Final report / Voluntary Hospitals Committee.

Mr Powell.

MINISTRY OF HEALTH.

Lancet

VOLUNTARY HOSPITALS COMMITTEE.

FINAL REPORT.

Presented to Parliament by Command of His Majesty.

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CONSTITUTION AND TERMS OF REFERENCE OF COMMITTEE.

I appoint :—

The Most Honourable The MARQUESS of LINLITHGOW,

The Right Honourable The VISCOUNT CAVE,

Sir CLARENDON HYDE,

Sir WILLIAM PEAT,

Mr. VERNON HARTSHORN, M.P., and

Mr. R. C. NORMAN,

to be a Committee to consider the present financial position of the Voluntary Hospitals, and to make recommendations as to any action which should be taken to assist them.

I further appoint the Viscount Cave to be Chairman, and Mr. L. G. Brock, C.B., of the Ministry of Health, to be Secretary to the Committee.

(Signed) CHRISTOPHER ADDISON.

25.1.21.

NOTE.

The estimated gross cost of the preparation of this Report, and of the Interim Report of the Committee (including the expenses of the Committee) is £540, of which £50 represents the gross cost of the printing and publishing of both Reports.

VOLUNTARY HOSPITALS COMMITTEE.

The Rt. Hon. Sir Alfred Mond, Bart., M.P.,
Minister of Health.

SIR,

1. We were appointed by the Minister of Health on the 25th January last to be a Committee "to consider the present financial position of Voluntary Hospitals and to make recommendations as to any action which should be taken to assist them." We understand that the Irish hospitals are not included in our reference. We have already submitted an Interim Report dealing with the question of contributions to Voluntary Hospitals by Approved Societies having a surplus on valuation, and this Report has been presented to Parliament [Cmd. 1206 of 1921]. We now have the honour to submit our final Report on the questions coming within the terms of our reference.

INTRODUCTORY.

2. We have held 28 meetings and have taken evidence from 93 witnesses. A list of the witnesses will be found in Appendix A.

3. In view of your desire that we should present our Report at the earliest practicable date, we have limited the evidence so far as possible to witnesses representing groups of hospitals or hospitals which might be taken as typical of a number of similar institutions. In the case of the London hospitals, we have taken evidence from the majority of those having medical schools, as well as from representatives of the different groups comprised in the London area. In the case of the provincial hospitals in England and Wales, the time at our disposal precluded us from attempting to take evidence from all the more important hospitals, and we have selected typical institutions situated in various parts of the country. But even if the period of our inquiry had been extended, we do not consider that any additional evidence which might have been obtained would have led us in any way to modify our conclusions. In order to avoid the expense and inconvenience of bringing a large number of Scottish witnesses to London, we asked Lord Linlithgow to hear some of the Scottish evidence in Edinburgh; but evidence from the Glasgow hospitals was heard by the Committee in London. The oral evidence was supplemented by a questionnaire which was issued to all hospitals outside the London area.

4. In addition to hearing witnesses representing particular hospitals or groups of hospitals, we have taken evidence from representatives of the Royal Colleges of Physicians and Surgeons, the British Medical Association, the British Hospitals Association and its committees, King Edward's Hospital Fund for London,

and from the superintendents of three representative Infirmaries established under the Poor Law; we have also received assistance from officers of the Ministry of Health and the London County Council. We take this opportunity of expressing our thanks to those hospital committees, secretaries and others who have so readily responded to our requests for information. We are specially indebted to King Edward's Fund and the British Hospitals Association, as well as to Sir Napier Burnett and to Dr. D. J. Mackintosh, of Glasgow, for the detailed and valuable statistics which they were good enough to furnish to us.

PRESENT FINANCIAL POSITION.

5. The number of voluntary hospitals in Great Britain is considerable. In the area covered by King Edward's Fund, which corresponds to the Metropolitan Police District, there are 117 voluntary hospitals of different kinds, including cottage hospitals. In the rest of England and Wales there are 728 hospitals, including general, special and cottage hospitals; and in Scotland there are 107 hospitals, making a total for Great Britain of 952. The number of beds available in these hospitals at the end of the year 1920 was, approximately, 12,797 in London, 31,265 in the rest of England and Wales, and 8,132 in Scotland, making a total for the whole of Great Britain of 52,194. These figures do not include convalescent homes or commercial undertakings, nor do they include the Poor Law Infirmaries, which are estimated to contain 92,000 beds. The number of out-patients treated at the hospitals is difficult to estimate, but some idea of their number may be derived from the fact that in the year 1920 the number of out-patient attendances at the 12 London hospitals having medical schools was 2,825,120. Probably the total number of out-patient attendances in Great Britain in that year was not less than 20 millions. The Poor Law Infirmaries have generally no out-patient department.

6. In dealing with the financial position of these hospitals we have treated them as going concerns, and have not considered it to be any part of our duty to ascertain the realisable value of their buildings and other capital assets, or the amount of the charges upon them. Our attention has been mainly directed to the question of their yearly income and expenditure.

London Area.

7. We propose to refer first to the hospitals in the Metropolitan area, in respect of which some figures abstracted from the returns are contained in Appendix B. These figures show that in the year 1920, 40 out of the 113 hospitals in that area for which figures are available, had a surplus of income over expenditure amounting, in the aggregate, to £97,240; but the remaining 73 hospitals had deficits amounting together to £463,413. These figures include free legacies amounting to £266,606, and the proceeds of some special appeals, and also the normal grants in

aid made by King Edward's Fund amounting to £153,700; but they do not include the special emergency distribution of £254,150 made by King Edward's Fund out of its capital assets on the 5th July, 1920, in order to help the hospitals over their immediate difficulties, nor do they include the sum of £200,000 granted by the National Relief Fund towards the reduction of war deficits. These special grants were sufficient, except in the case of some large hospitals with medical schools and a few special hospitals, to make up the deficiency for the year; but it is obvious that a renewal of these special grants cannot be looked for, and accordingly they should not be taken into account in estimating the future prospects of the hospitals.

8. As to the causes of the above deficiencies there is no room for doubt. Until the year 1913 these hospitals, notwithstanding some temporary difficulties, were able to meet their expenditure out of their receipts, and in many cases to invest a portion of their legacies and special donations. With the war came a steady increase in the cost of provisions, fuel, drugs and dressings, etc., and a growing demand for an increase in the salaries and wages of the nursing and domestic staffs; and although this increase was partly met by additional subscriptions and by the Government grants for pensioners, the expenditure has grown faster than the income, and the withdrawal of many of the military patients in 1919 completed the process. If the figures for 1920 in those hospitals which do not report any material alterations in size are compared with the corresponding figures for 1913, it appears that, while ordinary income has increased since 1913 by 67 per cent., ordinary expenditure has increased during the same period by 138 per cent. The increase since 1913 in the items of provisions, drugs and dressings, "domestic" (the principal item of which is fuel), and salaries and wages is shown in the table in Appendix B.

9. In order to complete this survey of the financial position of the London hospitals at the end of 1920, it should be added that at that date there was owing by those hospitals a considerable sum for overdrafts incurred during the preceding year, and also that at many of the hospitals the necessary repairs had been allowed, owing to war conditions, to fall into arrear. Further, there was in some cases great need for extension and improvement; and there had been submitted for the consideration of King Edward's Fund schemes for this purpose, the estimated cost of which, after crediting amounts received or promised (including a special grant of £250,000 by the Red Cross Society and the St. John Ambulance Fund), was no less than £4,505,450, of which £1,461,765 had been passed by the King's Fund as entitled to priority on the ground of urgent need.

England and Wales outside the London Area.

10. Turning now to the hospitals in England and Wales outside the Metropolitan area, we find that the conditions, though

in some cases serious, are generally of a more satisfactory character. The fact that, while in London the King's Fund is able to secure that the accounts shall be kept on the Uniform System, that system is only partially adopted elsewhere, makes it difficult to ascertain and compare the figures in the Provinces; but figures abstracted from the returns made by 452 of these hospitals are contained in Appendix B. These figures show that, while of the 452 hospitals 204 had a surplus amounting in the aggregate to £220,126, the remaining 248 had deficiencies amounting in all to £501,282. To this must be added any deficiencies arising in the 276 hospitals which have made no return, and the sums required for deferred repairs, improvements and extensions.

Scotland.

11. When we pass to the Scottish hospitals, the position is more hopeful. The returns obtained for us in respect of the year 1920, which are summarised in Appendix B, show that of these 107 hospitals 50 have a surplus amounting in all to £169,865, while 57 have deficits of which the total amount was only £73,623. These figures include free legacies amounting to £235,804, but not the special grant of £77,000 made by the National Relief Fund. This result is mainly due, apart from careful management, to the increase of workmen's contributions (which is a growing feature of many Scottish hospitals), and to the generous legacies bequeathed to these institutions; but it should be remembered that it is undesirable that the whole receipts from the latter source should continue to be treated as income. It should be added that there is a real need for the extension of hospitals in Scotland, and we were informed that there is little prospect of obtaining the amounts required for that purpose by voluntary contributions.

Summary.

12. Reviewing the financial position as a whole, we conclude that, whiile in certain areas and at particular hospitals the governing bodies have been able to encounter the difficulties caused by the war without permanent injury to the institutions under their care, the position of a large number of hospitals is such as to make it improbable that they can be continued on a voluntary basis unless prompt and vigorous measures are taken to re-establish the position of 1914. The receipts have not fallen off—indeed, they have increased; but the cost of provisions, drugs, dressings, fuel and labour has grown to such an extent that it far more than counterbalances the increase of income. There are indications that the cost of food, drugs and dressings, which is already falling, should show a marked reduction before the end of this year; but as to fuel the position is doubtful, and we do not anticipate that there will be any substantial reductions in the cost of the nursing and domestic staffs. Under these

conditions we estimate that unless some remedy is found there will be deficiencies in the present year in respect of the hospitals in the whole of Great Britain, including London, amounting to not less than £1,000,000, and this without any provision being made for the necessary extensions and improvements. The position thus disclosed appears to us to involve danger to the whole of the existing hospital system Two of the large London hospitals (King's and the London) have quite recently closed some of their beds owing to lack of means, and others have indicated their intention to take a similar course. Indeed, it cannot be expected that hospital managers will continue indefinitely to carry on their hospitals at a loss amounting, in some cases, to £1,000 a week And if any considerable number of hospitals should close down, the shortage of accommodation would be such that the public would be compelled to step in and supply the deficiency, and the position of the hospitals throughout the country would be imperilled We proceed, therefore, to consider what steps should be taken to meet the serious contingency that has arisen.

STATE OR RATE AID.

14. It has been suggested by some, but a very small minority, of the witnesses that liability for the hospitals should be taken over by the State or thrown upon the rates, or at least that a regular yearly grant in aid should be made from one of those sources. In our view either proposal would be fatal to the voluntary system. If it is once admitted that there is an obligation either on the State or on the local authorities to make good deficits, hospitals will have lost their incentive to collect and subscribers their inducement to contribute. A limited grant in aid, if proportioned either to voluntary subscriptions or to the cost of beds occupied, might not so swiftly have that effect; but it would be the beginning of the end, and not many years would pass before the hospitals would be "provided" out of public funds. Further, any yearly grant in aid would presumably be made to all hospitals alike, including those which are able to pay their way and require no such assistance; and this would involve a waste of public money which should by all means be avoided. If the voluntary system is worth saving, any proposals for continuous rate or State aid should be rejected.

VOLUNTARY SYSTEM.

15. Is the voluntary system worth saving? We are convinced that it is. If that system falls to the ground, hospitals must be provided by the public, and the expense of so providing them would be enormous. They must then be carried on without the aid of the voluntary subscriptions and donations estimated at not less than £3,000,000 a year, and presumably without the income (about £1,000,000 a year) from endowments which were given to support voluntary hospitals only. The wages and

other disbursements would undoubtedly increase; and the payment of full remuneration to the administrative and medical staffs would at once become an urgent question. But the money loss to the State would be a small matter compared with the injury which would be done to the welfare of the sick for whom the hospitals are provided, the training of the medical profession and the progress of medical research. The physicians and surgeons, many of them of world-wide reputation, who now readily give their time and experience on the visiting staffs of the voluntary hospitals—in a few cases at a nominal remuneration (which dates from Tudor times) of about £50 a year, but otherwise wholly without remuneration—could hardly be expected to render the same service to a State-supported institution; and that personal relation between the patient and the doctor and nurse which is traditional in voluntary hospitals, and which in many cases renders the time spent in the wards the happiest period of a patient's life, would be difficult to reproduce under an official *régime*. The educational side of the present system, although this is hardly sufficiently realised by the general public, is of not less importance. The combination of the hospital with the medical school is of inestimable value to both. On the one hand the teaching of medicine would be ineffective without the opportunities for observation and experience which the hospital affords, and on the other hand the constant presence in the wards of teacher and student and the desire of both to maintain the reputation of their hospital are an incentive to care and vigilance in the treatment of the sick. Until quite recently, when some assistance has been rendered through the University Grants Committee, medical training in this country has been a private enterprise; and it is still so in a large measure. It is in the wards of the voluntary hospitals that most of the doctors who rendered such fine service in the war were trained, and it is there that the majority of the young doctors and nurses upon whom the future health of the country depends, are being equipped for their work. Moreover, the existence of this field for experience and research has resulted in many discoveries which have been of inestimable service to the health of the race and have made our medical service second to none in the world.

Nor does this conclude the list of losses which might be incurred if the voluntary system came to an end. The infinite care and time which is given to the management and support of voluntary hospitals by Boards of Management, Hospital Aid Societies and other bodies could hardly be reproduced under a State system; nor would that system attract in like manner the public help and sympathy on which the voluntary system rests. The following extract from the evidence of Sir Anthony Bowlby illustrates this point:—

> "In this country and in America, on account of the fact that voluntary hospitals are maintained by the

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they occupied before the war, and to enable them to continue their work. We think it clear that in order to save the hospitals from immediate disaster some assistance must be forthwith given from public funds; but we are also firmly of opinion, first, that the assistance should be temporary only and that it should be clearly understood that it will not be continued beyond a limited period, which may be fixed at two years; and secondly, that no grant should be made except to a hospital which is able to show that it is taking all steps which are open to it for re-establishing its financial position and that it has a fair prospect of so doing before the end of the period of probation. A grant so limited and conditioned is not open to the objections which we have raised to a continuous yearly grant, that it would destroy the voluntary system altogether. On the contrary, it would, if so administered as to comply with the above conditions, give to that system a real opportunity of repairing the damage caused by the war and of becoming established on a firm basis. We propose then to consider (1) what machinery should be established for administering the proposed grant, (2) what measures may be adopted by the hospitals themselves either to reduce their expenditure or to increase their income, (3) in what manner Parliament or the Government may give assistance, and (4) what should be the amount of the temporary grant.

Hospitals Commission.

17. First, then, we recommend that there be set up a central body for Great Britain, which shall have as its first and principal duty the administration of the temporary grants here mentioned, but which would be available for the other functions mentioned in this report. This central body should be formed on the lines of the University Grants Committee, and might bear the name of the "Hospitals Commission." It should be appointed by the Minister of Health and should consist of not more than 12 members, of whom the chairman and three others should be selected by the Minister of Health and one by the Secretary for Scotland, and of the remainder one should be nominated by each of the following bodies, namely: The Joint Committee of the Red Cross Society and the Order of St. John of Jerusalem; King Edward's Hospital Fund for London; the British Hospitals Association; the Royal College of Physicians; the Royal College of Surgeons; the British Medical Association; and the Scottish Committee of the British Medical Association. Service on the Hospitals Commission should be voluntary, but it should be advised by a technical expert and will require a small clerical staff. Its expenses should be borne on the votes for the Ministry of Health.

Local Committees.

18. But the Hospitals Commission, if set up, would not alone be in a position to deal effectively with the many questions of finance and policy which would arise in the different areas under

its control; and for this purpose it would require the assistance of bodies formed for those areas and possessed of local knowledge and influence. It appears to us therefore that there should be in each area a Committee or other body to which any application by a hospital to share in the grant should, in the first instance, be made, and which should consider the circumstances of the applicants and the conditions which should accompany the grant, and should report to the Hospital Commission. The Commission would make no grant (save in urgent and exceptional cases) except upon the recommendation of the local committee.

19. So far as the London area is concerned, the necessary organisation exists in the King Edward Hospital Fund for London, which has already performed admirable work in the organisation of the London hospital system; and we believe that the Fund would be willing to undertake the additional responsibility of receiving and reporting upon the applications arising in that area.

20. With regard to England and Wales outside the London area and to Scotland, we think it clear that a single authority would not be appropriate for the purpose now in hand. The ground to be covered is too extensive, and a single authority would find it difficult to obtain that local interest and co-operation which is necessary for success. The Regional Committees of the British Hospitals Association are unsuitable for the same reason, and also because being constituted of representatives of the hospitals they would find a difficulty in enforcing their views upon their constituent members. It appears to us that normally the unit should be the County or County Borough; but in many cases it might be desirable that a county borough should be grouped with the surrounding districts, or that particular counties should be grouped or divided. There should be formed in each County, County Borough or other selected area, a Voluntary Hospitals Committee for the purposes here mentioned; and in order to secure uniformity and prevent overlaping the constitution of each Committee should be subject to approval by the Hospitals Commission. A Committee should be constituted of nine or more persons of ability and local influence representing all classes of the community, and should be nominated by the Lord Lieutenant, with whom might be associated, in the case of a County the chairman of the County Council, and in the case of a County Borough the Lord Mayor or Mayor, as the case might be. A Voluntary Hospitals Committee would have no compulsory powers, but would derive authority from its personnel and from its functions in relation to the grants here recommended. Its expenses, which would not be large, might be provided locally; but we think that public interest would be stimulated if power were given to the County Councils to contribute towards these expenses.

21. The formation of local committees is desirable quite apart from present circumstances, and we hope that they would

continue to exist and perform their functions even after the period for which Government grants are contemplated. In particular, these Committees might render great service in co-ordinating the work of the hospitals in their areas.

We are impressed with the view, which was put before us by many witnesses, that the present lack of organisation and co-operation among the voluntary hospitals not only detracts from their efficiency, but is the cause of much avoidable expenditure. These institutions, which should be parts of a connected system, are for the most parts units working in isolation or in competition with one another and learning little or nothing from the successes or failures of others. Each hospital stands where chance or the choice of some founder has placed it. Sometimes two hospitals of similar character are within a stone's throw from one another; and sometimes a special hospital exists side by side with a special department of a general hospital doing similar work. Within half a mile of the room in which the Committee met, there are no less than three important general hospitals which are also medical schools, while in other parts of London where there is a far denser population there are large areas for which the present hospital provision is manifestly inadequate. Similarly, there are large industrial areas in the North where the expansion of voluntary hospitals has not kept pace with the growth of the population. Not only do neighbouring hospitals compete against one another in their appeals to the generosity of the public, but they make (generally speaking) no attempt to reach any common agreement as to the definition of their functions and the province which they should serve. We recognise that, in the special case of the teaching hospitals, any definition of "province" is a matter of extreme difficulty, not only because the eminence of the medical teaching staff makes these hospitals consultant centres for large areas outside the city or town in which they are placed, but also because the need for providing clinical material for the students compels them to select their cases over a wide area. We recognise also that the special hospitals perform a most useful function, and we are far from saying that they should be absorbed in the general hospitals. But, subject to these observations, we see no reason why arrangements should not be made both for defining the functions of hospitals and for promoting co-operation among them. The present practice leads to overlapping, to needless multiplication of clerical staffs and of expensive apparatus, and to waste of bed-space which is badly required. One hospital may be full and have a long waiting list, while another has vacant beds. Mr. H. Wade Deacon, the chairman of the Council of the British Hospitals Association, said :—

> "At present there are waiting lists at most of the general hospitals and empty beds in other hospitals, which would seem to indicate that, possibly, there would be enough accommodation already if it were properly used."

Mr. Rea, of the King Edward VII Hospital, Cardiff, said :—

"It seems a scandalous thing that, if there happens to be a vacant bed in Pontypridd, they should send a case of hernia down to Cardiff, where we are overcrowded, when it ought to be dealt with at Pontypridd. There ought to be some co-ordination."

And Sir Napier Burnett gave a striking instance :—

"In one county hospital, where I found only half the beds were occupied, I was informed by the Committee of the Hospital that that was the more or less chronic state they were in, with all their standing charges going on for the full complement of beds; yet that, 13 miles further north in the same county, there was a hospital which had a waiting list of over 1,200, and 13 miles further south another hospital had a waiting list of 800 patients. If there had been some co-ordination, a system of motor transport could have dealt with these patients, instead of the people lying waiting for a vacant bed. Motor transport exists in the county and could have sent these people to and fro and filled up the empty beds.

Q. Is there no communication between the two?

A. No, they are isolated units and there is no communication, and there is nobody who has authority to say them : 'Send along some of your waiting patients to our empty beds'."

If there were some body, such as a Voluntary Hospitals Committee, with authority to organise and grade the hospitals in a district and to act as a clearing house for patients requiring accommodation, a considerable saving might be effected. No doubt there are objections to amalgamating one hospital with another; but it would surely be possible, without destroying the individuality of any hospital for which a real need exists, to effect a working arrangement between the large hospital, the smaller hospital and the cottage hospital, and to allot the patients, the apparatus and the staff on some reasonable basis.

We quote Sir Napier Burnett once more :—

"In every county area there is what may be called as the 'key hospital,' the large hospital, and a considerable number of smaller hospitals; and we would not give any money to any of the smaller hospitals unless they had a working arrangement with the 'key hospital.' For instance, for the investigation of fluids taken from patients—bacteriological and patho'ogical—into the causation of disease, the smaller hospitals often have not the appliances and staff necessary, whereas the big hospital has and could do it if there was this spider-web arrangement in the county, the key hospital in the centre, with the other hospitals circulating round about it, sending acute cases into the central hospital for expert treatment with all

their appliances there, and then the big hospital returning them eventually to the care of the smaller hospital to complete their cure. Such a system can only be arranged through some body outside the hospitals; it will never come from the hospitals themselves, because immediately they can get enough money for the time being they may say: 'We do not want to have anything to do with you.' Some Council or Board outside the hospitals is needed, that would exercise, not State control, but some sort of supervision, to grant them money and be able to say if necessary: 'We regret that we cannot make you a grant of money unless you are prepared to co-operate with the neighbouring hospitals.'"

Mr. G. Verity, Chairman of the Charing Cross Hospital, put the point with characteristic force when he said:—

"I think that if we had a body like the King Edward Fund, with compulsory powers to smash us into line with regard to expenditure, we should save a lot of money. . . . If the King Edward's people had power to smash us into line as regards expenditure and to shut up or amalgamate those hospitals which they know should be shut up or amalgamated, I think that would help."

22. No doubt something has been done in this direction. The Great Northern Central Hospital is absorbing the Royal Chest Hospital, and is endeavouring to make working arrangements with the four cottage hospitals in the Great Northern area. University College Hospital has taken over the Royal Ear Hospital, and the Hampstead General has amalgamated with the North-west London and has converted it into an out-patient department. There are joint hospital committees in Birmingham, Sheffield and Glasgow, but only of an advisory character. The Regional Committees of the British Hospitals Association meet for discussion, and the King Edward's Fund has made great progress towards the organisation of the work in the London area. But more general and more drastic steps are required. Voluntary Hospitals Committees, such as we have described, would be in a position to collect information, to advise as to accounts and expenditure, to marshal appeals for funds, to act as a clearing house for patients, to promote the grading and the co-operation of the hospitals in their area, and to deal with the other matters referred to in the later paragraphs of this report. They would be independent of the hospitals, and would have power (by their control of the grants or funds entrusted to them and otherwise) to bring pressure upon hospitals when required. They should consult when necessary with the Regional Committees of the British Hospitals Association.

Poor Law Infirmaries.

23. It seems desirable at this stage to say something regarding the relations of the voluntary hospitals with the poor-law

infirmaries. We have been impressed with the volume and quality of the work carried out by the able Infirmary officers whom we have seen, and it seems unfortunate that the abundant and varied clinical material in these institutions should be hardly used at all in the training of medical students. Further, we are informed that during the winter months there are, on an average, over 20,000 vacant beds for sick persons in poor-law institutions, and that during the summer months the number increases to over 30,000; and it is very desirable that these vacant beds, many of which are suitable for general use, should, if possible, be used for reducing the long waiting lists at the voluntary hospitals. In a few instances, the voluntary and poor-law hospitals do to some extent work together. At Paddington arrangements have been made by which members of the staff of St. Mary's Hospital act as part-time officers of the Paddington Infirmary, and the laboratory work required by the Infirmary is done at the hospital. At Lambeth the Infirmary is visited by members of the staff of Guy's, and patients are sometimes transferred from one institution to the other. At Dudley Road, Birmingham, the Guardians have expressed their willingness to allow students from the University to visit the wards. At Wolverhampton it is proposed that the hospital should take over one of the pavilions of the Infirmary (which is not required for poor law patients) and use it as an annexe to the hospital. But such instances are rare. It appears to us that it should be possible to make arrangements under which the staff and apparatus of voluntary hospitals should (so far as possible) be available for the treatment of Infirmary patients, while the students at the hospital should be allowed to visit the Infirmary wards, and the vacant beds at the Infirmary should be at the disposal (on proper terms as to payment) of the hospital patients awaiting admission. Such arrangements could best be negotiated through the Voluntary Hospitals Committees when formed, or in London through the King's Fund; and if statutory authority is required, it should be given.

REDUCTION OF EXPENDITURE.

24. We pass to the question what other economies in expenditure might be required as a condition of the grant.

With regard to the general expenditure in the hospitals, it has not been possible for us in the time at our disposal to make systematic inquiry. But the striking differences in expenditure between hospitals of like size and character appear to indicate that there is room in some cases for greater economy. No doubt "cost per occupied bed," the test adopted by the King's Fund, is at best an unsatisfactory criterion. It is largely affected by the design and internal arrangements of a hospital, since a compact building costs less to light and heat and requires a smaller domestic staff than a straggling building with long corridors and wards at a distance from the kitchen; but nevertheless the enormous differences between one hospital and

another in "cost per occupied bed" and "cost per out-patient attendance" appear to show that there are cases in which further economies might be effected. We are also struck by the wide variation between the average period of treatment in hospitals dealing with substantially the same range of cases. We do not suggest that a rigid uniformity is either possible or desirable; but when one teaching hospital in London is found to be keeping its patients on an average twice as long as another, it is difficult to escape the conclusion that either the one is taking too many patients or the other too few. We think that the expenditure at every hospital should be carefully reviewed by the managers year by year, and also that the question of comparative expenditure might be usefully investigated by the Voluntary Hospitals Committees when formed, and the King's Fund.

25. The uniform system of accounts inaugurated and enforced by the King's Fund in London is of great value in enabling comparisons of cost to be made, and so in suggesting opportunities for economy. The same system has been voluntarily adopted by many hospitals outside London, but not by all; and we think that this system, perhaps in a simpler form, should be universally followed, and that this should be made a condition of any grant.

26. The practice of co-operative buying, if applied to such things of general use as drugs, dressings, apparatus and some kinds of provisions, could not fail to produce substantial economies. The great hospitals, which already buy in large quantities, might gain little by it; but if these larger institutions would so arrange as to secure for the smaller hospitals in their neighbourhood the benefit of reduced prices, the latter would profit substantially. And co-operation in buying would have the further advantage of securing the adoption of standard specifications, instead of each hospital being left as at present to fix its own standards. An experiment in co-operative purchase made in London in 1910 fell through, apparently on account of some mutual jealousies between the hospitals concerned: and the failure has discouraged like attempts elsewhere. But here and there, thanks to the good will of the large hospitals, the system has met with success; and we think it should receive a further trial. We are informed that the Red Cross Society is organising a general scheme for the provinces, and the Voluntary Hospitals Committees when formed might give effective help in this direction.

27. The question of the length of time required for the proper treatment of cases is closely connected with the need for increased accommodation. The larger hospitals are necessarily in densely populated districts, where land is valuable and any extension of the present buildings is correspondingly costly. We are of opinion that the cost of new accommodation might be substantially reduced if the main buildings could be restricted to the accommodation of cases requiring constant medical or surgical supervision, and the less serious cases were removed to an auxiliary hospital

on the outskirts of the city. It is uneconomical to retain patients who are recovering from illness in the centre of a great city, where the overhead charges are inevitably high, while an auxiliary hospital further out is less expensive to build and maintain, and a healthier situation makes recuperation pleasanter and more rapid. We realise that this system may involve some inconvenience to the visiting medical staff, but with modern means of transit we do not believe that these difficulties are serious. As instances where the practice here recommended is being or is intended to be put in operation, we may mention the Great Northern Hospital in London, which has a "Home of Recovery" at Southgate; the Radcliffe Hospital at Oxford, which is about to remove its less serious cases to a building on Headington Hill, where "food, air and nursing will be the main cost"; and the Glasgow hospitals, which are considering the establishment outside the city of a "Convalescing Hospital" for similar cases. We hope that the Voluntary Hospitals Committees when formed will give this matter their attention; and we recommend that before any extension of existing buildings in crowded districts is approved, it should be considered whether the required accommodation could not be provided more economically elsewhere.

INCREASE OF INCOME.

28. We pass to the question how the income of the voluntary hospitals may be increased. The present sources of income may be classified as follows:—

(1) Income from endowments and invested funds;

(2) Subscriptions, donations and free legacies (*i.e.*, legacies not subject to trusts or ear-marked for specific purposes);

(3) Annual grants from central funds, such as the King Edward VII. fund, the Hospital Saturday fund, the Hospital Sunday fund and the Red Cross Society;

(4) Payments by patients;

(5) Payments by public authorities.

While some increase of endowments in the form of endowments of single beds and cots may be looked for, it would appear imprudent to count upon any large addition to hospital endowments while taxation continues at its present level. With regard to subscriptions, donations and free legacies, it is satisfactory to record the fact that these have not fallen off, but have rather grown in amount. We venture to suggest that appeals for donations should be of a more systematic character. Hospitals are rather prone to wait until a serious deficit has been incurred, and then to make a desperate effort to pay it off. We are convinced that more could be done by systematic canvassing and personal appeals regularly carried out. We further suggest that competing and overlapping appeals should not be made, and that no special appeal should be launched without consultation

with the Voluntary Hospitals Committee for the area, or in London with the King's Fund.

Collections from Wage Earners.

29. A consideration of the evidence, both from hospitals which have succeeded in paying their way and from those which have failed to do so, has convinced us that, if the voluntary hospital is to continue and prosper, it must rely not only on the large subscriptions and gifts, but also, and to an increasing extent, on moderate and continuous contributions from all classes of the community. During recent years appeals to those engaged in industry to make a weekly contribution out of their wages have become more frequent, and the ready and generous response made to these appeals is perhaps the most encouraging feature which has come under our notice. In most cases these contributions take the form of a sum of from 1*d.* to 3*d.* per week deducted "at the source" by the employer with the consent of the employed and paid over by him to the hospitals. This is by far the most convenient and the most reliable method; but sometimes the contribution is made directly by the employed by means of weekly collecting cards or sheets. In every case the payment has the cordial assent of the wage earners, generally elicited at meetings at which the matter is fully discussed and explained, and the support of the Friendly Societies and labour organisations.

30. Some instances of this form of contribution may be of interest. In the North of England (Northumberland, Durham, and the Cleveland District) sums varying from 1*d.* a week upwards, have for some time been contributed in this manner, and an endeavour is being made to stabilise these contributions at 3*d.* per week per person. The amount so contributed to the Sunderland Royal Infirmary was in the year 1919, £11,673, and in the year 1920, £16,195; and in 1921 it is expected to reach nearly £30,000. In the Hartlepools similar results have been obtained. The Royal Victoria Infirmary at Newcastle-on-Tyne received from this source in the year 1920 no less than £44,876, which is believed to be the largest contribution from working men and women to any hospital in the United Kingdom; and the process by which this result was obtained was explained to us by Mr. Charles Irwin, the Chairman of the Subscriptions Committee of that hospital, as follows:—

> "The question may be asked: How did you manage to get this sum? First, let me say that it has taken sixteen years to get these results, and during the whole of this period much arduous work has been done. Secondly, this has been accomplished by the education of the workmen in the work done and the financial needs of the Infirmary. The education has been imparted in many ways. Groups of trade unionists and their leaders have been invited to fullest conferences at the Institution. Meetings have been held at

shipyards, works and collieries; wherever a group of men were employed, an endeavour was made to address them.

Q. Do you have working men on your hospital Committee?

A. Yes. Hundreds of meetings have been held. These were addressed by the Chairman, Vice-Chairman, members of the Subscriptions Committee, many of whom are workmen, and by the financial Secretary, whose duty it was to organise the meetings Literature in many forms was freely distributed. Everything was done not only to educate and interest the workmen, but to maintain their interest and secure thei support. We find that very necessary. The plan adopte in most cases was to get the workmen to agree to pay one penny or more per week, and if they agreed, to ask the employer to deduct the sum from the weekly or in the case of the miners fortnightly wages. . . . In some cases the workmen agreed to give more, and after a special appeal made last year most of them pay two-pence per week. . . . The advantage of weekly contributions may be illustrated in this way, I have seen it myself. If I asked a man to give me 4*s.* 4*d.* or 8*s.* 8*d.* for the Infirmary, he would say he could not afford it, but he most willingly agreed to give the amount when it is paid in weekly instalments. If I said, 'Give me 5*s.*,' he said 'I can't afford it.' If I said 'Give me 1*d.* a week,' he gave it and I got the 4*s.* 4*d.* without him knowing it. If I may remark, this is one of the arts of getting contributions from the working classes. It involves organisation and entails clerical labour, but the results are worth them. There is no class of the community more willing to listen to the work done in hospitals, and, when informed, to support them. That has been my experience at many meetings that I have addressed."

At the Glasgow Royal Infirmary the amount collected in like manner was for 1919, £16,565, and for 1920, £30,934; and the following passage from the evidence of Mr. James Macfarlane, the Chairman of the Infirmary, appears to be worth quoting:—

"We began by interesting the public through the press. Then I got the Lord Provost to convene a meeting of representatives of the working classes. First of all, we sent out literature to all the large employers of labour, to the employers themselves, and to the employees, and we suggested setting up an organisation for obtaining weekly levies from the wages. After that had been in force for perhaps a couple of years, the Lord Provost called a meeting of the representatives of the working classes and we set up a regular organisation. The Secretary of the Royal Infirmary was appointed Secretary to that organisation. That was only set up in February 1920, so the full effect

of the organisation was not felt for the whole of the year 1920.

Q. Do you find the men ready to give?

A. Yes.

Q. How much a week do they give as a rule?

A. In this matter I am quoting my own infirmary. The males earning under 20*s.* per week give 1½*d.* a week and those earning 20*s.* a week and over give 2*d.* a week. Then with regard to females those earning under 20*s.* a week give 1*d.* a week and those earning 20*s.* a week and over give 1½*d.* a week. Our old system used to be to send round a sheet to the various departments once a year, and then each man or woman put down what they like. Some of the women put down 2*s.* 6*d.* and some of the foremen put down 6*d.* We raised (at one factory) between £40 and £50 annually by that method; after the levy system was adopted we raised over £400."

Like methods have been adopted with success in South Wales, and the following replies given by the Secretary of the Porth and District Hospital are of interest:—

Q. "Does your income, as you estimate it, include any contributions by workmen?

A. Our receipts are made up in part of levies made on the workmen. The estimated income of £9,000 for 1921 is due to the fact that we have persuaded all the workmen to contribute 2*d.* a week. We have also got the tramway employees, the postal employees, the railway employees, and teachers to contribute. We are hoping to get other societies, insurance agents, and so forth, to contribute in the same manner. The teachers pay now, and so do the postal, the gas and the tramway employees.

Q. How have you succeeded in getting those contributions?

A. We have taken the bull by the horns, if I may use that expression. The method adopted has been to write to the Lodges and ask them if they would kindly convene mass meetings of the workmen, and then deputations have waited on the workmen and we have stated our case. We have shown them the need of the hospital, the urgency of the matter, and also the benefits that accrue to them. In practically every case they have unanimously decided to grant us our request.

Q. You found them very reasonable?

A. Yes. As long as they are shown the balance sheets, and they receive explanations as to how the money is spent, and also as long as they are allowed to appoint representatives upon the Board of Management, they seem to be willing to give us, within reason, almost anything.

Q. Are they mostly miners?

A. Yes. There are roughly about 20,000 miners."

Similar evidence was given by the representatives of the Wolverhampton Hospitals, of the King Edward VII. Hospital at Cardiff, and of the Merthyr Hospital; and we were informed that at Merthyr practically every organised worker of the Borough contributes 1*d.* per week and that it has lately been decided to double the contribution.

31. Inquiry was made of the witnesses whether these generous contributions by the employed are met by similar contributions from the employers; and we were informed that in some works this course is followed. For instance, at Cardiff, some of the employers give 25 per cent. and some 50 per cent. of the amounts contributed by the men; and at Sheffield the leading employers are proposing to add one-third. At Glasgow some employers give one half, but others little or nothing. At Sunderland many of the large firms pay 1*l.* to the hospital for every 1,000*l.* which they pay in wages, which works out at about 1*d.* per man per week; and at Birmingham a well-known firm repays to the hospitals every quarter the whole cost of the maintenance in those hospitals of patients who are in its employ. These examples, however, are too rarely followed, and there are many business houses whose workers contribute largely but who are themselves content with a small yearly subscription. We think that an appeal should be made to employers to co-operate generously in this way with those whom they employ.

32. Before leaving the subject of collections from wage earners, we desire to add—

(1) That it will in many cases be desirable that, in order to avoid competing appeals by different hospitals, these collections should be made by some central body such as a Voluntary Hospitals Committee on behalf of all the hospitals in the area and should be distributed among the hospitals on some agreed basis;

(2) That these contributions should not be treated as giving any claim to priority of treatment, which should be determined by medical considerations only;

(3) That it is essential to the success of the scheme that the contributing workmen should be given proper representation on the governing bodies of the hospitals concerned; and

(4) That the amount raised in this manner is liable to be affected by unemployment or cessation of work.

33. It is also necessary to refer to the effect on these collections of the operations of the Hospital Saturday Funds in certain parts of the country. In some districts the collections from workmen are made entirely by the hospitals, in others entirely by a Hospital Saturday Fund; but there are districts where both methods are followed, sometimes to the detriment

of the collections. And in some places, as at Birmingham and Manchester, complaint is made that the local Hospital Saturday Fund, while basing its appeals on the treatment given in hospitals, applies the greater part of its collections to the support of convalescent homes. Any such conflict of interest is plainly undesirable; but as between these organisations engaged in charitable work there should be no difficulty in making an equitable adjustment.

The Oxford Scheme.

34. The system of weekly contributions has been carried further by the Radcliffe Infirmary and County Hospital at Oxford, which affords an admirable instance both of the benefits of this system and of the advantages of hospital co-ordination. The Radcliffe, which is the only large hospital in the northern part of Oxfordshire and is connected with the medical school of the University, appears to perform the functions both of a "secondary health centre" and of a "teaching hospital" as defined in the interim Report of the Consultative Council on the future provision of medical and allied services (Cmd. 693 of 1920). It takes all the active cases for the poor law infirmaries in its district, and has succeeded in linking up with its work the primary and cottage hospitals and (to some extent) the district nursing service within its radius. And it has recently organised a scheme for obtaining weekly contributions, not only from workmen, but from the whole wage-earning population of the towns and villages in its area—and with conspicuous success. The conditions of this scheme are stated in the Supporter's Weekly Contribution Card as follows :—

> "1. A Contributor of 2*d*. a week is entitled to free treatment.
>
> "2. In the case of married people, when the husband and wife each subscribe 2*d*. a week, their children are also entitled to free treatment up to wage-earning age, and from then until they are earning adult's wage, each child pays 1*d*. a week. The children of a widow or widower are also entitled to free treatment up to wage-earning age on the 2*d*. contributions of their parent.
>
> "3. Non-contributors will in future be expected to contribute towards their maintenance in the Hospital, but no payment is required from Old Age Pensioners.
>
> "4. Every case must be accepted by a Doctor or Surgeon as suitable for Hospital treatment.
>
> "5. No supporter will in future require a 'turn'."

We were informed that, although the scheme was only established in September last, there are already 35,000 supporters paying 2*d*. per week.

35. The method by which this scheme was launched was described to us by the Rev. G. B. Cronshaw, the Treasurer of the Hospital, as follows :—

"It is an attempt to try and develop a large area like ours, which consists of Oxford City with 50,000 inhabitants, and a few country towns like Banbury and Witney with 5,000 to 8,000 inhabitants, and places like Woodstock with 1,500 or 2,000 inhabitants. Those little market towns do not number beyond six or seven all told. Then there is a large rural population. Badminton comes within our area. It is the biggest town, and also has the biggest number of works and the largest number of employees. All the rest is practically farming population and village population scattered all over the area. It was a question as to how we could best get contributions from them all. We knew the methods adopted in the north of England and in large towns, of employers either deducting a small contribution from the men's wages week by week, or the employers contributing by a scheme of their own. That is comparatively simple compared with our problem. The lethargy of the country is well known. We knew it was no good writing. It was therefore essential, if we were to carry on on a voluntary basis, to have propaganda. We got hold of an ex-Service man as a paid collector. He belongs to the working classes. He is a keen worker. We got him to help us We pay him 300*l.* a year. With the help of a Committee, in which we all work, we began to traverse the district. We started Hospital Aid Associations in every part. We get a meeting together, if that is possible, and get a Committee appointed there and then from amongst the people. We ask the Chairman of the Parish Council to call a meeting and take the chair, and we get a Committee appointed called a Hospital Aid Committee.

* * * * *

Q. How long has the scheme been going ?

A. Since last September.

Q. How many people have you now in the scheme ?

A. 35,000.

Q. At 2*d.* a week ?

A. Yes. That is new money, of course. It is more than the actual 8*s.* 8*d.* a year, because local patriotism has been aroused. Some villages have guaranteed to send us £150 a year, whatever it may be. A little village of 240 inhabitants has guaranteed to send us £150. They have come into the 2*d.* a week scheme, but their organisers have covered the district thoroughly, and they are getting in a class of person who has never contributed before, such as farmers. They make them subscribe to their scheme. In many cases it will be more than 8*s.* 8*d.*; 8*s.* 8*d.* is the

minimum. The 35,000 contributors comprise 288 firms and 165 Village Aid Associations, and we have 150 more villages yet to be worked, so we have at the present time new money coming in to the amount of about £18,000 for the present year by the scheme. If it goes on, we can provide for the beds and for the work which will have to be done in the future. The scheme ought to yield something like £25,000 or £26,000 a year new money."

It should be added that the Aid Committees are represented on the Board of Governors, and it is proposed that they shall appoint one-third of the Management Committee.

We are informed that the Counties of Wilts and Hants are organising schemes on somewhat similar lines.

The Sussex Scheme.

36. A method of voluntary insurance, called a Provident Scheme for Hospital Benefits and Additional Medical Services, has been inaugurated by the Sussex hospitals at Brighton, Hove, and Preston, and was described to us by its author, Dr. J. Gordon Dill, Senior Physician at the Royal Sussex County Hospital. The scheme is confined to persons whose income does not exceed £260 per annum for a single member, £400 per annum for a man and wife without children or a widow with one child, and £500 per annum for a married couple with a family. The subscription for an unmarried person or a widow or widower without children is £1 per annum; married people without children or a widow or widower with one child pay a joint subscription of £1 10*s.* per annum, and married people with a child or children under 16 or a widow or widower with children under 16 pay a family subscription of £2 per annum. In the case of persons employed at works or factories, the amount is collected as far as possible by weekly deductions from wages. Members are entitled to free consultation and treatment at any of the co-operating hospitals or, in the case of members unable to leave their beds, at their homes, but subject in the case of country members to payment of half the usual mileage rate from Brighton. The treatment includes ordinary dental treatment, laboratory and X-ray examinations, massage and electrical treatment when required. Urgent cases are admitted to hospital at once and others in their turn, but a member has no precedence over more urgent cases. Of the proceeds of the scheme one-fortieth is reserved for the cost of laboratory work, one-fortieth for X-ray work, one-fortieth for secretarial work, thirty-five-fortieths are divided among the co-operating hospitals on a basis determined according to an estimate of work done, and the remaining two fortieths are retained until the end of the year and are then distributed among those hospitals which have had the heaviest calls made upon them. Of the sums paid to the hospitals 25 per cent. is placed in a fund which is at the disposal of their medical staff.

The scheme is not yet fully established; but Dr. Dill estimates that if 100,000 members can be obtained, the financial problem of the co-operating hospitals will disappear. The main objection taken to the scheme is that it implies a contract on the part of the hospitals to provide such institutional treatment as subscribers may require; and if a large number of contributors are secured, it may be impracticable to provide the necessary beds without largely increasing the hospital accommodation or excluding non-contributors. But the scheme is interesting and well worth careful consideration, and we understand that its adoption in London and elsewhere is being considered.

London.

37. We have dwelt at some length on these schemes of mass contribution, because we are inclined to believe that in the adoption of one or other of them may be found the key to the problem which voluntary hospitals have to solve. At all events, they deserve the attention of the governing bodies of hospitals and of the Voluntary Hospitals Committees when formed. The question whether and in what manner any of these schemes can be applied to the London area, while it is of special urgency by reason of the serious financial position of the London hospitals, is also one of special difficulty. The system of weekly collections from wage-earners has been little developed in that area, partly, no doubt, because of its size and the absence of local patriotism, and partly because the London workman commonly lives away from his work and it is difficult for a particular hospital to guarantee treatment both to him and his family; but the latter difficulty would be removed if the scheme were worked by King Edward's Fund or by some other organisation on behalf of the whole area. The Hospital Saturday Fund for London, besides having collecting boxes in many business houses, collects weekly sums by means of collecting sheets and cards; but the total amount collected by the fund in 1920 was only £106,000, a wholly insufficient sum for this enormous area. Whether this work could be best done by the Saturday Fund or by some other agency, we are not prepared to say; but it is obvious that the matter should be the subject of early discussion between the King's Fund and the Saturday Fund with a view to an adjustment.

Payments by Patients.

38. The practice of asking patients treated at a hospital, other than the necessitous poor, to contribute to the hospital fund is comparatively new and is a product of the financial stringency. Payments of this character received at the London hospitals alone increased from £78,000 in 1913 to £124,000 in 1919 and to £230,000 in 1920; and a further increase in 1921 is anticipated. Some London hospitals, including the London, the Middlesex and

the St. George's, make a fixed charge (except in the case of poor people) as a condition of admission, the charge for an in-patient being generally about 20*s.* a week and for an out-patient from 6*d.* to 3*s.* per attendance according to the nature of the case. Other hospitals adopt a practice which they consider to be more in accordance with the voluntary principle, and after the admission of an in-patient make inquiries as to his means and apply to him (generally through a lady almoner) to make a voluntary contribution to the hospital funds according to his ability. We were told that the latter method is not less productive than the former, as patients readily recognise the debt which they owe to the hospital. In either case the amount asked for is far below the actual cost incurred. There appears to be no reason why this practice should not be generally followed, provided that great care is taken not to exclude the very poor from benefits which are primarily intended for them. We were informed that the increase of the weekly collections at Newcastle has not materially interfered with voluntary payments by patients; but this experience may not be general, and it is obvious that if any system of insurance (such as the Sussex scheme) were generally adopted, this source of income would become less productive.

39. At the Great Northern Central Hospital supporters of the Hospital receive "contributors' certificates" to the amount of their subscription, which if presented within 10 years exempt the holder from any charge for treatment. To the extent that these vouchers are actually presented there is no net gain to the hospital, but it is expected that a large proportion will not be used. It is anticipated that these certificates may produce from £5,000 to £10,000 per annum; but the scheme is in its infancy, and we are unable to express an opinion as to its value.

40. As to paying wards, that is to say, private wards where patients are received on the terms of paying the whole cost of maintenance and treatment, we doubt whether hospitals can look for any substantial increase of income by the establishment of such wards. Nor is it desirable that they should do so, since wards of this character occupy considerable space, and the experience of other countries goes to show that a hospital which makes a profit on paying patients is tempted to extend its paying wards to the detriment of the poorer patients. But there may be instances in which vacant space may usefully be filled in this way.

INSURED PERSONS.

41. It has been suggested to us by some witnesses that persons insured under the National Health Insurance Acts stand upon a special footing, and that the cost of the maintenance and treatment of these persons in a voluntary hospital should fall upon the insurance funds. This suggestion appears to rest

upon a misconception of the purpose and effect of the Acts. The sickness premiums payable under the Acts are calculated to provide (among other things) a medical benefit, which is described by the regulations as follows :—

> "The treatment which a practitioner is required to give to his patients comprises such treatment as is of a kind which can consistently with the best interests of the patients be properly undertaken by a general practitioner of ordinary professional competence and skill."

The benefits so defined clearly do not include the more advanced treatment normally given in a hospital or the maintenance of an insured person as an in-patient. It is probable that many insured persons suffering from ailments which should properly be treated by their panel doctor prefer to apply at the out-patient department of a hospital for advice and treatment; but such applicants may be and often are referred to their panel doctor for advice. Indeed, some hospitals decline (save in urgent cases) to treat a person not recommended by his doctor for hospital treatment. But insured persons suffering from ailments which are suitable for hospital treatment stand in the same position as other applicants for such treatment, and no discrimination should (we think) be exercised against them.

42. Whether it is desirable that the sickness premiums should be increased so as to provide a "hospital benefit" which would entitle insured persons to advice and maintenance in a hospital willing to receive them, the hospital receiving suitable payment for the cost incurred, is another question. Upon this point reference may be made to the report of the Departmental Committee appointed by the Secretary of State for the Home Department to inquire into the system of compensation for insurance to workmen [Cmd. 816 of 1920] which recommends that medical and surgical treatment of a special nature (such as massage, X-ray, and hydro-therapeutic treatment and in-patient hospital treatment) should be included in a new Insurance Act as an additional benefit and that the expense of such extra services should be provided by the employers. This proposal, which would effect a radical change in the position of the Voluntary Hospitals, requires very careful consideration. But pending or in default of the adoption of some such proposal, we are of opinion that the Courts dealing with compensation to insured workmen under the Employers' Liability and Workmen's Compensation Acts should be authorised to include in an Award a reasonable sum for the cost of the treatment of the insured workman in hospital, and that this sum should be recoverable by the hospital at which the treatment has been given. But the Court should be directed in framing such an Award to have regard to any recent contribution by the employer to hospital funds. In this connection it is remarkable that most of the companies insuring against claims for Workmen's

Compensation, although profiting largely by the treatment of insured workmen in hospital, make little or no contribution to hospital funds. We are informed that in the United States of America the insurance companies contribute largely to, and in some cases actually maintain, hospitals, with results which are satisfactory to the companies themselves.

43. While we hold that the Approved Societies are not under any obligation, legal or equitable, to provide the whole cost of the maintenance and treatment of their members in hospital, we are strongly of opinion that they do owe to the hospitals a large measure of support. As pointed out in our Interim Report [Cmd. 1206 of 1921] the effect of hospital treatment is not only to relieve from suffering the many insured persons who take advantage of it, but also to reduce the periods during which they have a claim upon the insurance funds for sickness benefit. We understand that since the issue of that Report an important society, the National Deposit Friendly Society, had decided to apply one-third of its available surplus, as ascertained by the recent valuation, for the benefit of the hospital and nursing services. We hope that this generous example will be widely followed. But the arguments in favour of contributions being made to hospitals out of insurance funds have weight even apart from any question of surplus. Approved Societies are authorised by section 21 of the Act of 1911 to make donations to hospitals, and we trust that this power will be freely exercised. If the reluctance of a few Approved Societies should render agreement on this point impossible, it would not be unreasonable to ask Parliament to sanction a contribution to hospitals out of the Central Fund established under the Acts; and we believe that the general opinion of the Approved Societies would be in favour of that course. But it seems possible that a general agreement on the matter may be reached without legislation; and we therefore make no recommendation for immediate legislation under this head.

44. The clerical labour involved in distributing any contributions from insurance funds among the hospitals concerned will be considerable; and we suggest that, if the Approved Societies desire it, that task should be undertaken, as to the contributions of Societies having a local character by the Voluntary Hospitals Committee for the area, and as to those of the larger Societies by the Hospitals Commission.

PROPOSALS FOR LEGISLATION OR EXECUTIVE ACTION.

45. It remains for us to consider some proposals which have been made with a view to providing additional income for the hospitals or to reducing the public charges upon them, and which would require legislation or executive action.

Payments by Public Authorities.

46. The payments now made by Public Authorities for services rendered fall under the following heads :—

(1) Pensioners (by the Ministry of Pensions).

*(2) Tuberculosis patients (by the County and County Borough Authorities).

*(3) Venereal Disease (by the County and County Borough Authorities).

*(4) Maternity and Child Welfare (by the Local Authorities).

*(5) School Medical Services (by the Local Education Authority).

It has been suggested to us that these payments should be increased in amount. So far as our inquiries have proceeded we think that the payments made, except in the case of School Medical Services, are generally reasonable; but there may be exceptions in certain districts. As the cost of treating these cases differs in different localities, we think it best that any negotiations as to the increase in the amount of existing payments should be left to be undertaken by the hospitals or the Voluntary Hospitals Committees when formed; and we therefore make no recommendation as to those payments. It has also been proposed that the treatment as in-patients of persons suffering from puerperal fever or epidemic diarrhœa should be added to the list of diseases in respect of which payment is made by Public Authorities; but we are advised that these ailments are not suitable for treatment in general hospitals, and accordingly we make no recommendation on the subject.

47. It was represented to us by a number of witnesses that the Local Authorities should be required to pay the cost of the treatment in hospital of their employees and of patients sent there by the police, such as victims of street accidents or of criminal attempts. It does not appear to us that payments of this character should be made compulsory, as the local authorities are not legally responsible for the health of the persons here described. But there is no reason why the local authorities should be compelled to be less considerate than other employers of labour, and we think they might be authorised in their discretion to pay the cost of treatment at hospitals of persons in their employ.

48. A considerable volume of evidence was given in support of a proposal that grants should be made for the training of nurses, who not only receive a practical education in the wards but at many hospitals are taught by lectures and classes. This proposal was supported by the witnesses called on behalf of the British Medical Association, who pointed out that nurses trained in the hospitals are regularly absorbed by the education authorities or by the general nursing service of the country. We think that grants for this purpose might be considered by

* There are Government grants in aid of these services.

the bodies having charge of the funds applicable for technical education.

49. The following further suggestion was made to us by Mr. N. Bishop Harman, who gave evidence on behalf of the British Medical Association, and is submitted for the consideration of the Ministry :—

> "There is one other point in which the State might very fitly subsidise the hospitals for work done. The patients that go in have their notes; these notes should be collated, and there should be returns from every hospital, and the returns should be collected and form part of the data for medical research. At present this is not done. In the Royal Commission for Venereal Diseases the Commissioners made some caustic comments on the inability of the hospitals to furnish them with any data as to the prevalence of syphilis. The comment was unjustifiable because the hospitals have no funds to expend on the collection of these data. I am attending on the Committee as to the Causes and Prevention of Blindness, and we have come up against the same lack of information, and we had to apply to the Treasury for a grant to pay certain hospitals to procure this information.
>
> "*Q.* I suppose notes are kept?
>
> "*A.* Yes, but unless they are tabulated they are of no use. At one hospital that we approached they said: 'We have all the notes but have not been able to tabulate them for twenty years; we have no money.' It does not matter to the hospital whether they are tabulated or not; the patients and subscribers are not interested in that kind of thing, but it is of the greatest value to the State, and the State should contribute to the cost of it. The State is doing it so far as venereal disease is concerned. It could be done generally. The Venereal Diseases Commission were just as critical of the State Hospitals not providing returns, and in our Blind Committee we found some of the State Departments were worse than the Voluntary Hospitals; they could not bring us any data since 1903."

Staff Funds.

50. In connection with the grants by Public Authorities it appears desirable to refer to the practice which obtains in some hospitals of carrying a proportion (from 10 per cent. to 20 per cent.) of these grants to a staff fund which is placed at the absolute disposal of the honorary staff. In some of these hospitals, as at St. Bartholomew's, at the Royal Infirmary, Manchester, and at the Radcliffe Infirmary, Oxford, the fund has hitherto been applied by the staff to such purposes as the purchase of expensive apparatus or books, and the support of young practitioners taking up special branches of work; but in other cases the fund has been divided among the staff. The practice is supported by

the British Medical Association on the ground that patients sent by a public authority are in the position of paying patients and that in the fees paid for such patients the medical practitioner is entitled to share. On the other hand, the honorary staffs of some hospitals are unwilling to share in such a fund; and two distinguished physicians expressed the view that if the medical staffs came to be subsidised to any substantial extent "the bottom would drop out of the voluntary system." It should be remembered also that, although the services of the staff are honorary, they obtain a valuable return in the form of medical and surgical experience and the enhanced reputation which accrues to a member of the visiting staff of a great hospital. If the system of carrying a percentage to a staff fund is confined to cases where the full cost of maintenance and treatment is paid by or on behalf of the patient, not much objection can (we think) be taken to it; but any extension of the practice beyond those limits appears to us to endanger the future of the voluntary hospitals.

Rates.

51. We are asked to recommend that hospital buildings should be exempted from rates. Many of these buildings are not unfavourably assessed; but there is no doubt that upon some of them the burden of rates falls very heavily, and some London hospitals pay upwards of £5,000 a year in rates. It is true that a general statutory exemption would be a serious matter for some parishes, and especially for those London parishes which include several large hospitals; but this difficulty might be overcome by spreading the loss over a larger area or by giving to the rating authority a discretion to remit all or part of the rates. The proposal to give such a discretion has found some support; and there is a precedent in Scotland, where the power to excuse hospitals from police rate is freely used. But the view has prevailed that any proposal leading to the exemption of voluntary hospitals from rating would lead to similar claims on behalf of other charitable and public buildings, and that it is undesirable to make so large an inroad into the rating system. We therefore make no recommendation under this head.

Income Tax.

52. The income of hospitals, except when it takes the form of profit, is exempt from income tax; but in connection with this tax two alternative proposals have been made. First, it is suggested that with a view to encouraging contributions to hospitals taxpayers should be entitled to claim exemption from income tax on such contributions. Secondly, and as an alternative, it is proposed that a hospital should be authorised to claim from the Government a sum equal to the tax received by the Government on the sums so contributed. These proposals have been carefully examined by a sub-committee appointed by the Executive Committee of King Edward's Hospital Fund, who by a majority have reported in favour of the latter alternative

and have framed a scheme for giving effect to it. By this scheme it is proposed that, when a hospital receives from a contributor a certificate stating that income tax has been paid on his contribution and that he desires that relief in respect of such tax shall be granted to the hospital, the hospital shall be entitled to claim payment by the Government of tax at a flat rate of 4*s*. for every 16*s*. received. The principle of a flat rate is adopted in order to avoid difficulties caused by the differences in the rates of tax paid by individual subscribers. It is estimated by the sub-committee that the relief so obtained by the London hospitals alone would amount to £191,279; and probably the relief to other hospitals in Great Britain would exceed that amount. We are satisfied that, if the principle of granting relief in respect of income tax on subscriptions to hospitals is accepted, the scheme proposed by the sub-committee of the King's fund is well conceived; but it appears to us that the proposal is, in substance, one for a direct and permanent yearly grant from the Exchequer to the hospitals and is inconsistent with the permanent maintenance of the voluntary system. We are therefore unable to recommend it for adoption.

53. It will be remembered that a subscription given by an employer to a charity which directly or indirectly benefits his workmen, is allowed as a deduction from profits for the purpose of income tax. It appears doubtful whether this rule applies to all subscriptions to hospitals; and we think that it would be made clear that it does so apply.

54. Attention was called by Mr. H. Wade Deacon to a recent case (Dr. Barnardo's Homes *v*. the Commissioners of Inland Revenue) in which it was held that hospitals cannot claim exemption from tax on the income from residuary estate bequeathed to them except as from the time when the residue is actually paid over. The effect of this decision is that, where the residue of an estate is left to a hospital and for some reason the winding up of the estate is delayed, the tax is payable during the period of delay. We think that the law applicable to such cases might well be amended, so as to allow a hospital to claim repayment of tax as from the expiration of a year from the testator's death.

Death Duties.

55. The above conclusions as to income tax have no application to the request which is put forward that testamentary gifts to hospitals should be exempt from the 10 per cent. legacy duty. We understand that such an exemption is allowed in the United States and is believed to have a marked effect in encouraging bequests to hospitals. There appears to be no good reason why the State should intercept at the source one-tenth of all sums bequeathed for the benefit of the sick; and we recommend that these gifts be freed from the duty. This recommendation applies to legacy and succession duty, but not to estate duty.

TEMPORARY GRANT.

56. We now reach the final stage of our report, and we ask whether, with the help of the new sources of income which are being opened to the voluntary hospitals and of the relief recommended in the preceding paragraphs of this report, those hospitals will be able to attain a stable financial position. We think they will; but the process must take some little time, and unless some temporary financial help is provided without delay from public funds some of them are likely to collapse. After most carefully considering the amount required, we recommend that Parliament be asked to sanction an immediate grant of £1,000,000 to be expended in assistance to such voluntary hospitals as are in need of it. The administration of the grant would be entrusted to the Hospitals Commission on the terms set forth above. This grant, if sanctioned by Parliament, should be looked upon, not as a windfall to be divided among all the hospitals or to be distributed equally over the different parts of the country, but as an ambulance fund to be applied at the discretion of the Commission to the relief of actual and pressing needs.

In recommending some temporary assistance from public funds, we would point out that the State is indebted to the voluntary hospitals for the services which they rendered during the War in the treatment of wounded soldiers. It is true that most, if not all, voluntary hospitals which admitted military patients received a capitation grant from the War Office, the amount of which was gradually increased as the war went on. But this capitation grant in no way covered the full cost of maintenance; and the Committee of King Edward's Fund informed us that their accountants, Messrs. Deloitte, Plender & Co., had calculated that the aggregate War Office payments to the London hospitals alone fell short of the total cost of maintaining and treating the military patients by £530,000. We have not been able to obtain corresponding figures for the provincial and Scottish hospitals, but we have no reason to believe that their loss on the treatment of military cases was proportionately less than in London.

57. It is probable that the grant suggested for 1921 will not of itself be sufficient to enable the hospitals to tide over the crisis, and that a further grant (possibly of less amount) will be required in 1922. But we think that it should be made clear that Parliament will not consider itself under any obligation, express or implied, to continue the grant beyond the latter year, and that the responsibility for maintaining any voluntary hospital after that time will rest wholly upon those who have the charge of the institution. We have every confidence, that if the assistance recommended is given by the Exchequer, it will be within the power of those having control of our hospitals, by means of economy in management and energy in interesting the public in their work, to maintain that voluntary system of which we are justly proud.

GRANTS FOR EXTENSIONS AND IMPROVEMENTS.

58. Apart from difficulties in maintenance, there is a crying need in many parts of the country for further hospital accommodation; and this is especially the case in the poorer parts of the great cities, in South Wales and in Scotland. The practical suspension of all new building since the beginning of the war means that for the last seven years little or no provision has been made to meet the expansion of the population, while, at the same time, the proportion of the population who look to the voluntary hospitals for institutional treatment is probably larger than it ever was before. It is plainly impossible under present conditions to raise by public subscription the whole of the sums required for this purpose, and we think that some help from the Exchequer will be required. We accordingly recommend that the Hospitals Commission be authorised during a period of two years from this time to recommend grants for the extension or improvement of hospital accommodation, any such grant to be subject to a contribution of not less amount being hereafter made from other sources, and no such grant to be recommended by the Commission except after consultation with the Voluntary Hospitals Committee of the area, and on that Committee being satisfied that full provision has been made for meeting any increase in yearly expenditure which may be consequent upon the extension or improvement. We estimate that a sum of £250,000 may be required for this purpose in the financial year 1921–22.

59. In conclusion, we desire to express our thanks to the Secretary of our Committee, Mr. L. G. Brock, C.B., of the Ministry of Health, who has rendered us invaluable help throughout our enquiry; also to Captain H. G. Howitt, D.S.O., M.C. (of the firm of W. B. Peat & Co.), who undertook gratuitously the task of collating and analysing the returns received from a large number of hospitals throughout the country.

SUMMARY OF RECOMMENDATIONS.

60. We do not think it necessary to repeat here the suggestions which we have ventured to make as to the steps which may be voluntarily taken by hospital managers for the improvement of the financial position of the hospitals under their charge. These relate to reduction of expenditure (para. 24), accounts (para. 25), co-operative buying (para. 26), auxiliary hospitals (para. 27), appeals for donations (para. 28), contributions by wage-earners and employers (paras. 29 to 33), other contributory schemes (paras. 34 to 37), payments by patients (para. 38), contributions by Approved Societies (para. 43), and staff funds (para. 50).

The following recommendations, if adopted, will requre legislation or executive action :—

(1) That a Hospitals Commission be formed in manner and for the purposes described in para. 17.

(2) That Voluntary Hospitals Committees be formed in manner and for the purposes described in paras. 18 to 22 of this report; the King Edward's Hospital Fund for London to perform the functions of a Voluntary Hospitals Committee for the Metropolitan Police District.

(3) That Poor Law Guardians be authorised to enter into arrangements as to the use of infirmaries (para. 23).

(4) That County Councils be empowered to contribute to the expenses of Voluntary Hospitals Committees (para. 20).

(5) That failing the provision in the National Health Insurance Acts of a "hospital benefit," the Courts be authorised to award to hospitals compensation under the Employers Liability and Workmen's Compensation Acts (para. 42).

(6) That local authorities be authorised to pay the cost of the treatment in hospitals of persons in their employ (para. 47).

(7) That the payment from technical education funds of grants for the training of nurses be considered (para. 48).

(8) That provision be made for obtaining and tabulating returns of cases treated in hospitals (para. 49).

(9) That all contributions by employers to hospital funds be allowed as deductions from profits for income tax purposes (para. 53).

(10) That where the payment to a hospital of a testamentary gift of residue is delayed for more than a year, the hospital be authorised to claim repayment of income tax (para. 54).

(11) That legacy and succession duty on testamentary gifts to hospitals be remitted (para. 55).

(12) That Parliament be asked to sanction a temporary grant of £1,000,000 to be expended under the direction of the Hospitals Commission in the assistance of hospitals which require it (para. 56).

(13) That the Hospitals Commission be authorised during a period of two years to recommend grants for the extension and improvement of hospitals subject to like contributions being made from private sources (para. 58).

We have the honour to be,
Sir,
Your obedient Servants,

CAVE, *Chairman.*
LINLITHGOW.
C. HYDE.
WM. B. PEAT.
VERNON HARTSHORN.
R. C. NORMAN.

L. G. BROCK, *Secretary.*

Dated the 31st May 1921.

APPENDICES.

APPENDIX A.

Date.	Witnesses.	——
26th Jan., 1921.	Sir Arthur Stanley, G.B.E., C.B., M.V.O.	British Red Cross Society.
	Sir Napier Burnett, K.B.E.	
	Lord Knutsford	
	Mr. E. W. Morris, C.B.E.	London Hospital.
	Mr. Richardson	
2nd Feb.	Sir Cooper Perry, M.A., M.D., F.R.C.P.	King Edward VII. Hospital Fund.
	Mr. H. R. Maynard	
	Mr. G. Verity, J.P.	Charing Cross Hospital.
3rd Feb.	Sir Samuel Scott	London Lying-in-Hospitals.
9th Feb.	Sir Walter Kinnear, K.B.E.	National Insurance Dept., Min. of Health.
	Dr. J. Smith Whitaker, M.R.C.S., L.R.C.P.	Ministry of Health.
	Mr. G. G. Panter	Great Northern Hospital.
	Viscount Goschen, C.B.E.	Guy's Hospital.
	Dr. Eason, C.B., C.M.G., M.D.	
10th Feb.	Mr. Vernon Miles	Small General Hospitals in London.
16th Feb.	Viscount Hambledon, D.L., J.P.	British Hospitals Assoc., London Regional Comm.
	Mr. Courtney Buchanan, C.B.E.	
	Mr. A. R. Prideaux	St. Mary's Hosp., Paddington.
	Lt.-Col. W. Parkes	
	Dr. Gordon Dill, O.B.E., M.A., M.D.	Sussex Provident Hospital Scheme.
17th Feb.	Mr. Alfred Langton	Royal Free Hospital.
	Mr. Montague Ellis	
	Mr. R. R. Garratt	
23rd Feb.	Mr. N. Bishop Harman, M.B., F.R.C.S.	British Medical Association.
	Mr. H. G. Dain, M.B., M.R.C.S., L.R.C.P.	
	Mr. J. R. Drever, M.A., M.B., Ch.B.	
	Mr. W. McAdam Eccles, M.S., F.R.C.S.	
	Mr. A. E. Morison, M.B., C.M., F.R.C.S.	
	Sir John Young, C.V.O.	Central London Throat, Nose & Ear Hospital.
	Mr. Richard Kershaw	
	Mr. Thomas Hayes	St. Bartholomew's Hospital.

Date.	Witnesses.	——
24th Feb.	Dr. G. F. Blacker, C.B.E., M.D., F.R.C.S.	University College Hospital.
	Mr. J. G. F. Buckle, B.A.	
2nd Mar.	Sir Norman Moore, Bart., LL.D., M.A., M.D.	Royal College of Physicians.
	Sir John Rose Bradford, K.C.M.G., C.B., C.B.E., M.D.	
	Sir James Galloway, K.B.E., C.B., M.D.	
	Dr. H. W. G. Mackenzie, M.A., M.D.	
	Dr. J. Fawcett, M.D., F.R.C.P.	
	Mr. R. F. Norton, K.C.	King's College Hospital.
	Mr. John Murray, C.V.O.	London Hospitals for Children.
	Mr. A. C. Norman	
	Lord Winterton, M.P.	London Hospitals for Women.
3rd Mar.	Mr. M. Osborn	Sheffield Joint Hospitals Council.
	Mr. S. R. Lamb	
9th Mar.	Mr. J. Albert Davies	Porth & District Hospital.
	Sir William Diamond, K.B.E.	Cardiff — King Edward VII. Hos.
	Mr. Leonard D. Rea, F.C.I.S.	
10th Mar.	Mr. William Griffiths	Merthyr General Hospital.
	Mr. John Williams	
16th Mar.	Sir Anthony A. Bowlby, K.C.B., K.C.M.G., K.C.V.O., F.R.C.S.	Royal College of Surgeons.
	Sir Cuthbert S. Wallace, K.C.M.G., C.B., F.R.C.S.	
	Mr. H. J. Waring, C.B.E., F.R.C.S.	
	Mr. Raymond Johnson, O.B.E., F.R.C.S.	
	Sir Alan Anderson, K.B.E.	King Edward VII. Hospital Fund.
	Mr. H. R. Maynard	
	Dr. J. E. Thomas	Carnarvonshire & Anglesey Infir.
	Mr. Perkins	
	Sir John Paget, K.C.	National Hospital for Paralysed & Epileptic.
	Mr. Hamilton	
17th Mar.	Mr. Charles Irwin	Newcastle - on - Tyne, Royal Victoria Infir'y.
	Mr. R. Orde, B.A.	
6th April	The Rt. Hon. The Earl of Arran, K.P.	Royal Westminster Ophthalmic Hospital.
	Mr. Gustavus Hartridge, F.R.C.S.	
	Captain J. H. Johnson	
	Mr. C. R. Scrase Dickins	Royal Sussex County Hosp., Brighton.
	Mr. L. W. Gage	
	Mr. Phillip Inman	Hospital Sat. Fund.
7th April	Mr. T. Ratcliff	Birmingham General Hospital.

Date.	Witnesses.	——
13th April	Mr. H. J. Eason	London Lock Hosp.
	Dr. A. L. Baly, M.A., M.R.C.S., L.R.C.P.	Lambeth Infirmary.
	Mr. Frank Inch	Norfolk & Norwich Hospital.
	Mr. Alfred Whitham	Beckett Hospital, Barnsley.
	Lt.-Col. Egbert Lewis, J.P.	Royal United Hospital, Bath.
	Mr. Forbes Fraser, F.R.C.S.	
14th April	Sir Edward Penton, K.B.E.	Middlesex Hosp.
	Mr. Walter Kewley	
	Dr. A. G. Stewart, M.A., M.D., F.R.C.S.	Paddington Poor Law Infirmary.
20th April	Mr. Frederick Wood	Brompton Hosp. for Consumption.
	Dr. H. Batty Shaw, M.D., F.R.C.S., F.R.C.P.	
	Sir William Cobbett	Manchester Royal Infirmary.
	Mr. Frank G. Hazell	
	Dr. F. W. Ellis, M.D., Ch.B., F.R.C.S.	Birmingham Dudley Rd. Poor Law Infirmary.
27th April	Mr. James Macfarlane	Glasgow Royal Infirmary.
	Mr. W. C. Gray	Glasgow Victoria Infirmary.
28th April	Rev. G. B. Cronshaw, M.A.	Radcliffe Infirmary & County Hosp., Oxford.
4th May	Mr. H. Wade Deacon, C.B.E.	British Hospitals Association Regional Committees.
	Mr. W. H. Harper	
	Mr. Radcliffe	
	Mr. J. F. Burnicle	
	Mr. Courtney Buchanan, C.B.E.	
	Sir Basil Mayhew, K.B.E.	King Edward VII. Hospital Fund.
	Sir Alan Anderson, K.B.E.	
	Rt. Hon. Lord Somerleyton, K.C.V.O.	
	Sir Cooper Perry, M.A., M.D.	
	Mr. H. R. Maynard	
	Col. D. J. Mackintosh, C.B., M.V.O., M.D.	Glasgow Western Infirmary.
5th May	Dr. F. N. Kay Menzies, M.D., Ch.B., F.R.C.P.	London County Council.
6th May	Sir Arthur Robinson, K.C.B., C.B.E.	Ministry of Health.

Witnesses representing the Royal Infirmary, Edinburgh, and the Nottingham General Hospital were unable to attend personally and tendered their evidence in writing. Written evidence was also received from the Hon. Stephen Coleridge on behalf of the National Anti-Vivisection Society.

APPENDIX B.

Income and Expenditure Summaries.

(*a*) Normal Income and Expenditure, in 1920, of 672 Hospitals making Returns :—

	Total No. of Hospitals.	No. of Hospitals making Returns.	Surplus.		Deficit.	
			No.	Amt.	No.	Amt.
				£		£
London - -	117	113	40	97,240	73	463,413
Provinces - -	728	452	204	220,126	248	501,282
Scotland - -	107	107	50	109,865	57	73,623
	952	672	294	£427,231	378	£1,038,318

The following Special Grants in respect of the Hospitals making Returns have been excluded in ascertaining the Normal Income of such Hospitals :—

	£
London.	
Emergency Grant from King Edward's Fund (paid out of the Capital of that Fund) - - - - - -	254,150
National Relief Fund (in reduction of war deficit) - -	200,000
Provinces.	
National Relief Fund (out of a sum of £360,000 distributed to all the Provincial Hospitals towards the accruing war deficit for the 5 years ending 31st December 1919) - - - - - - - - -	273,091
Scotland.	
National Relief Fund (in reduction of war deficits) - -	77,000

(*b*) The above may be re-classified among the different kinds of Hospitals in London and the Provinces as follows :—

Classification.	London.						Provinces.					
			Normal Income and Expenditure.						Normal Income and Expenditure.			
			Surplus.		Deficit.				Surplus.		Deficit.	
	No. of Hos.	No. of Beds.	No. of Hos.	Amount.	No. of Hos.	Amount.	No. of Hos.	No. of Beds.	No. of Hos.	Amount.	No. of Hos.	Amount.
				£		£				£		£
I. General with Medical School and with over 100 beds in daily occupation	12	5,260	2	22,883	10	275,875	14	4,706	4	51,362	10	166,025
II. General without Medical School and with over 100 beds in daily occupation	9	1,455	—	—	9	55,343	50	9,433	12	55,822	38	192,208
III. General with less than 100 beds in daily occupation	12	888	5	9,169	7	21,351	185	7,289	83	57,521	102	81,413
IV. Consumption	2	511	1	25,303	1	3,102	5	562	2	1,143	3	11,555
V. For Women	5	296	2	2,007	3	2,281	14	689	6	3,081	8	8,835
VI. For Children	6	698	—	—	6	47,497	18	1,242	5	3,200	13	16,198
VII. Ophthalmic	5	276	1	392	4	8,851	14	704	8	8,943	6	5,246
VIII. For Epilepsy and Paralysis	3	350	—	—	3	7,134	—	—	—	—	—	—
IX. Cottage	14	410	8	9,383	6	2,491	125	1,667	71	24,413	54	7,973
X. Lying-in	8	381	5	4,325	3	4,708	6	344	3	496	3	5,051
XI. Not covered by Classes I to X	37	2,126	16	23,778	21	34,780	21	3,167	10	14,145	11	6,778
	113	12,651	40	97,240	73	463,413	452	29,803	204	220,126	248	501,282

(*c*) The items contributing to the above Summary, so far as details have been supplied are as follows :—

London (113 Hospitals only).	Amount.
Income—	
(*a*) From Invested Property (including Income from Continuing Trusts)	£ 439,149
(*b*) Subscriptions, Collections, &c. (not for Capital purposes)	724,430
(*c*) Central Funds	283,328
(*d*) Patients	257,719
(*e*) Public Authorities	280,436
(*f*) Miscellaneous	65,936
(*g*) Free Legacies (*i.e.*, not subject to Trusts or specifically earmarked for Capital Expenditure or endowment of Beds)	266,606
(*h*) Special from Bazaars, &c.	118,991
Total	£2,436,595
Expenditure—	£
(*a*) Provisions	617,716
(*b*) Surgery and dispensary	315,851
(*c*) Domestic	522,775
(*d*) Establishment	145,829
(*e*) Salaries and wages	836,549
(*f*) Miscellaneous	47,474
Administration	148,062
Rent, rates and taxes	88,768
Interest	37,741
Contributions, finance, &c.	42,003
Total	£2,802,768

(*d*) *Provinces* (452 hospitals only).	Amount.
Income—	
(*a*) From invested property (including income from continuing trusts)	£ 460,932
(*b*) Subscriptions, collections, &c. (not for capital purposes)	1,867,407
(*c*) Patients	302,016
(*d*) Public Authorities	502,235
(*e*) Miscellaneous	96,903
(*f*) Free legacies (*i.e.*, not subject to trusts or specifically earmarked for capital expenditure or endowment of beds)	269,093
(*g*) Special appeals and bazaars	222,524
Total	£3,721,110
Expenditure—	£
(*a*) Provisions	1,060,975
(*b*) Surgery and dispensary	538,670
(*c*) Domestic	724,078
(*d*) Establishment	274,182
(*e*) Salaries and wages	939,595
(*f*) Miscellaneous	81,740
Administration	155,799
Rent, rates and taxes	44,535
Interest	44,117
Special sundry	138,575
Total	£4,002,266

	Amount.
(*e*) *Scotland* (107 hospitals).	
Income—	£
(*a*) Annual subscriptions	187,050
(*b*) Donations, entertainments, &c.	100,462
(*c*) From churches	25,737
(*d*) From employees	137,719
(*e*) From investments	151,892
(*f*) From or on behalf of patients	110,755
(*g*) Fees from students, nurses, &c.	25,203
(*h*) Free legacies, &c.	235,804
(*i*) Special donations, &c.	68,485
(*j*) Miscellaneous	22,577
Total	£1,065,684
Expenditure—	£
(*a*) Provisions	299,992
(*b*) Surgery, &c., drugs and appliances	106,247
(*c*) Domestic, heat, light, cleaning and furnishings	166,548
(*d*) Establishment, rates, taxes, feu duties, repairs and general upkeep	99,464
(*e*) Salaries and wages of medical and hospital staff	205,064
(*f*) Administration, secretarial expenses, printing and advertising	35,319
(*g*) Extraordinary expenditure—Additions to plant, &c.	56,230
(*h*) Miscellaneous	60,578
Total	£1,029,442

(*f*) *Statistics*—

In the case of 282 hospitals in London and the provinces which have kept the necessary records, the following information is available :—

Total number of beds	23,933
Average number of beds occupied in 1920	19,586
Cost per bed occupied per annum	£167
Out-patient attendances in 1920	9,540,371
Cost per out-patient attendance	1*s.* 5*d.*

(*g*) Comparing the results of 1919 and 1920 of those hospitals which do not report any material alterations in size, &c., during the period :—

	In London, 113 Hospitals.	In Provinces, 400 Hospitals.	In Scotland,* 107 Hospitals.
Normal income has increased as compared with the income of 1919	Per cent. 15	Per cent. 23	Per cent. 39
Normal expenditure has increased as compared with the expenditure of 1919	19	22	25

* Irrespective of alterations in size of hospitals.

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