereal disease. Such cases should not be mixed up with the sick-poor in our medical charities.

SUB-CHAPTER.

VIII.

There is no Uniform System of publishing the Annual Reports and Balance-Sheets of Medical Charities.

One of the recommendations of the Poor-Law Commission of 1834 ran as follows: 'We recommend, therefore, that the central board be empowered and required to take measures for the general adoption of a complete, clear, and, as far as may be practicable, uniform system of accounts.'

Anyone looking into reports with the view of obtaining accurate information will be disappointed. The idea seems to be that the public do not require information; and if it were given they could not understand it. I have already referred to the report of the Dublin Hospital Sunday Fund; the reports of the Salford Hospital, and that of the Children's Hospital, Manchester, as being fairly well drawn up. As regards the reports of the Liverpool charities it is impossible for one to work out, with any approach to accuracy, the cost per bed, or the cost of in- or out-patients. Even if these charities stated the cost per bed was a certain sum, little good would

result if one wished to make a comparative return of the various charities; each would have its own plan of working out the cost. This is one reason why there should be uniformity in the drawing and working out of the reports.

Each medical charity report should contain full information on the following heads: Name of hospital; when founded; number of *in*-patients treated during the twelve months ending December 31st; number of *out*-patients; number of home patients; number of casualty patients; name, residence and occupation of out-, home-, and in-patients; number of confinements; out-patients treated daily; new out-patients treated daily; number of attendances; number of beds; average number of beds occupied daily during the year; average number of days of each in-patient under treatment; average number of days of each out-patient; average cost of each in-patient per week; average cost of each out-patient; average cost of each bed per week; number of consulting, visiting (including out- and home-patient staff); resident and dental staff (with dates of appointment); number of beds to each of the visiting staff; number of dispensers; number of nurses; number of nurses to in-patients; list of operations, and number of deaths; complete statement of the diseases from which patients suffered; amount paid to resident medical staff, to visiting medical staff, medical and surgical registrar, pathologist, chloroformist, matron, nurses, dispensers, porters, to auditors, to solicitors, to chaplains; cost of drugs; cost of instruments; total salaries and wages; total costs of patients; amount paid by *in*- and *out*-patients; daily average of household; average weekly cost of each officer, nurse, and servant in housekeeping; total income from (*a*) donations; subscriptions, and collections; (*b*) from invested funds and legacies; income from Hospital Sunday Fund, Hospital Saturday Fund; workshop collections; property; total expenditure; balance to credit; in debt; invested funds; estimated value of hospital buildings. State what system of checking the abuse of the charity by improper applicants is used, and what number of applicants are found to be ineligible, and why. The cost of *in*- and *out*-patients and cost per bed to be worked out after a definite plan. Is the charity used for the training of sick-nurses, pupil midwives, monthly nurses, and students? If so, how many of each were trained last year? State for how long a patient is given continuous treatment without requiring a 'renewal form.'

The following rules for working out the cost of beds, and of out- and

in-patients, are based on the different statements and reports made by J. W. Nixon, Esq., House-Governor, London Hospital, E.

To estimate the average cost of each in-patient: from the total expenditure deduct all extraordinary expenditure, such as new buildings, etc. From the balance left deduct all expenses incurred for out-patients only (which is done as stated in paragraphs below).

The cost per bed is found by dividing the amount left, after the above deductions, by the number of fully occupied beds.

The number of fully-occupied beds is found by obtaining a *daily* return of the number of beds in actual use, and adding the numbers obtained together for the whole year, then dividing this by the number of days in the year.

The total cost per in-patient is found by dividing the cost per fully-occupied bed by the number of patients who occupied each such bed.

To find the cost of out-patient: reduce the total number of out-patients to *genuine continuous patients* by deducting from the total number of out-patients all minor casualties and dental cases; divide the number deducted by 28 (as the latter are looked upon as one attendance cases, and this division makes them into continuous cases). Add the result to the number remaining after minor casualties and dental cases have been deducted from the first grand total. This will, therefore, give *the number of genuine continuous out-patients.*

Next, deduct from the total cost of drugs the cost of surgical appliances, and items ordered only for *in*-patients, such as ice, scientific appliances, surgical instruments and mechanical aids (leave 10 per cent. of the last as out-patient expense). The balance of expenditure in drugs, etc., is to be divided equally among the number of in- and out-patients. To do this, find the daily cost of these medical and surgical items, as follows:

(*a*) Multiply the number of in-patients by the number of days' residence (this number is found by multiplying the number of occupied beds by 365 days, and dividing by number of in-patients).

(*b*) Multipy the corrected number of out-patients by 28—their average days of attendance.

(*c*) Add these two results together, and you get the total number of days for which medicine and surgical appliances have been supplied, of a kind common to both in- and out-patients.

Now divide the total cost of dispensary and surgery expenditure common to both in- and out-patients by the total number of days, and this gives the cost per patient per day for medical and surgical items. Use this result to find the part due to out-patients, multiplying this daily cost of patients by the days of out-patient attendances. To this add dispensary expenditure (partly real, partly estimated, which would not be wanted were there no out-patients); to this add—

(*a*) Cost of drugs, and honorarium to out-patient medical staff.

(*b*) Salaries of dispenser or dispensers, as paid for out-patient work.

(*c*) A third cost of clerks.

(*d*) A fourth cost of porters employed in issuing and re-sorting tickets and keeping order in the waiting rooms.

(*e*) Surgical and medical waiting-hall porters, and occasional cleaners.

(*f*) Estimated minimum cost of coals, water, steam, gas, white-washing, repairs, and printing.

(*g*) Cost of nurses for out-patients' bath-room and female patients.

These give the total cost of the out-patient department; and dividing this by the corrected total of genuine out-patients, you get finally the real approximate cost of each genuine out-patient. Multiply this by the number of genuine out-patients and deduct the result from the total current expenditure before dealing with the in-patients.

A reference should be made to the balance-sheet which the Metropolitian Hospital Sunday Fund insists on the medical charities filling in. Unless such a form is filled in, a grant of money is refused. Mr. H. N. Custance, Secretary of the fund, agrees generally with the above plan, as recommended by Mr. Nixon.

If the managers of the medical charities agree to adopt a uniform system of report and accounts, and if our local Sunday Fund refuse grants to those charities which do not conform with the rules, then improvements would be effected.

A reference to the report of the Leeds Infirmary shows that the *address* of all patients is given; the report of the general hospital for sick children gives the *cost of patients, and beds*, as well as a good *medical report;* that of St. George's, London, gives the *occupation* of patients, and states whether they are *in or out of work;*

that of the Salford Hospital gives the *cost of out-, and home, and in-patients; cost per bed; average number of beds daily occupied*, and *average number of days in hospital.*

SUB-CHAPTER.

IX.

The System of Home Hospitals is not Developed.

By home or private hospitals I do not mean voluntary medical charities, or cottage hospitals, the former having no connection with medical charity. Home hospitals have been established for the benefit of the well-to-do, and therefore to speak of charity when referring to this class is worse than cant.

Abroad, the system of pay hospitals is far in advance of anything of this kind in the United Kingdom. Indeed, it has been somewhat tabooed by a few 'leading' practitioners, and charity managers. The former generally work with some retired nurse who keeps a lodging-house for patients, where the well to-do, coming from a distance, are housed. As a rule, the sanitary condition of many lodging-houses totally unfits them for the reception of surgical cases. Many charity managers object to the home hospital system because its presence removes their lame excuse for having pay beds or 'pay wards.'

As early as 1840, the subject of home hospitals was brought forward by Dr. Southwood Smith, and he actually established one then. I shall refer to a few.

The Home Hospital, Fitzroy Square, London.—This was opened in 1880, and incorporated under the Companies' Acts. £20,000 of shares were issued, over £10,000 of this having been subscribed. The liability of subscribers is limited to the amount each wishes to contribute.

Contributors of £50 and £20 are given the following privileges: (*a*) priority of admission for themselves or families, and the nomination of patients; (*b*) a discount of 5 per cent. to members and governors if they become patients.

The terms are:

Rooms per Week.

	£	*s.*	*d.*
Fourth floor-room	4	4	0
Third „ „	5	5	0
First and second floor-room . .	6	6	0

Double-bedded room for patient and private or special nurse, £9 9s. to £10 10s. per week.

The above charge includes board and nursing. Drugs are charged for. Every room is furnished as a bed and sitting-room. All payments are made in advance, and, at least, for one week. Every patient is treated by his own medical adviser; he having to instruct the lady superintendent as to the diet and nursing. The home supplies the nurses, or if the patient prefer it, their own nurse may be brought in, an additional £1 1s. per week being charged for her board. No official of the association is permitted to attempt to influence the choice of the patient in selecting a medical practitioner. Each patient must pay his own medical adviser. Male and female patients are admitted, but lunatics, infectious, contagious, and confinement cases are not admitted. In 1889, 514 persons applied for admission, and 301 were admitted. Each patient stayed on an average 18·2 days, and these paid £4,450.

The Bolingbroke Home Hospital, Wandsworth Common, London.—This is not a self-supporting institution, as patients who can pay, either wholly or in part, are admitted. The charges are from 10s. 6d. to £2 2s., and from £1 13s. to £5 5s. per week, according to the rooms. A resident medical officer is employed, but patients may select their own medical adviser.

The Hampstead Home Hospital, London, has somewhat similar rules. In 1888 its report showed £210 from subscriptions, and £334 from donations. It is, therefore, not a home hospital altogether.*

In Dublin the Claremount Street Private Hospital was established in 1854. It is the property of several medical practitioners. At first charitable donations were offered, but declined, as the management wished to have the hospital in their own hands. The institution admits both sexes, medical and surgical cases, and 'combines the comfort of a private residence with the advantages of a well-regulated hospital.' Patients are treated by their usual medical adviser, and the lady superintendent sees that patients conform with the rules. The scale of charges is: General male ward, £1 11s. 6d. per week, in advance; private rooms, £2 2s. to £3 3s., including

* *In Liverpool* a medical and surgical home has been established at 2, Canning Street. The terms and regulations are similar to other pay hospitals. It is difficult, however, to see how it can succeed when practically the medical charities are touting for pay-patients, and doing their best to destroy all self-help measures. Another has been established at Plymouth.

board, lodgings, medicine, medical attendance, and ordinary nursing. Separate charges are made for surgical operations. Relations of patients can be accommodated in the home. There are twenty-six beds, and about £3,000 invested in the building, etc.

The complaint has been made that the private hospital is undersold by the voluntary medical charities, and that several practitioners will not use it because it is owned by medical men.

In Belfast a pay hospital for surgical cases only has been established. A charge of £2 2s. to £5 5s. per week is made, and this includes residence, maintenance, and nursing. The surgeon's fees are independent of the weekly charges, and the hospital is owned by two of the principal surgeons.

In Italy, according to Mr. C. H. Burdett, each large city has its Casa de Salute, or Home of Health. In Milan it is managed by a society of one hundred shareholders, each of £50. It contains about fifty separate rooms. Medical, surgical, and midwifery cases are admitted. There are three scales of payment: 1st class, 6s. per diem; 2nd class, 7s. 6d.; and 3rd class, 9s. Contagious and infectious diseases are not admitted. As a rule, a dividend of 5 per cent. is declared after paying *all* expenses, and deducting 10 per cent. of the profits for wear and tear, and 25 per cent. towards the reserve fund. A balance-sheet is published yearly, and presented to the shareholders. All payments from fourteen to thirty-one days in advance. A large number of the chief towns in Italy possess a Casa de Salute.

In France the Maison de Santé represents the home hospital. There are two kinds: the public maison, which is managed by the Town Council; and the private hospital, which is a private undertaking by individuals who establish and work it as an ordinary business.

I should like to see a home hospital established in every large city in the United Kingdom. Such a home should be absolutely distinct from all charity; it should be floated by capital subscribed in shares, and conducted as a business undertaking. If all the practitioners in the town became the owners of shares, it would lessen their desire for pay beds and pay wards in the charities, and induce them to take a business-like view of the question. In every large city there are a number of men belonging to the Church, the different professions, and businesses, to whom such a home would be a great blessing—more especially to those who reside in apartments.

SUB-CHAPTER.

X.

There should be a Public Medical Service for the Benefit of a Portion of the Wage-paid Classes.

Although the Oddfellows and other Friendly Societies provide members with medical treatment, it would be much better if there were a Public Service approved and recognised by the public as a national institution.

I propose the above service consist of two parts—one, a department at which treatment be given on the payment of a small *cash* fee ; and the other a department where no immediate treatment be given, but which should be administered on a provident system, in which, by making payments *during health*, treatment would be guaranteed during sickness to subscribers.

The object of such a service would be to supply medical, surgical, obstetric, and dental treatment to that portion of the wages-paid class who are making under

25s. per week per family from all sources, and
15s. „ „ single person.

This 'wage limit' would be applied to both departments.

(*a*) *The Provident Department.*—The Provident Dispensary has been before the public for many years. The Poor Law Commissioners in their report of 1834 called attention to it as a proposal well worthy of trial. In an article in the *Churchman* of October, 1883, Dr. Ogle, of Derby, refers to the efforts of Mr. Smith, of Southam, and Dr. Calvert and Mr. Jones, of Derby, medical practitioners, who, about 1830, inaugurated the scheme. Dr. Calvert stated to the Commissioners that : 'The essential point is, *the poor* should pay one penny a week, or families a half-penny each per person, and should for this be insured medical attendance and medicines ; that medical men should receive all or part of this, and that additional money should be subscribed by the richer classes, who should manage the whole by a committee.' Mr. Yateman also wrote in the *Lancet* of April 31, 1831, on the same subject.

If the supporters of provident dispensaries had followed Mr. Calvert's plan, the present grumblings would not be heard. He evidently proposed it *for the benefit of the poor*, and as a scheme

which was to take the place of, or partly the place of, the Poor-Law Medical Service. Those who now help in working provident aid societies know well that scarcely any poor belong to them, but that well-to-do persons enter who, in their greed, threaten to kill a most useful institution.

In 1883, the Liverpool Charity Organization Society tried to induce the dispensaries to divide themselves into two parts—one provident and the other charitable. This was not agreed to, although a similar system is now in force at Coventry, Leicester, and London.

In the *British Medical Journal* of June 18, 1887, I give tables relating to eighty-eight provident dispensaries, having 293,720 members. These paid £52,252, while £16,691 came from honorary subscribers. I am at present engaged in collecting statistics from dispensaries for the year 1889. From these the following figures have been obtained:

On an average each member received 6·15 visits.

Each member paid 3s. 11¾d. per annum, or 0·90 of a penny per week.

The proportion of honorary subscriptions was 24·2 per cent.

„ „ paid by benefit members was 75·5 „ „

The wages and salaries was 14.02 of the total expenditure.

Each doctor received, on an average, 2s. 11d. per member per annum, or 6¼d. per visit.

The costs of drugs was 8·70d. per member per annum.

In referring to the above payments to doctors it must be remembered the visits include night and day visits, vaccinations, and confinements. Also, that all members do not contribute, as the rules provide that not more than 3 and 4 of a family shall pay. So that more are treated than are paid for or included in the total of members.

Only persons in good health should be admitted as members. Provident societies have been grossly abused; if a reform is not soon inaugurated the system will permanently suffer. Two causes have brought this about. First, no adherence to rules, with the result that persons become members who should not. Second, the voluntary charities have cast a jealous eye on this thrift movement, and by granting free medical aid to well-to-do persons have taken members from the societies. This conduct must always be a standing reproach to medical charity managers. In their pecuniary difficulties they have cast about for means by which they could

snatch a few 'pay patients.' The idea of indirectly offering the working classes free medical relief at the charities was sprung so as to seriously injure this thrift scheme.

I am aware many doctors object to the provident dispensary. They do not object so much to the provident system as to its abuse. A few who hold hospital appointments object to it because they see in it a reflection of their own actions, and think one charity is quite sufficient. Some who hold clubs object for this reason: when a doctor contracts to treat a club patient for, say, 3s. or 4s. per annum, he hopes to secure the club patient's wife and family; he calculates on securing the confinement and vaccination, and those due to illness of children.

Others object because the rules have been drawn up with disregard as to whether the proposal rests on a sound financial basis. Remember, I am not now speaking of a charity proposal. No tables of the rates of sickness have been consulted. No attention has been given to the fact that the extremes of life are admitted on equal terms of payment with adults; in fact, infants are admitted at a lower rate of payment, although their average rate of sickness may be put down at fourteen days per annum, while the adult generally averages nine days. Again, the originators do not seem to have fixed a 'wage limit.' Again, they made a rule which must prove deadly to any insurance scheme—namely, that a person, by paying what is known as the 'sick entrance fee,' had power to demand *immediate* treatment. Fancy any insurance company giving immediate benefits, and that, too, without a medical certificate. Therefore a great part of the failure of the provident scheme is due to this—that there is little use paying while well, as there is no difficulty in joining when sickness comes. Here the very essence of the insurance system is ignored. Take, again, another rule, which says: 'Not more than four children of a family shall be charged for, all the others being free to benefits.' What is the result of this? Dr. Stewart, of Manchester, has shown that fully 13 per cent. of provident (!) dispensary members are treated as charity cases; this, too, in a provident insurance.

Again, there is no 'sliding scale' for ages. All insurance companies have been careful to take particular note of this, as it would be unreasonable to expect all ages to pay a similar amount. Our provident dispensary promoters professed to take in old men, adults, infants, and chronic invalids. As regards the remuneration of the

medical staff, this is insultingly low. I found that the doctors were paid on an average a little over 6d. per visit. Dr. Stewart found it to be 4½d. Perhaps a wage-earner will say this is sufficient; well, ask this man if he is not paid from 6d. to 10d. per hour, and if he does not generally secure double wages if he work after 5.30 p.m.; yet he expects the skilled workman—one who has served an apprenticeship of some fifteen years, and who has expended from £600 to £800 on his education—not only to work at a lower wage, but to go out on a winter night, to walk a mile or so, to prescribe for a patient, and then to walk home (for I do not think the wage-earner would allow him a cab at 5s.), and all for the magnificent fee of 4½d., medicines thrown in. Why, even the privy and cesspool cleaners are better paid. If the working man says it is enough, then offer to give him 4½d. for every time you are called out at night, knocking him up and making him go with you. Rather than pay a night visit for four coppers to a class of the community who consider themselves many grades above paupers, who do not advance the plea of poverty, and who would feel insulted if told they were in reality charity cases—I would rather go out for nothing, than give them the power of pretending they were paying me for my services. And so I hold the doctor who goes out for such a fee is prostituting himself and degrading his profession. If his wife and children are starving, he should make some other start in life; or if he is treating these well-to-do people for this sum, so as to starve out a neighbour, he may be doing a sharp business trick, but I question the morality of his conduct.

Scarcely any provident dispensary has troubled itself with drawing up a scale of surgical fees. Perhaps these are included in the 4d.! The Shipston-on-Stour has tried to grapple with this point. Again, no dental tariff has been drawn up. Perhaps the scale to be suggested for the Public Medical Service would do. Another step in the downward direction is the rule which appoints midwives.

I am a firm believer in the provident system. It is the one suited to the financial condition of limited means. It can be placed on a firm financial basis. I would say the provident system cannot be self-supporting, whatever theorists may say to the contrary. Why, even the Foresters' Society has 13,971 honorary members, and look what they make from fines and lapsed membership. Practical Germany has recognised this plain fact. There they have compulsory insurance against sickness, accident, and old age for the wage-earning classes, and the employer has to pay one-third opposite

the two-thirds paid by the *employé*. The rent and taxes of a provident dispensary, cost of coal and gas, printing and stationery, drugs, wages of collector and dispenser, should be defrayed out of an honorary subscription list. Some have such, but it is not sufficient, for I notice that although eighty-eight dispensaries had an income of £52,252 from members' payments, still the medical staff receives only £34,989. The doctors, therefore, lose £17,262 by this unbusiness-like transaction, this money going to pay for the requirements of the members, that is, the fee has to pay, besides the visit, the collector and dispenser, printing, coal, and gas for the members.

One more point must be noted. If we charge at the rate of 1s. per man and wife, 6d. for each member of a family (taking four as an average), and allow six bottles of medicine at 2d. per bottle, this will put a cost of 42s. per annum on each family, or 8s. per member per annum, or 1½d. a week—the price of one glass of beer—a not too large sum when we consider the great advantages offered.

One thing we must have, and that is, hospital co-operation. No one can point to a provident dispensary having succeeded when it has had to compete with a free hospital. The present condition of affairs is a disgrace to us all, and the sooner we get rid of it the better. I do not wish to be a prophet of evil, but I have no hesitation in saying that the epitaph of a provident system will be, if it do not secure hearty and genuine co-operation, 'it died because it had not the good wishes and active encouragement of our brethren on the hospital staffs.'

In drawing up a table of payment for the benefit members, an 'age table' should be used, as in other insurances. I would charge every member 6d. per month, and place the different rate of payment on the 'entrance fee'; for, though the entrance fee would be paid yearly, each member would require to be examined by one of the medical staff before admission, and for this he would be paid 2s. out of the Hon. Members' Fund.

The scale of 'yearly entrance fees' would be—

	s.	d.
From the age of 0 to 8 years	2	0
„ „ 8 to 16 „	1	3
„ „ 16 to 40 „	0	6
„ „ 40 to 55 „	0	9
„ „ 55 to 70 „	1	0
„ „ 80 and upwards	2	6

When the entrance fee exceeds 1s., the balance to be paid from 'Hon. Members' Fund.' One penny would be charged for each separate prescription. A levy of 1d. per month would be placed on each benefit member, so as to help in defraying management. The fees for vaccination, surgical or obstetric operations, and confinements would be the same as those of the public medical service. The sum subscribed by honorary members would be one-third the amount paid by benefit members. I would fine any doctor or dispenser 5s. who supplied any benefit member with treatment or medicines who was in arrear with payments. Members would enter into benefits two months after joining. In case of confirmed illness, or infirmity or old age, a yearly entrance fee of 5s. would be charged, plus the 6d. monthly and levy.

The plan of placing the different scale of payments on an annual entrance fee is better than different monthly payments for each member. If hospitals turn away at least 42·32 per cent. of their present out-patients, the provident system would soon be a success. London —to begin with—would have a total of 700,000 benefit members in the first year.

Supposing we had a provident society of 1,000 benefit members, the following would give a fair idea of the expenditure:

	£	s.	d.
Rent and taxes	36	0	0
Coal and gas	3	0	0
Printing, postage, and stationery	12	0	0
Drugs, bottles, bandages, instruments, etc.	25	0	0
Examination fees to medical staff	100	0	0
Cleaning of branch	5	0	0
Dispenser, including residence at branch	65	0	0
Commission on collection of members' payments, 5 per cent.	15	0	0
Part payment of entrance fees	12	10	0
Furnishing branch	15	0	0
Salaries to medical staff	350	0	0
	£637	10	0

The income of such a branch would be :

	£	s.	d.
Sale of members' books, 2d. each . . .	8	6	8
Fines	1	0	0
Sale of drugs	20	6	8
Levy on benefit members	50	0	0
Entrance fees at 1s. 3d. each (average) . .	50	0	0
Monthly payments from branch members .	300	0	0
Subscriptions from honorary members . .	214	16	8
Total income . . .	£644	10	0

thus leaving a balance of £7.

The balance-sheet shows that with 1,000 members we should require an income of £637, and to meet this there would be a payment of £429 13s. 4d. from benefit members. A third of the former sum must, therefore, come from honorary subscribers, that is, £214 16s. 8d.

As regards the amount this would give to the medical staff of, say, four doctors, we should have from

	£	s.	d.
Examination fees from honorary subscribers .	100	0	0
Part entrance fees	12	10	0
Entrance fees from benefit members . .	50	0	0
Monthly payments	300	0	0
	£462	10	0

This would give on an average £115 12s. 6d. to each doctor, and, giving five visits to each member, this would make a fee up to 1s. 10d.

The average yearly payment by each benefit member would be :

	s.	d.
Average yearly entrance fee	1	0
Member's book	0	2
Twelve monthly subscriptions	6	0
Levy	1	0
Five prescriptions per annum	0	5
	8	7

This is about 8d. per month—2d. per week, or 1 farthing per diem; each benefit member would cost the society 12s. 10d. per annum, and would pay 8s. 7d. of this himself.

Some employers of labour will object to pay part, but such must be let to know that medical men have gone as far as they can in supplying medical aid on a charitable basis. The limit of unpaid medical service has been reached. I do not think 1s. 10d. is too high a fee for a night visit.

If a provident medical service is to be a success, there *must* be:

1st. Co-operation on the part of the medical charities.

2nd. Benefits confined to those who come within the wage limit, and

3rd. Assistance from employers of labour.

A provident society cannot be self-supporting. It may be *if the medical staff are unpaid;* when all income goes to provide medicine for members; and when collectors, dispensers, and others are paid. The rule, in some provident societies, which provides for the taking of one-third to one-half of the income due to the medical staff for the payment of management, is dishonest. It would be better if a levy were put on to cover expenses. This idea of insisting on the medical staff not only providing medical aid, but a sum sufficient to cover the cost of drugs and the salaries of others, is unfair.

The laws in Germany relating to insurance against sickness, accident, infirmity, and old age, insist on the employer paying one-third to the first fund, and one-half to the third.*

Will the working-classes accept the opportunity of becoming members of a provident society? In return, I ask, is not the desire to deal in the cheapest market always uppermost? Let a baker open a shop and invite all to accept free loaves. Will he not only soon run off his opponent, but degrade the neighbourhood? Yes; even if he go through the farce of giving his loaf for one penny. Just as the medical charity do, he will have a run on his shop—not only of the poor, but of all those who previously had no difficulty in paying for their loaf in the usual honest way. Fortunately, bakers have not yet gone in for this 'charity' business!

Consequently, if medical charity managers offer *free medicine*, we need not expect to see any thrift movement prosper.

I would here refer to the unfortunate effects caused by a non-

* See *Liverpool Daily Post*, of July 3rd, 8th and 11th, 1891, for a full description of these laws.

adherence to the rules in the case of the Manchester Provident Dispensaries. Originally, their wage-limit rule ran thus: 'The members shall be artizans and others in receipt of weekly wages, whose average family earnings do not exceed 35s. per week, and who are not in receipt of Poor Law relief.'

On January 19, 1882, the above dispensaries formed, with the Manchester Medico-Ethical Association, a committee, and recommended the following: 'It is the unanimous feeling of the committee that a wage limit is not satisfactory, and must lead to suspicion and jealousy among the medical men living in the neighbourhood of the dispensaries, while the inquisitorial investigation of their circumstances will naturally be resented by the working-classes. Your committee, therefore, think that the "wage limit" should be done away with, and that a sufficient check against the admission of those above the class of the really poor will be provided in part by making the admissions subject to the approval of the managing committee, one of whose functions should be to decide on the admission and removal of the members, and further by reference direct to the district provident society by medical officers and others of such cases as in their opinion ought not to have been admitted.' This was adopted at the adjourned annual general meeting of the dispensaries held in April.

Since then the dispensaries have been grossly abused, and it is not too much to say that a considerable part of the abuse of charities has not been eradicated, but simply transferred to the provident dispensaries.

In previous pages I referred to the provident or insurance department. I shall next refer to that part in which a wage-earner can obtain treatment by the payment of a small *immediate* fee.

In the *British Medical Journal* of June 22, 1889, I drew attention to the necessity for the formation of a Public Medical Service. The service is framed for the benefit of those who either do not wish to accept charity, or who are refused, after investigation, aid at the charity. Such a service is an absolute necessity. Suppose an inquiry into the social circumstances of charity cases showed that of every 100 who applied, 42 were found to be ineligible. The managers and the public have a right to ask: 'Suppose these are refused help —where are they to receive proper treatment?'

Again, the wage-paid classes have as perfect a right as any others to say, 'We object to join a sick insurance; we shall pay for our medical

treatment as others do.' If so, then we must provide them with treatment on the payment of a cash fee.

The argument in favour of this department is, that no immediate benefits in the way of treatment can be given under the provident department unless the person has been a member for some weeks. The chief rule of a provident society is, 'No person shall be eligible for treatment until he or she has been a member for at least one month.' If it were otherwise the idea of joining *while in health* would break down. Now, supposing a member is refused treatment at the charity, where can he go? Not to the provident department, for no immediate benefits are given. Consequently, there must be a cash department. Some enthusiasts propose to give *immediate benefits* under the provident department. Such a grant must, however, ruin the service. Others think that if a cash department were established it would work against the provident one. Well, if the wage-paid classes wish the one in preference to the other, are they to be denied their choice?

PROPOSED RULES.

1. Each town to be divided into districts, a branch being in each. The rent of the branch to vary from £25.

2. Each branch staff to consist of three to six medical practitioners and a dental surgeon. Medical and dental staff to be registered. No unqualified men to be engaged to assist or to act as *locum tenens*. Each practitioner to practise, in so far as he wishes, that branch of his profession which he may select, and to arrange the days and hours on which he will treat patients at the branch. Each practitioner to take the fees paid to him by the patient, but in cases of operations the doctors to arrange beforehand to assist each other and at a certain division of the fees paid in this case. No practitioner who keeps an open or branch dispensary, or an unqualified assistant, to be eligible to serve on the staff. Practitioners who have resided in the locality for two years to be eligible to serve.

3. Rates and taxes and other expenses of branch to be defrayed by an equal levy on the medical staff; no expenditure to be incurred without the consent of two-thirds of the staff.

4. That the registered chemists in the vicinity of each branch supply medicine to the patients at the rate of 4½d. for each prescription, this sum to be paid to the chemist by the patient when

the prescription is left to be dispensed. No prescription to be dispensed a second time by the chemist unless the patient has been advised again by his doctor. Prescriptions to be stamped and dated by the chemist. Standard mixtures, their formulæ to be arranged by the medical staff along with the chemists, to be prescribed, as far as is consistent with the right treatment of the patient. No prescriptions to be copied by the chemist into his books. The medical staff not to use any influence with patients so as to induce them to go to any particular chemist, but each patient to select whom he wishes, or that one who has recommended him to seek advice. Chemists to have the right to refuse to dispense a prescription on more than one occasion, if they believe that the patient so prescribed for is above the 'wage limit,' and until they discuss the matter with the doctor who has prescribed, and to arrange accordingly. [Such a plan is now carried out by many doctors who have clubs, and by those who act as surgeons to post-office officials. It would also save the cost of drugs and dispenser to the service, and by gaining the co-operation of chemists would do away with what is known as 'counter prescribing' or 'prescribing chemists.']

5. That the medical staff of each branch possess the right to refuse treatment to any who they know are making over the 'wage limit,' and further, that each doctor has the right to remonstrate with his *confrères* when he knows that a patient is receiving treatment who is above the 'wage limit.' That each practitioner has the right to tell patients to come to his house in cases where any special examination, as of the eye, ear, or throat, etc., is required, provided always that the patient is charged the service fee.

6. That registered dental surgeons be asked to co-operate, and that they arrange the days and hours on which they treat patients, and that patients be treated at the dentist's residence.

7. Patients to have the right to complain to the branch committee, and further, to the central board. Complaints to be made in writing, and not less than six days after alleged irregularity.

CONSTITUTION.

A central board for each city, to be composed of one medical practitioner, one dental surgeon, and one chemist from each branch —each elected by the branch committee—to have supreme control.

This central board to elect twelve public laymen who take an interest in provident and thrift subjects, these being eligible for re-election each year. The board to hold quarterly and annual meetings. Application to be made by not less than three medical practitioners, not in partnership, to the board when they wish to form a new branch. No one to use the title 'Public Medical Service' without the written permission of the central board. Each branch to have a committee composed of the medical and dental staff, to meet monthly. No branches to alter, or add to, any rules passed by the board. Proposed alterations to be sent in six weeks before the annual meeting. No branch to in any way canvass for patients, to distribute handbills, or to have any printed material on the branch other than a small brass plate on the entrance door, with the name of the service and of the branch on it. Each branch to fill up vacancies occurring in the medical and dental staff.

[Each branch may have a man and wife to reside there, the latter to act as matron; these to occupy rent free. It will be easy to obtain the services of a retired midwifery nurse or a pensioner and his wife.]

PROPOSED SCALE OF FEES FOR THE CASH DEPARTMENT OF THE PUBLIC MEDICAL SERVICE OF ENGLAND.

All Payments to be Immediate.

MEDICAL FEES.—Visit at a branch: 2s. for the first, and 1s. for subsequent visits during the same illness; or 4s. per week in advance for five visits (with or without prescription).

Visit at patient's home: from 11 A.M. to 6 P.M., 2s.; from 6 P.M. to 11 A.M., 5s. (with or without prescription).

Consultation at patient's home before 6 P.M., 10s. 6d.; after 6 P.M., 20s. for each doctor.

Visiting a second, third, or fourth patient at the residence of the first patient treated, 2s. each for the first day visit, and half this fee for subsequent visits.

When the patient lives more than two miles from the doctor's residence, and when he has to visit at this patient's home, the doctor may charge the cost of cab for out and home journey.

	£	s.	d.
Remaining all night with a patient	1	0	0
Remaining with a patient after the first half hour, per hour, or part of an hour	0	5	0
Not more than two visits a day to be paid to a patient unless he or his relatives request further visits to be paid			
LETTERS AND CERTIFICATES OF ALL KINDS.—2s., exclusive of postage.			
VACCINATION.—With human lymph, including subsequent inspection and filling up certificate, 2s. 6d.			
With calf lymph, ditto, 3s. 6d.			
OBSTETRIC FEES.—Abortion or premature labour (with three subsequent visits)	1	0	0
Normal labour (including three subsequent visits)	1	5	0
Labour, with forceps	1	10	0
„ „ turning	1	15	0
„ „ craniotomy	2	2	0
„ „ transfusion	2	2	0
Anæsthetic at any of the above	0	7	0
Removal of after-birth without conducting confinement	1	0	0
Dilatation of cervix with tents, bags, or instruments	0	10	0
Help, in connection with difficult labour, from another doctor	1	0	0
Induction of premature labour, and completion of such labour	1	15	0
Treatment of severe *post-partem* hæmorrhage	0	10	6
Treatment of *ante-partum* hæmorrhage (exclusive of confinement fee)	0	7	6
Examination of wet nurse	0	2	0
Operation for recent rupture of perineum	0	5	0
Cæsarean operation	2	10	0
Irrigating vagina or uterus	0	2	6
GYNÆCOLOGICAL FEES.—Treatment of minor affections of uterus	0	2	0
Removal of small tumours from vulva, vagina, or cervix	0	3	6
Introducing pessary (pessary included)	0	2	0
Curvetting interior of uterus	0	7	0
Operation for atresia of vulva, vagina, or cervix	0	7	0
Operation for imperforate hymen	0	7	0

	£	s.	d.
Operation for old rupture of perineum . . .	1	1	0
Post-Mortem Fees.—External examination of dead body	0	7	6
Post-Mortem examination, partial	1	0	0
„ „ „ complete	2	2	0
Written statement regarding *post-mortem* examination .	0	10	6
Surgical Fees.—Passing catheter	0	2	0
Removal of small tumour . . . . 3s. 6d. to	0	10	0
Removal of tonsils, or enlarged glands . . .	0	10	0
Removal of nævus, tenotomy, circumcision . . .	0	10	0
Harelip, operation for	0	10	0
Reduction of hernia	0	10	0
Removal of ingrowing nail, or opening of abscess .	0	2	6
Treating simple wounds, burns, or scalds . . .	0	2	0
Treatment of simple or compound fracture or dislocation (apparatus included) of the arm . . .	0	15	0
„ „ „ „ ribs or clavicle	0	12	6
„ „ „ „ thigh or leg .	1	10	0
„ „ „ „ jaw . .	0	10	0
Amputation of finger or toe	0	10	0
Testing sight (glasses not included) per visit . .	0	3	6
Operation on eyelid or eye . . from 5s. to	1	0	0
Treatment of disease of the ear	0	2	0
Operation on ear by knife or snare	0	3	6
Washing out of stomach	0	5	0
Chloroform or ether administration	0	7	0
Consultation at branch	0	7	0
Consultation at patient's home (see above) . . .	0	10	6
Testing urine, chemically and microscopically . .	0	2	0
Removal of nasal polypus	0	5	0
Removal of foreign body from ear or nose . . .	0	2	0
Tracheotomy	0	12	6
Skin-grafting	0	2	6
Paracentesis of the thorax or abdomen . . .	0	7	6
Tapping hydrocele	0	5	0
Operation for fistula *in perineo*	0	7	6
Operation for internal hæmorrhoids	0	12	6
Operation for imperforate anus	0	10	6
Cupping, dry or wet	0	5	0
Venesection	0	7	6

	£	s.	d.
Leeching	0	2	6
Washing out the bladder or bowel	0	3	6
Seton, or issue	0	2	6
Administering an enema	0	2	6
Wet packing	0	2	6
Application of constant or induced current	0	3	0
Stretching or stitching a nerve	0	10	6
Arresting arterial or venous hæmorrhage	0	2	6
Removal of foreign bodies from eye or throat	0	2	6
First treatment of a sprain of upper or lower limb	0	2	6
Operation for paraphimosis	0	10	6
Injecting bowel with air or fluid for intussusception	0	4	6
Reduction of strangulated hernia	0	10	6
Operation for strangulated hernia	1	0	0
„ rectal ulcer	0	2	6
„ „ fissure	0	2	6
„ „ stricture	0	7	6
Extraction of foreign body from urethra	0	3	6
Treatment of urethral stricture by bougie, per sitting	0	2	6
„ „ „ „ operation	0	15	0
Puncture or aspiration of bladder	0	4	6
Crushing stone in the bladder	0	10	6
Aspiration of joints or cavity	0	4	6
Strapping testicle	0	2	6
Extirpation of testicle	0	10	6
Plugging the nostrils	0	4	6
Measuring and fitting felt or plaster jacket	0	3	6
Doctor's assistance at an operation at patient's home or at branch, equal to that mentioned as the full surgical fee			
Excision of the breast	0	10	0

In case the fee for an operation is not mentioned in the above list, such fee shall be fixed at a meeting of the branch committee, at which at least three-fourths shall be present. Scale of fees to be revised every fifth year. The above scale of fees refers to operations performed before 7 P.M. After that hour an extra half fee may be charged.

	£	s.	d.
DENTAL FEES.—Extraction per tooth	0	1	0
Extraction each extra tooth	0	0	6
„ under gas	0	2	6
„ „ and each extra tooth	0	0	6
Stopping with amalgam, per tooth	0	2	0
„ „ gold „	0	4	0
Extractions under ether or chloroform	0	12	6
Artificial tooth, with vulcanite plate	0	4	6
„ „ „ „ and each extra tooth	0	2	0
Scaling teeth	0	2	6
Examination of all the teeth without operation	0	2	0
Small operations on the gums, or removing tumour	0	3	6
Regulating apparatus for deformed jaw or teeth, made of tin or vulcanite	0	7	6
Visits to patients' homes, the same as medical fee for such.			
Cleansing and stopping of root, the same fee as stopping of tooth.			
Administration of ether or chloroform by doctor for dental operation	0	7	0

CHEMIST'S CHARGE.—4½d. per prescription.

In case more than one prescription is dispensed at one time for the patient, such as a mixture, pills, ointment, or liniment, the sum of 3d. shall be charged for each. No prescription to be renewed for the patient by the chemist until the patient has been again advised by the doctor. No copies of prescriptions to be given by the chemist to the patient. All prescriptions to belong to the doctor who wrote them.

I have drawn up this scale after prolonged deliberation, having taken the opinions of doctors, dentists, chemists, and employers of labour. The scale is drawn up greatly in favour of the wage earner, and the fees quoted are much below those paid by the Poor Law. I suggest the scale of surgical, obstetric, gynæcological, dental, and vaccination fees, and those for letters and consultations, be adopted as the scale for the provident department, while the fees relating to visits and medicine be considered separately.

In none of the above surgical fees do the amounts mentioned include subsequent visits, these being charged at the usual rate for

visits. Nor do they include the fee for an anæsthetic. They include material used for dressings. In these cases, when the surgical fee is fixed at, say, 2s. 6d., this means the fee covers all the charge, and, therefore, does not give the doctor the right to charge the surgical fee *plus* the fee mentioned for a visit. I have been asked to draw up a scale of fees which will compete against bogus dispensaries and commercial medical charities. I had rather not do so.

In this proposal we should give each doctor the right to refuse treatment to those whom he considers ineligible, such as fever cases, or those suffering from acute illness, which should be treated at home. Also, doctors would be given the option of refusing to visit a patient at his home, although he would treat patients at the branch two or three times each week at certain hours. By having a branch in each district of large towns the doctors would not be required to travel more than a mile or so, and so would save much time.

It has been asked, How could the wages paid classes and medical practitioners be prevented from abusing the service? That it will be open to abuse few will doubt. One of the great facts of life is, we can never secure perfection, except, perhaps, in ourselves! As the doctors, dentists, and chemists are to act, they will mutually check each other. The two latter do not pose under the 'self-denying' order. A notice should be placed in the waiting-room calling attention to the 'wage limit,' and below it another, stating any doctor, dentist, or chemist found by four-fifths of the branch committees to have treated or supplied medicines to persons making over the 'wage limit' shall be fined 40s., such fines to help in defraying the rent of branch; or, perhaps the rules might be registered under the Friendly Societies Act, or a memorandum of the society registered under the Companies Act.

As regards the scale of fees fixed, they are fair. In Saxony a Government tariff of fees has been drawn up. A full translation of this will be found in the *Provincial Medical Journal* of February, 1890. The tariff is drawn up for the guidance of County Court judges for cases of dispute. Any practitioner may *arrange* for the payment of a fee, but if no such arrangement has been made and the payment is disputed then this tariff comes in. In this country there is a scale of charges drawn up for solicitors, but not for medical practitioners. The scale of fees in Saxony appeared in the *Deutsche Medizinal Zeitung*, No. 56, July 15th, 1889. I have to thank Dr. K. Grossmann for his help in translating the paragraphs.

I have called attention to the two branches of this proposed public Medical Service separately, so that either one or both might be established. However, the two departments are closely dependent on each other.

It would be better if friendly societies and medical aid associations joined this Service. Friendly societies cannot supply *all* wage earners. Only about three and a half millions belong to them. There are also among these a considerable number of lapsed members. The Oddfellows and Foresters have 54,158 who lapsed in one year. Again, these societies frequently exclude those of dangerous callings, and take only those between the ages of eighteen and forty-five. The sick and infirm are also excluded, and but few women belong to them. Again, infants, boys, and girls are left out.

Practically, the working of the immediate payment department of a Public Medical Service is now in force. The plan requires to be only recognised and organized as a *public* service. A great number of practitioners now take lower fees than those mentioned. Such practitioners frequently supply large quantities of medicine, and charge extra for them. They also employ students and chemists as their assistants, and so, by employing cheap labour, can *apparently* supply cheap material. In reality, however, these 'cheap' doctors are the most expensive. I claim for a well-organized Public Medical Service :

1st. That it would relieve the voluntary medical charities of the well-to-do classes who now attend, and so check abuses.

2nd. It would supply a large proportion of the wages-paid classes with efficient medical treatment, and encourage them to depend more on their own efforts.

3rd. It would help to diminish both the sick-rate and death-rate by encouraging patients to apply at once for advice.

4th. It would lessen the number of quacks, prescribing chemists, unqualified assistants, herbalists, patent medicine vendors, and bogus 'workmen's clubs.'

5th. It would save practitioners a great amount of trouble, by reducing bad debts to a minimum, in keeping of books, the employment of collectors, or County Court summons.

No service should be established, (1st) unless the active co-operation of the Medical Charities Committees is guaranteed ; (2nd) unless the society is conducted as one of the public institutions of the town ; and (3rd) unless sufficient support is guaranteed to command success.

CHAPTER IV.

SOME EXISTING OBSTACLES TO THRIFT.

In the United Kingdom charity is 'the fashion,' and frequently the stepping-stone to notoriety—of a kind. Consequently we manufacture charity cases so as to maintain the reputation of being the most charitable nation.

How long the working classes will permit themselves to be degraded by accepting sops of charity—*i.e.*, generally money in aid of small wages—it is difficult to tell. As their rates of wages are increasing it is to be hoped there will be a corresponding decrease in their dependence on the charity of others, and efforts made to keep their relatives out of the poorhouses, and other charitable institutions. Unfortunately the fashion in many cases now is to relieve the sons and daughters of the duty of maintaining their aged relatives, and to break up the home. The best administration is that which makes the home the unit and the occupants of that home clean, temperate, and self-reliant. No doubt in a number of cases the wages are not sufficient to permit of the carrying into effect of such self-reliance. All along the principle in England seems to have been—and in some cases yet is—that the wage-paid classes are to be granted such wages as will always keep them depending on charity. The English Poor Law perpetuated this evil kind of charity by granting relief in aid of wages, and making grants proportionate to the number of children in the worker's family. Since then improvements have taken place. If the wages of the industrial classes go on increasing, and if at the same time they do not progress in thrift, then the middle classes—a class who have sometimes to bear privations—will refuse to contribute poor-rate. It is not the duty of anyone to support those who can, but will not, work. All along the order has been, if a man work not, neither shall he eat. A mawkish charity has done its best to prevent

the carrying into force of this everlasting law; some even asserting the Poor Law system of free medical relief should be extended to the entire community! Much better results would accrue if each person were educated to rely on his or her own efforts and to depend less and less on the charity of others. I have already referred to our voluntary charities as being one of the most pauperizing influences in force. The Poor Law also contributes its share, as it is impossible to have a widespread thrift organization where wage-earners know there is always the 'workhouse' to fall back upon. The Rev. Malthus has said: 'I feel persuaded that if Poor Laws had never existed in this country, though there might have been a few more instances of very severe distress, the aggregate mass of happiness among the common people would have been much greater than at present.'

On the 1st of January, 1889, of 817,335 persons who received Poor Law relief on that day, 73,418 were insane, 7,058 were vagrants, 170,090 were adult males, 308,543 were adult females, and 257,407 were children under the age of sixteen. Of the adult men and women 374,635 were not able-bodied. A large proportion of the above became insane through drink, while the 'not able-bodied' should have been provided for by a scheme of pensions for infirmity and old age. Unfortunately for them, Thrift is not fashionable.

A reference to the return—No. 36, December 9th, 1890—moved for by Mr. Burt, M.P., shows that the number of persons, exclusive of lunatics and vagrants, *above the age of sixty* in receipt of Poor Law relief on August 1st, 1890, was 286,867. Of this number 102,563 were males, and 184,304 females.

These figures show that, taking all inhabitants in England *who were above the age of sixty*, one in every seven was a pauper. Is this a 'necessary evil,' and are not the industrial classes chiefly responsible for this evil? No doubt there are members in every stage of society who disgrace themselves and their relatives, but usually the well-to-do do not allow these to become chargeable to the State. If it is true, as Dr. Farr states, that an agricultural labourer who is worth £246 at the age of twenty-five, is worth only £1 at the age of eighty, surely we should lay this lesson to heart, and have insurance against infirmity and old age, as in Germany. Or is every old or infirm person to be bundled into a workhouse? Looking on this subject from a thrift point of view, is it to be wondered at that Dr. Chalmers

and others offered so firm a resistance to the introduction of the Poor Law system into Scotland?

The enormous consumption of spirits and beer in this country is a third great obstacle to Thrift. The Rev. Dr. Burns, in his letter on the National Drink Bill, calls attention to the deplorable fact that £139,495,470 were spent on alcohol during 1890. Taking the population of the United Kingdom at 38,227,321, *on an average each person* spent £3 13s. a year, and *each family*, consisting of five members, spent £18 5s. a year on alcohol. Therefore, each person spent, on an average, 1s. 4d. per week. It is to be noted the expenditure, if laid against only those who drink, would be much greater. In order to lessen the apparent expenditure, the entire population, even infants, and those who abstain, is included. In 1881, the consumption of wine and spirits was 1·29 gallons per head; in 1888, that of beer was 26·8 gallons per head—infants included.

The increased expenditure is said to be due to the rise in the wages paid and to improvement in trade. It would have been better had no improvement taken place. A surplus has been secured to the Imperial Budget, and unfortunately this has been obtained, to a large extent, from the increasing drunken habits of the people. Such an increase means more asylums for lunatics and idiots, more police, more gaols, and more criminal work. Here are opinions of some of her Majesty's Judges: 'There is scarcely a crime before me that is not directly or indirectly caused by strong drink.' Another: 'I have no hesitation in stating that intemperance is directly or indirectly the cause of by far the largest proportion of the crimes that have come under my observation.' Another: 'If the enormities that have been committed in the last twenty years were divided into five parts, four of them would have been the issues and product of drinking at tavern or alehouse meetings.'

Had one-half of the above money been placed in the Post Office Savings Bank, there would be now fewer depending on State and voluntary charity. Unfortunately for humanity, Temperance is not fashionable.

In Liverpool, in 1888, there were 1,874 public-houses, and 241 beerhouses, or a total of 2,115, or 1 public-house for every 280 persons, infants included.*

* The *Manchester Guardian* of Jan. 5, 1889, published 'The Drink Map of Manchester,' showing the location of the public-houses. A similar map of Liverpool is published.

In the same year, 15,976 persons were drunk when apprehended, and of the apprehensions the great majority took place on Saturdays and Mondays. If each person spent 2s. on 'getting drunk,' a sum of £1,597 would be required. It is not the sum required 'to get drunk' which is so large, but the total expended by those who drink without touching the line of intoxication. This sum is small when compared with the loss of time, the loss of health, and the loss of life, due, directly or indirectly, to the consumption of alcohol.

The expenditure on tobacco is a fourth obstacle to thrift. In the year 1889-1890 the revenue from tobacco was £9,214,627. In 1889, 56,010,206 lb. were retained for home consumption in the United Kingdom. That is, the average consumption of tobacco, in its various forms, amounted to about 1½ lb.—infants, girls, and women included. Taking the average price of tobacco at 8s. per lb., here is an unnecessary expenditure of 12s. per annum per member. Some two years ago a practitioner connected with a medical charity called attention to thirty cases of blindness due to smoking of tobacco.

A fifth obstacle to thrift is *prostitution* and its accompanying diseases. In Liverpool, during 1890, 2,677 prostitutes were proceeded against by the police. In 1885, according to Dr. Lowndes, 1,165 were known to the police. In the city, at least 443 brothels were known to the police. If we take it that there is an expenditure of £20 per annum on each prostitute, this will give a total of £53,540. This figure does not include the sums spent on the diseases contracted by exposure to infection—a risk run in every case.

A reference need only be made to the amount of money expended *on music halls, boxing entertainments, theatres, and such places.* Anyone who has been present can easily calculate the large sums of money expended at these, which sums should not be so thrown away, so long as those who spend them are beholden to the charity of others in any shape or form.

Few practical persons will deny that humanity requires a certain amount of innocent amusements. But the honesty of the action *of any person* in depending on the charity of others, or in accepting help from a fund subscribed for the benefit of the sick poor—the poor in deed and not in word alone—when such person is spending money in any of the above 'luxuries,' or refuses to accept work of any reasonable kind when offered, is very questionable. It may be

—from the professional mendicant's point of view—a fine trick, but is it honest? This kind of charity, with your hand in your neighbour's pocket, is not a desirable—although a too common—custom.

Some sentimental natures may consider these remarks too strong, but I take it as a starting-point that none of us are entitled to spend either money or time in luxuries until we have paid twenty shillings in the pound, and until we have provided for that 'rainy day' which must come to the great majority.

If little money were expended on alcohol, tobacco, prostitution, or entertainments costing money, and if charity would confine its functions to assisting the deserving poor, some of the greatest obstacles to Thrift would be removed.

CHAPTER V.

SOME REASONS WHY THE INDUSTRIAL CLASSES SHOULD PRACTISE THRIFT.

As the industrial classes become old, their power to subsist on their wages becomes less and less. In other words, the young and healthy crowd out the aged. Dr. Farr has laid it down that—deducting the amount required for subsistence, the mean net value of each member of the male population, and estimated by the standard of the *agricultural labourer*, is £150. And as Newsholme, in his work on 'Vital Statistics' has shown, the child of the agricultural labourer

At birth	is worth	£5
„ 5 years	„	56
„ 10 „	„	117
„ 15 „	„	192
„ 25 „	„	246
„ 70 „	„	1

while at 80 years of age, the cost of future maintenance is greater than the earnings by £41.

The mortality *or death rate* in different occupations varies greatly. This can be seen by referring to Dr. Ogle's Supplement to the 45th Annual Report of the Registrar-General.

The *sick rate* also varies in different occupations, so much so that some friendly societies will not admit particular trades.

In England there is a large industrial population. The census of 1881 showed there were 5,772,092 males, and 2,877,176 females, between the ages of 15 and 65, entered under the three following heads:—

Males.		Females.
Domestics	238,577	1,401,030
Agricultural	1,123,241	52,036
Industrial	4,410,274	1,424,108

No practical person will suppose that these 8,649,259 men and women can attain any degree of comfort unless they are thrifty. Sir James Paget, with the aid of Mr. Sutton—the Actuary to the Registry of Friendly Societies, has shown that the 7,375,874 males between the ages of fifteen and sixty-five had 9,692,505 weeks' sickness, or on an average 1·314 weeks' sickness each per annum. Also, that the 7,941,330 females between the same ages had 10,592,761 weeks' illness, or over 1·334 weeks', or nine days each per annum. Therefore both males and females suffered 20,284,266 weeks' sickness. Supposing each had been making £1 per week, here is a loss of over £20,000,000 in one year through sickness.

It must be remembered, Friendly Societies such as the Oddfellows' when calculating the average number of days' sickness, do so on the number of days or weeks on which the members draw sick-pay. Also, that no sick-pay is given to those who bring on disease through their own misconduct, or until they have been members for six months.

The above figures take in only those between the ages of fifteen and sixty-five. If, however, the number of weeks' sickness which affects those *under* fifteen years of age, and those *over* sixty-five were included, the number of days' sickness per head would be doubled. Even among the British troops stationed at home, the average annual sickness to each soldier is 16·27 days.

Dr. Farr has stated that to one annual death in a body of men, two, on an average, are constantly sick. In 1888, the number of deaths registered in England, was 510,971; therefore there must have been at least 1,021,942 constantly sick. It may be here stated that the average duration in weeks of each attack of total (bedfast) sickness occurring between the ages of ten and thirty-five is, according to Neison, 4·372 weeks.

These statements go to show that owing to sickness, and the loss of wages, forethought must be exercised by those who have only moderate incomes, and especially when the income often ceases during sickness.

Few—very few—have any idea as to the enormous amount of money lost through sickness or death. The following figures may serve as an object-lesson. From 1861 to 1870 there were, on an average, 22,416 deaths to every 1,000,000 persons living; while from 1871 to 1880 the proportion of deaths was 21,282. This, therefore, gave a saving of 1,144 persons annually to each million, or

a gross yearly saving of about 30,000 lives. If each one of the entire population is worth £150, then the saving effected through the prolongation of life and the shortening of the duration of sickness is worth about six and a half millions sterling to the country.

This saving of life and health has led to the formation of a New Life Table, which has been based on the death rate from 1871 to 1880. The Old Life Table gives the mean lifetime of males at 39·91 years, while the New Life Table fixes it at 41·35 years. Therefore a million males would now live 1,439,139 years more than would be the case according to the Old Table. Similarly, for females, the expectation of the duration of life has been augmented by 2·77 years each. Consequently a million females would now live 2,777,584 more years than those who lived prior to 1871. Such facts should encourage medical charities not to rest contented with treating the symptoms of disease only, but to remove the causes; while they should stimulate the industrial classes to cleanliness and thrift.

The late Sir Edwin Chadwick estimated the cost of *avoidable* deaths and sickness in Manchester in 1881 as amounting to 7s. annually per head of the population, or an unnecessary outlay of £51,800 in one year.

CHAPTER VI.

SOME PRESENT CONDITIONS OF THE INDUSTRIAL CLASSES.

(*a*) *In England.* (*b*) *In Liverpool.*

THAT the industrial classes are fairly well paid few will doubt. Broadly speaking, they possess opportunities which should make them less dependent on charity. A great improvement is necessary, when one in every thirty-seven of the population receives relief from the Poor Law; and when one in three say they are unable to provide themselves with medical treatment. Some years ago Lord Shaftesbury said the aggregate receipts of the wage-paid classes in this country was not less than £400,000,000 per annum.

Mr. Giffen—the eminent actuary—stated in the journal of the Statistical Society, March, 1886, that the wages of the working-classes have improved by 50 to 100 per cent. during the last fifty years, and that the hours of labour have been shortened by about 20 per cent. It is to be hoped a further improvement will take place, and that year by year the granting of charity in aid of wages will become less frequent.

Mr. C. Booth, in his work, 'Life and Labour in the East-End of London,' says that 'out of a population of 908,958, fully 577,000, or 65 per cent., are classes in comfort rising to affluence.' In arriving at these figures, he had the assistance of the inspectors of the London School Board. The East-End of London is held up by some as one of the poorest localities, yet 65 per cent. are in comfort.

In the Savings Banks of England and Wales, for the year 1887, no less than 1,193,803 'accounts' had a total of £35,872,468 owing to them.

In the Post Office Savings Banks, in 1888, there were 4,220,927 accounts open, with £58,556,394 standing to their credit, or on an average £13 13s. 10d. due to each.

Such figures are encouraging, but instead of the 5,000,000 of accounts, there ought to be, at least, 20,000,000.

Mr. S. Smith, M.P., has said that in Germany and France, of every 1,000 persons, 900 save in times of prosperity, while in England, of every 1,000, probably 200 do not.

In 1888, one in every seven of the population of England had a deposit account in the Post Office Savings Bank; one in twenty-seven persons in Scotland, and one in twenty-eight in Ireland.

Mr. Ludlow, the Chief Registrar of Friendly Societies, has stated about 7,000,000 persons belong to the different collecting and friendly societies; and of this number about 3,500,000 are insured for sick pay, the others being death policies. Not less than 20,000,000 of people should be insured. About 16,000,000 are insured in Germany.

Mr. Farrie has called attention to the fact that in 1886, out of a population of 36,000,000 in the United Kingdom, fully 30,000,000 are not paying income-tax, this number depending on incomes of less than £3 per week per family. As each family consists of, on an average, five persons, this would give 6,000,000 heads of families, or what Mr. Farrie styles 'bread-winners.' Therefore, supposing that only one in five is a wage-earner at £3 per week, or £18,000,000, this would give the enormous sum of £936,000,000 *per annum* as the income of 30,000,000 of people. It is not right to suppose that only one person in a family of five is a 'bread-winner,' as in a large number of cases those over the age of ten earn wages. Mr. Matthews, M.P., in a speech made in the House on the Free Education Bill, said there were in Lancashire, Cheshire and Yorkshire 32,400 children between the ages of ten and twelve earning £302,000 a year, there being in the rest of England 175,437 half-timers in the factories. How much more is made by boys and girls not working in factories? It must be remembered the income-tax returns are filled in so as to fix incomes at the lowest figure. Besides, a great amount of income is received on which no income-tax is paid.

The following will give some idea of the rates of wages drawn by a class who frequently apply for free medical relief:

If anyone will refer to Blue Book c. 5,505, 'Statistical Table of Trades Unions,' he will find there the rates of wages mentioned. It is to be noted that the *average* wage is struck. This 'average wage' is very much less than the ordinary weekly wage, for the average is struck after deducting the loss from sickness, strikes, unemployed, and accidents.

The following are taken as examples :

Name of Trade Union	Average Weekly Wage.
Society of Engineers	26/- to 38/-
Society of Carpenters and Joiners	20/- „ 42/4½
Steam Engine Makers' Society	26/- „ 38/-
Society of Ironfounders	24/-
Boiler Makers and Iron Shipbuilders	34/-
National Union Boot and Shoe Riveters	Piecework
Society of Coach Makers	24/- to 40/-
Pattern Makers' Association	31/7½
Bricklayers' Society	Sum. 24/- to 42/- ; Wint. 18/- „ 38/6
Ironmoulders of Scotland	31/6
Society of Compositors	36/-
Journeymen Bookbinders	32/-
Blacksmiths' Society	28/-
Operative Cotton Spinners	—
Society of Railway Servants	—
Stone Masons' Society	20/- to 35/3½
Society of Painters and Decorators	38/6
Carpenters and Joiners	—
Glass Bottle Makers	30/-
Northumberland Miners	32/- to 40/-
Kent and Sussex Labourers	12/6
Warehousemen's Phil. Society	24/- to 28/-
Association of Pressmen	36/-
Operative Bakers	26/- to 30/-
London Operative Zinc-workers	36/- „ 39/-
Bristol Institute of Engineers and Operatives T. U.	varies greatly
Leith and District Coopers	27/-
Bricklayers' Trade and Accident	27/- to 36/-
Society of Carpenters and Joiners	39/-
Overlookers' Provident Society	varies
Operative Plasterers	26/- to 39/-
Smiths' Society	30/-
Plumbers' Association	33/4

These figures give a fair idea of the average amount of weekly wage earned by various classes in the community.

(*b*) *In Liverpool.*—The following statistics will, approximately, give an insight into the conditions of the population of the city of Liverpool.

Population in 1890, 517,951.

Area, 5,210 acres, or 115 persons to each acre; thus giving forty-two square yards, on an average, to each person. This area includes the docks and half-way into the river. It is the smallest area per person to any city in the United Kingdom. If the local area of certain portions of the city were taken it is likely there would be one person to fifteen square yards.

Sex.—Of the above population in 1881, males 271,996; females 280,512.

Condition as to marriage.—Unmarried, 326,385; married, 190,026; widowed, 36,097.

Age:

Under 15 years of age	196,868
Between 15 and 60	341,528
Above 65	2,392

5,070 died before reaching their fifth year. Farr has said, the chances of an infant living one year are 851 to 149.

Inhabited houses, 92,307; uninhabited, 10,291; building, 816. On an average, five persons to each house.

Occupations in 1881:

	Males.	Females.
Domestic .	3,079	30,549
Agricultural	1,641	57
Industrial .	96,869	28,996
	101,589	56,602

Total, 151,191.

These figures are taken from the Census returns of 1881. When the Census is taken the community is divided into six classes—professional, domestic, commercial, agricultural, industrial, and non-productive. These are again sub-divided into twenty-four orders of occupation, and eighty sub-orders. Errors creep into these returns, as one person may have two or more occupations, while a person entered under 'tailor' may be either a wage-paid or a merchant tailor. I have been unable to state the 'occupations' of the in-

habitants of West Derby and Toxteth, as these are not given in the Census returns as presented to Parliament Only sanitary districts with a population over 50,000 are so returned.

The difficulty of obtaining accurate *local* returns will be felt until English cities follow the example of Paris and Berlin, these possessing power of taking a census for their city whenever it is so wished.

Number in receipt of Poor-Law relief on December 29, 1888, from the parish of Liverpool, 6,474.

Inmates of workhouses, hospitals, gaols, etc., on Census day, 1881: 11,355 resided in the above, and in the barracks and non-medical charitable institutions *in the three unions;* of which number 5,791 were located in the city. There were also 641 blind, 337 deaf and dumb, 417 officially recognised idiots, and 137 lunatics.

Number who received relief from the twenty-two voluntary medical charities during 1888, 272,372.

Number of public-houses and beerhouses in city, exclusive of 115 grocers' licenses, 2,115.

Number of brothels against which the police took action in 1890, 137.

Number of prostitutes proceeded against during 1890, 2,677.

Number of cases proceeded against for drunkenness, 15,628.

Habitual male drunkards, 4,718; habitual female drunkards, 2,696.

Number apprehended on Saturdays for drunkenness, 4,315; on Mondays, 2,258; on Thursdays, 1,203.

Average consumption of beer per head (assuming this is at the same rate in Liverpool as throughout the United Kingdom) in 1888, 26·8 gallons.

Average consumption of spirits per head, 1881, 1·29 gallons.

Average consumption of tobacco per head, 1½ lb., or 12s. per head.

Average expenditure on alcohol, per head, in 1889, £3 6s. 8d.; or £16 13s. 4d. per family.

Number of theatres and music-halls, 8 and 6.

Number of insanitary houses in the city, 16,039.

Number of houses, with one, two, and three apartments, in the city. Such returns cannot be obtained, and so far as I can find out, only the census enumerators' books could furnish them.

Income-Tax Assessments.—I have failed to obtain returns of the amount of income-tax paid. These returns can easily be given, only officialism cannot be troubled. Some information on this head may be obtained from the Parliamentary returns of income-tax

assessments, 1890; the paper, number 234 of session 1885, and in Mr. Giffen's work 'On the Growth of Capital.' For the purposes of reference to the city of Liverpool I make use of Mr. Farrie's figures in his 'Toiling Liverpool.' As regards this city 17,766 persons paid under schedule 2. Allowing for a large number who transact business in, but reside outside of the city, he states that out of a population of 600,000, 550,000 are depending on incomes of less than £3 per week.

It is to be remembered that those who have incomes under £150 do not pay income-tax; and those making up to £400, deduct £120, and so pay on only £280. Most people fix their incomes for assessment purposes at the lowest. Again, under the Schedules B and C only property is recorded—no notice being taken of persons. Persons residing in the city may have incomes of over £1,000, derived from distant investments and property, no tax on which is paid in this city, and so no notice is taken of those in local returns. Besides, Mr. Giffen says there is an income of about £67,000,000 a year derived from capital on which no income-tax is paid.

Mr. Farrie states that about one in every five of the people in the city is a 'breadwinner.' I fear this is not correct. Let us take note of the number of boys in the Post and Telegraph Office, in shops and works, and of the number of girls and young women engaged.

Taking the above facts into consideration they do not show any 'squalid' conditions *due to want of work and wage.* Existing squalidness is greatly the product of drink, vice, and laziness.

Rateable Value of Dwelling-houses for Purposes of Assessment of Poor-rate in the City.—It has been stated the rent of a house should be one-tenth of the occupier's income. Each year poor-law guardians obtain returns of the *actual* rent paid for each and all of the houses in their parish, or union; thus obtaining the gross estimated rental. From this they obtain the annual rateable value by deducting 10 per cent. from the gross. After this the poor-rate for the year is fixed at so many pence on each £ of rent paid. This is considered a fair system of valuation, and most of the other local rates take it as a basis by which to levy their rates. As a rule, the payment of poor-rate falls upon the occupier. But all houses under a certain rental are 'compounded for' by the owner, so that *the owner* pays the rate. He is usually allowed a deduction of 25 per cent. on the rents, and pays no matter whether houses are or are not occupied.

Prior to the celebrated Poor-law Act of Elizabeth, in 1601, the paying of poor-rate was not compulsory. At that time the clergy 'gently exhorted and admonished their parishioners to contribute according to their means.'*

The following figures give the number of dwelling-houses in the *parish* of Liverpool in 1890, and their annual rateable value:—

£10 and under	— 19,240	*dwelling-houses*
between £10 and £20	6,428	,,
between £20 and £60	2,889	,,
between £60 and £150	318	,,

In the parish there were 26,883 dwelling-houses, and 3,293 shops with dwelling-houses attached, and a total of 43,600 assessments made. The annual rateable value of the assessments was £1,598,012.

I have been unable to obtain the figures relating to the West Derby and Toxteth unions. They can be given if only 'officialism' would not so dread a little work. A very large proportion of the houses must be 'compounded,' and so the rents appear lower than they actually are.

Liverpool Savings Bank:—

Year ending.	Amount deposited.	Amount repaid.	Number of accounts open.	Balance due to depositors.
1888	£705,954	£719,067	86,779	£2,270,687

On an average, £26 3s. 0d. due to each depositor. In the year, more money was drawn out than deposited. It is to be feared that, even with the increase in wages, the annual increase in the amounts deposited and the number of depositors has not multiplied as it should have done.

Liverpool Penny Savings Bank Association, 1888.—Number of banks, 180; amount due to depositors, £8,808; number of depositors, 51,891.

Remission of School Fees.—Fees paid by parish, for year ending March, 1891, £2,128. Number of families relieved, about 5,085. For West Derby, in the city, the number of families thus relieved was 3,500.

In order to arrive at some conclusions as regards the wages of the industrial classes in the city, I sent a circular letter to 118 trade

* 'The English Poor Law System,' H. Aschrott.

societies represented on the Trades Council, asking for answers to the three following questions: 1. Number of members; 2. Number constantly in work; 3. Minimum wage—exclusive of overtime. Unfortunately very few sent returns. I give the replies:—

Dock Labourers' Union.—(1.) 25,000; (2.) 10,000; (3.) 4s. 6d., 5s., 7s., per day of 9 hours. Night work is paid at a time and a half of the day wage. Therefore if a man work 48 hours he would make 25s. in that time. In 1890, the gross tonnage which entered the port was 9,654,006, representing a revenue of 1,030,189.

Amalgamated Union of Operative Bakers and Confectioners.—(1.) 700; (2.) 650; (3.) 34s., 26s., 23s., per week.

General Railway Workers' Union.—(1.) 1,000; (2.) —; (3.) 18s. to 24s. per week.

Amalgamated Society of Engineers.—(1.) 1,257; (2.) 1,247; (3.) 34s. to 40s.

Packing Case and Box Makers' Union.—(1.) 106; (2.) 100; (3.) 31s.

Operative Braziers and Sheet Metal Workers.—(1.) 210; (2.) 95 per cent.; (3.) 34s.

Amalgamated Metal Planers.—(1.) 1,524; (2.) 1,450; (3.) 31s. to 40s.

Tailors' Society.—(1.) 500; (3.) 6d. per hour, or piece work.

Amalgamated Slaters of England.—(1.) 30; (2.) 20; (3.) 38s., 11½d.

Bookbinders and Machine Rulers.—(1.) 200; (2.) 180; (3.) 32s., 40s.

Core Makers.—(1.) 40; (2.) 38; (3.) 30s.

Carters' Union.—26s. to 30s. per week.

In the Engineers' department of the City Corporation, about 1,000 men are employed, the wage varying from 3s. 6d. to 6s. 6d. per diem.

In the Scavengering department the wage is 3s. to 3s. 8d.

In the Dock Board the wage varies from 3s. 6d. to 6s. 4d., and in 1890 about 5,800 were employed.

The Police pay varies from 25s. to 32s. per week. About 1,640 police.

Post Office, Liverpool.—About 1,993 employed. Sorting clerks and telegraph clerks, male, from 12s. to 40s., and from 40s. to 56s. weekly wage; female do., 10s. to 28s., and 28s. to 35s. Postmen, 12s. to 28s. per week. Sick pay, stripe allowance, free doctor and medicines, uniform clothing, and superannuation also given.

Customs, Liverpool.—About 647 employed. Examining officers, £110 to £300 per annum. Out-door officers, £55 to £100. Boatmen £55 to 80: exclusive of about £5,973 for extra attendance. (See Estimates, Parliamentary.)

Those acquainted with the large number employed in mills, shipbuilding, and other public works can form a fair estimate of the rate of wages. The enquiry now taking place by the Liverpool Corporation into the rates of wages paid by contractors will afford valuable information.

In so far as I am aware no statistics relating to the condition and occupations of the people in Liverpool have been made. Such statistics are to be found in the books of the Census Enumerators. But these books are private; and unless some one in the Commons moves for a return, the public will not secure any information. Perhaps the enquiry by the Corporation into contracts will furnish some useful facts. What Mr. C. Booth has done in London, Mr. F. Scott has attempted in Manchester. The former obtained the help of the School Board, while the latter secured the help of the Manchester Sanitary Association. Printed forms were supplied and tabulated. Mr. Scott divided the people into three classes:—*Very Poor*, with an income of 4s. per adult per week; *Poor*, 6s. 3d. per week; and *Comfortable*, 8s. per week. He says the supporting of two children is equal to one adult.

An investigation of 4,102 heads of families, representing 20,271, gave the following results:—

Earnings:

50·10 per cent. were 'very poor.'
23·05 „ „ „ 'poor.'
26·85 „ „ „ 'comfortable,' 8s. per week per adult.

Habits:

49·25 per cent. were clean and temperate.
18·68 „ „ „ dirty and intemperate.
32·05 „ „ „ not classified.

Employment:

77·53 per cent. were regularly employed.
20·74 „ „ „ irregularly „
3·58 „ „ „ unemployed.
35·87 „ „ „ not classified.

He also gives statistics relating to the number of persons in houses with one, two, three, or four bedrooms. Mr. Scott's paper is published by the Manchester Statistical Society. Bearing on the last point a reference to the annual report of the Medical Officer of Health for Liverpool, 1888, shows that in that year there were 18,967 sub-let houses, and 764 rooms were 'indecently' occupied. In 421 instances, one man and two women were found in one bedroom; in 240 instances, two men and one woman; in sixteen, three men and one woman, and in two, two men and six women. How many similar cases *did not* come under the notice of the inspector? As much disease as would keep ten medical charities going must be created in these houses.

I grant the foregoing statistics relating to Liverpool are incomplete. They go to show that the larger portion of the poverty is preventible, and that if the labouring classes only practised thrift and temperance, more than half of our charities might be swept away. I think too much fuss has been made by those who refer to the 'poverty' of the labouring classes in Liverpool. Much more good would be effected if a close study of *the causes* which produce this 'poverty' were entered upon. If this is not done, then the professional mendicant will find Liverpool a happy hunting-ground.

One point is brought out clearly, viz., the rates of wages and the rental of houses, show the industrial classes need not depend on charity if they practise Thrift, and that if they do not look ahead and lay by when in work they must fall back on the workhouse or other charity. In fact, this is a rule which must be observed by all who have limited incomes. The amount expended on such luxuries as beer, spirits, tobacco, theatres and prostitution would, if saved, tend to make every man and woman in Liverpool independent of charity.

CHAPTER VII.

RECOMMENDATIONS.

If a thorough reform of the administration and management of voluntary medical charities is to be brought about, the following recommendations if put into operation may be of service. I shall first refer to such as should be applied generally, and then to local reforms.

A.—General.

I. *A Central Board of Supervision.* Government should be petitioned to pass an Act providing for the formation of a board of supervision of voluntary medical charities of England and Wales, such board to form a department of the Local Government Board. (See p. 28.) It should have power to fix the limits of relief, and provide for the recovery of expenses incurred on behalf of those who have received treatment, when such are found to be ineligible. Such power is possessed by the Poor Law, Metropolitan Asylum Board, and Sanitary Authorities. Aid should be given only *as a loan.* Power to surcharge Local Medical Charity Boards which grant unnecessary relief should be provided.

II. *Local Voluntary Medical Charity Boards.* The same Act should provide for the formation of such board in every town or city. If Parliament does not so provide, then each town might at once proceed to form such board. (See p. 28.)

III. *Providing, by legislation, for the Opening of all Poor Law Infirmaries, so that students may receive clinical instruction in these.* (See p. 20.)

IV. *The Application of a 'Wage Limit' for In, Out, Accident, and Home Patients.* (The necessity for such limit is now fully recognised, see p. 35.) A money, or income limit, is the most satisfactory and

the best working. Almost all taxation is based on income—income tax, poor rates, and local taxes. Again, admission to most charitable institutions is based upon income, and the granting of Poor Law relief follows this plan. So does compensation under the Employers' Liability Act. The German laws of insurance also adopt a 'wage limit,' and so, indirectly, do the friendly societies.

V. *The Adoption of one Uniform System of Inquiry (and Wage Limit) into the Pecuniary Circumstances of all Applicants for Treatment.* (I have, p. 41, recommended the adoption of a modification of the Manchester system. Some recommend the total abolition of out-patient departments.)

VI. *The Adoption of one Uniform System of Drafting and Publishing Annual Reports and Balance Sheets.* (See p. 88.)

VII. *The Providing by By-Laws, or Otherwise, for the Recovery of Expenses connected with the Treatment of those who are above the Wage Limit.* (See pp. 19, 43.)

VIII. *Discontinuing the Payment of Resident Medical Officers.* (Service by these should be looked upon more as a completing of the student's training or apprenticeship.)

IX. *Election of the Out, Home, and Resident Medical Staff by Examination, and for a Limited Number of Years.* (Such a plan is in force in Paris, and is known as *Concours.* This system keeps down 'medical rings,' damps professional jealousies, and gives the best men a fair opportunity. It would also prevent the monopoly of appointments by a few, elevate the standard of medical education to a higher level, and so generally benefit the public.)

X. *Ruling no Practitioner shall hold more than One Appointment in Connection with the Voluntary Medical Charities.* (In 1888 the 153 appointments at twenty-two Liverpool medical charities were held by 134 practitioners, some holding as many as three, and a large number being at the same time connected with the Poor Law. Resident medical officers are not permitted to hold more than one appointment. If such a rule were enforced the seeing of charity patients at the rate of forty to seventy an hour would cease. None of the out and home medical staff should be allowed to hold an appointment for more than eight years. If practitioners are excluded from the staff this will only lead to the establishing of more charities, and rightly, too, so long as the public believe the mere holding of an appointment at a charity gives the holder any particular skill over the practitioner who does not possess such. There were

in 1888 415 medical practitioners in and about Liverpool, yet only 153 of these held appointments at the voluntary medical charities. Such is a gross monopoly, and shows the existence of a 'medical ring' for controlling the posts. Unfortunately for the good of the community there is a small but socially and politically influential clique in the medical profession determined at all costs to keep down the standard of medical education, so that the great body of the profession may not be considered able to compete with them. These long for a return of the old *régime* when there was the poor ignorant apothecary at one extreme, and the titled physician at the other.)

XI. *Paying each Member of the Out and Home Medical Staff.* (This plan is in force at St. Bartholomew's. At the General Hospital, Birmingham, the assistant physicians and surgeons are paid £250 each, and at the dispensary each consulting physician is paid £150 10s. At the Dundee Infirmary the four district surgeons are paid £60 each, and the visiting staff £60 each. The local dental, consumption, and homœopathic charities pay some of their medical staff. The custom exists largely abroad, and is extending in Great Britain. Poor Law medical officers are paid. The clergy are paid, and so are lawyers. Why, then, should not the medical staff receive their due? Surely the public cannot expect practitioners to go on doing work for nothing. Have not the limits of unpaid medical services been reached?

It has been asked, Would the medical staff encourage abuse of charity if they were paid? Do the Poor Law medical officers encourage well-to-do people to throw themselves on the parish? They do not, and not only so, but they help the relieving-officers to do their work efficiently. Does anyone suppose medical staffs would encourage half-guinea patients to obtain relief?)

XII. *Ruling that those in Receipt of Poor Law Medical Relief should not Receive Treatment at the Voluntary Medical Charities.* (Such a rule would compel the Poor Law to provide efficient treatment for their in, home, and dispensary patients. It should also prevent one of the greatest evils of medical charity administration—viz., 'overlapping'—three or four charities doing the work of one. In connection with this I would recommend that the administration of the Poor Law dispensaries should be greatly improved. More medical officers should be appointed, so that sick paupers be not treated at the rate of fifty or ninety an hour. The medical officer

should hold only one dispensary district, while he should be given the power of taking senior pupil students with him. In Paris all the State medical charities are used for training students.

XIII. *Enforcing a Rule that Practitioners acting to Tontines or Sick Clubs should not send the Sick Members to the Charities.* (A very large percentage of abuse is due to this, but if such a rule were in force it would encourage friendly societies to pay for, and provide, good medical services. Their present provision is an unmitigated farce, and almost every good practitioner is ashamed to have anything to do with them.

The average number of days' sickness per member per annum of the Foresters' and Oddfellows' Societies was, during 1888, a little over eleven days each, and as their surgeons are paid at a rate of about 3s. per annum per member, this gives a fee of about 3½d. per visit, supposing each sick member receives eleven visits. But the above 'average number of days' illness' is calculated, not from the actual number of days' sickness per member, but from the number of *days on which sick pay is obtained.* Also, no members receive sick pay for illness under *three* days' duration, and no sick pay is given until members have been paying for six months, although in both cases when sickness occurs the surgeon has to give his services. The above 'average number of days' sickness' is misleading in so far as it gives a fair idea of the work done by the club surgeons. It is also to be noted that the above fee of 3½d. has to cover the examination and certificate of applicant for membership, the cost of drugs, fortnightly certificate during sickness, and surgical treatment.)

XIV. *The Entire Surrender of the System of Selling Charity—i.e., Granting so many 'Forms of Recommendation' for so much Money Subscribed.* (See p. 70.)

XV. *If Medical Charity Managers* wish to have a 'form of recommendation'—a plan open to little or no objection—then the following might be adopted uniformly :

FORM OF RECOMMENDATION.

Name of Medical Charity .....
Name of Applicant .....
Address..... Age ..... Occupation .....
Name of Employer and Address.....
In or Out of Work ..... Married or Single.....
How much Sick Pay drawn Weekly .....
If in receipt of Parish Relief .....
Are any of your Children or Wife Ill? .....
Duration of Illness .....
The Total Weekly Income of my Wife, Children, and Self, from all Sources, is .....
Do You at Present Receive Treatment from any Charity, or Practitioner? .....
Rent of House .....

I declare the above to be a correct statement.

Signature of donor.....

N.B.—Applicants giving wrong answers forfeit all claims to treatment. Donors of such forms will please note that all the above questions must be answered, else the 'form' will be useless.

(The rule relating to wage limits, inspection, and recovery of expenses to be printed on the reverse side. Somewhat similar recommendation forms are used at the Staffordshire General Infirmary, Swansea General Hospital, and Aberdeen Royal Infirmary.)

XVI. *The Abolition of Lock Charities is also Recommended.* (Venereal cases should not receive relief from the funds subscribed for the genuine sick poor. I have referred to this subject on p. 83. The Corporation should establish a Lock charity, in the same way as it provides for infectious diseases. It must be remembered that not five in every hundred venereal cases are really *cured* in the charities. Consequently they are discharged at a time when they are as dangerous to the community as are cases of scarlatina when allowed to leave hospital in the infectious stage. Power, therefore, should be given for the detention of all venereal cases in a City Lock charity. The State of Massachusetts has lately passed an Act bearing on this subject.)

Among the suggestions made to Sir W. Fergusson's committee, referred to on p. 8, are the following :

'I would exclude all cases of syphilis and gonorrhœa. (1) Because it is prostituting the charity to prescribe for such. (2) Because it is not generally the necessitous poor who contract these diseases. (3) Because the young men who have paid for contracting the disease are generally able to pay for its cure.')

XVII. *Home Patient Medical Staff should be appointed by all the General Medical Charities.* (Such a system would reduce the great overcrowding of, the prolonged waiting in, the *out* patient rooms. More important still, it would bring practitioners into direct contact with the *homes* of patients. It would also tend to diminish the spread of infectious diseases, as at present a considerable number of such cases are spread by their collecting in the *out* patient rooms. If such *home* patient treatment were successful then the *out* patient departments might be gradually done away with. Such home patient departments would be a good means for training senior students.)

XVIII. *Furthering the Formation of a Public Medical Service of England.* (As fully described on p. 95.) So that that portion of the wages-paid classes who are unable to pay the usual medical fees may be able to secure medical, surgical, obstetric and dental treatment on one of two plans. (*a*) By the payment of a small *cost* fee: or (*b*) by insuring against sickness under the Provident plan. (Although I do not hold that Medical Charity Managers should *directly* establish or administer such a service, still if they do not encourage and co-operate with it, it cannot compete with the free charities. If such a service is not established, the scheme of organization will not be complete. Where, for instance, are the patients who are refused relief at the charities to go? Not into the hands of quacks, prescribing chemists, unqualified practitioners and illiterate doctors. Very important also, in relation with the proposed establishment of such a Service, is the question of the actual "wage limit" for charities, for this must depend upon the system of medical aid which intervenes between charity on the one hand, and the usual fees charged by practitioners on the other. For instance, if the charity fixes a high "wage limit," then the necessity for a Service disappears, as both Charity and Service would then attend to the same class of wage earners. If, on the other hand, the "wage limit" is low, then there will be room for, and a call for, a Service which will

embrace that portion who are above charity, but who are unable to pay the usual medical fees.*)

XIX. *Furthering the Formation of Home Hospitals.* (See p. 92.) (Here again, this is not directly a matter for medical charity. If, however, the charity provides pay beds and pay wards *at a cheap rate*, and is subsidized by charitable funds, how can a Home hospital succeed? If such a Home hospital were established, the shares being subscribed by the medical profession and the public, one great reason for the selling of charity would be removed. The population of this city, with its many men and women clerks, sea-going men, clergymen and others, would surely supply such a number of patients as would bring success to such a speculation. The condition of the sick man or woman in lodgings is not enviable.)

XX. *The Maintenance by the City Corporation of an Ambulance and the Abolition of the Ambulances of Medical Charities.* (It would be an advantage if the ambulances were directly under the control of the police. Besides this, it is unfair to cast a public duty on two charitable institutions. The Corporation could claim repayment from those who used the ambulances and who are able to pay, while patients could be removed to any locality, instead of to the charity.)

XXI. Some have felt *the formation of a Night Medical Service*, such as exists in Paris (see p. 56), and other towns in Germany and the United States, would act well in Liverpool. (Perhaps it would, if its services were confined to a certain portion of society. However, the charities are always ready, and medical practitioners are present in superabundance!) Intimately associated with the question of Medical Charity Reform is the encouraging of employers of labour in the city shops and warehouses to establish Sick Societies for the benefit of their employés. I would only refer to the West India and Pacific S.S. Co.'s Mutual Benefit Society, where the following grants are made: sick-pay 12s. per week, free medical treatment and medicine, and £10 at death. This is obtained on the payment of a sum of 4d. weekly. Messrs. Tate & Sons, and Messrs. Cope Bros., have also similar societies. Every firm in the city should follow their example.)

* The articles and rules of such a service should be registered under the Friendly Societies Act, and be strictly enforced.

B.—Local.

I. *The Abolition of the following Liverpool Voluntary Medical Charities:* Cancer and Skin, Dental, Hospital for Diseases of the Skin, Foundling, Homœopathic, St. Paul's Eye and Ear, and Myrtle Street. (If the general charities found special eye and ear departments, then the practitioners now acting at the above could continue their work. All the general charities should have departments for the eye, ear, throat, skin, and teeth. It is almost a public scandal that twenty-one medical charities have only eight dental surgeons attached, and these mostly ornamental.

II. *The Abolition of the In-Patient Department of the Ladies' Lying-In Hospital.* (When a charity has on an average three patients per week, its existence is not justified, more especially when expenditure on maintenance and management is taken into account. This charity should carry out the plan in force at Newcastle and Oxford. At both, the employment of midwives has been discontinued. District medical officers are appointed and paid—at the former, £70 per annum, and 10s. 6d. per confinement; and at the latter, £40, and 10s. 6d. per case. I wish to enforce this point—that the poor lying-in women are far more in need *of nurses* than of midwives. True, the midwife washes the mother and baby, but I think the fact that so many uterine troubles among poor women—almost enough to keep three hospitals going—exist, shows they require more *continuous* assistance. The adoption of this plan would be of national importance. At present the 'training' of the medical student in midwifery and diseases of infants is almost a national disgrace. Those who know, express little wonder that in 1888 4,160 mothers lost their lives through the accidents of childbirth. Those who know, agree with the Registrar-General when he says that the number of deaths *registered* is far less than the number which actually take place. The horrible infant mortality in this country is also greatly due to the fact that the student is practically ignorant of infants' diseases.

For these reasons I would urge the Ladies' Charity Committee to see that all the work of their charity is performed by paid district medical officers; that in as far as possible nurses be substituted for midwives; and that each medical officer be empowered to take a senior pupil student with him to the cases. If midwifery is to take its proper position alongside of medicine and surgery, then it must

be taught and practised in the ways in which medicine and surgery are taught and practised.

III. If the two Eye and Ear Charities are not abolished, then I would recommend *the amalgamation of the St. Paul's Eye and Ear Charity with the Eye and Ear, Myrtle Street*, the medical staff of the former being provided with posts at the latter charity. (A similar amalgamation has lately taken place in the union of the Ophthalmic Institution with the Royal Infirmary, Glasgow. Similar amalgamations have been recommended in Dublin and Cork.)

The present craze of special hospitals should be put a stop to. Fortunately the 'special' doctor is now less in demand, and a higher standard of *general* medicine is taking its proper place. In London there is now a 'temperance' hospital, while lately 'women's' hospitals—specially run by women doctors—have sprung up.

If the above recommendations were put into operation, public confidence in medical charity administration would return. In 1888, the expenditure at twenty-two charities was £58,107, the income being £57,387, leaving them in debt to £12,037. If the invested funds and the annual income of the charities which I have alluded to were handed over, then the remaining charities would benefit. If the recommendations were carried out there would be an annual saving of over £10,000. Supposing 25 per cent. of the out and home patients were found to be ineligible, and taking the average cost of each such patient so low as 2s., this would effect a saving of £2,791. In the same way, suppose even 10 per cent. of the in-patients were found to be ineligible, and that each patient cost 30s., this would save about £2,384. I have, on page 38, referred to the fact that the costs of enquiring into the patients at Manchester is 1½d. each to the charities and 4½d. to the Provident Society.*

However, my point is, not so much that a large saving would be effected, or that fewer patients might receive treatment, but that the genuine poor, and not well-to-do persons, would receive that relief which the founders of Charities intended they should secure.

* I calculate that for the first year the cost of investigation of all the patients at twenty-two charities would be about £1,500. The mere fact that people knew an enquiry system was established would prevent many from presenting themselves. Such was the case at the London Hospital (see p. 4).

Baillière, Tindall & Cox, 20 and 21, King William Street, Strand.