**Health services in Britain / prepared by Reference Division, Central Office of Information.**

# *Health Services in Britain*



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*Prepared by*

REFERENCE DIVISION

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# INTRODUCTION

The past century has been one of very great progress in the medical and health services in Britain. The second half of the nineteenth century was marked by the development of environmental health services providing the basic conditions of healthy living. The early twentieth century saw the start of State aid for medical research and, in the medical benefit of National Health Insurance in 1911, the beginnings of a State-aided general practitioner service outside the Poor Law.[1]

The first inter-war decade is chiefly notable for the development of maternity and child welfare and of national schemes for the control of tuberculosis and venereal disease. In the second inter-war decade the Local Government Act of 1929 stimulated a rise in the standard of service offered by the municipal hospitals. The second world war served to emphasise the importance of a sound diet, and as a result the Welfare Foods Service for expectant mothers was introduced and the school meals service and industrial canteens were expanded. War also stimulated developments in industrial health services and in the rehabilitation of the disabled and it was during the war that the way was prepared for the National Health Service, which was created in 1948.

These improved services, together with advances in science and raised standards of living, are reflected in the vital statistics. The figures show a steady decline from the 1860s in mortality rates at all ages. Although tuberculosis is today the most serious menace among infectious diseases, the death rate from it has fallen steadily over the last century, and rapidly in recent years: in England and Wales it has fallen to a thirtieth of its level of a century ago. Immunisation has reduced diphtheria deaths in the United Kingdom from 3,268 in 1941 to 8 in 1958. Where mortality rates show an increase, as they do for certain forms of cancer, this is in part due to the increased expectation of life which increases the risk of dying from the malignant and degenerative diseases of later life. Infant and maternal mortality have also declined very sharply since the mid-nineteenth century. The drop in infant mortality (under one year) has occurred mainly in the twentieth century—from 151 per 1,000 live births in 1901 in England and Wales to 22·5 in 1958. Maternal mortality, still over 4 per 1,000 total births in England and Wales up to 1934, had fallen to 0·43 per 1,000 total births in 1958. Similar improvements are recorded in Scotland and Northern Ireland. Physique, moreover, has improved. The average child of 7 years old in the mid-1930s was already as tall and heavy as the average child of 8 years old 30 years earlier, and reports of school medical officers show that school-children in Britain today are healthier, taller, and generally of better physique than those of 10 to 20 years ago.

This pamphlet describes first the organisation in England and Wales of the public health services, which seek to maintain a healthy environment and clean food, then the National Health Service, which provides a compre-

[1] The law governing the relief of destitution by local authorities between 1601 and 1948.

hensive personal health service for everyone in Britain. Industrial health services and the school health service are the subjects of separate chapters. The chapters on health services in Scotland and in Northern Ireland deal only with those aspects, mostly administrative, of the services in these countries which differ from those in England and Wales. To complete the picture, there are chapters on medical research and on professional training for medical and allied professions.

1

# PUBLIC HEALTH

Public measures to promote healthy living conditions in Britain preceded public provision for the care of the sick. Although at the Reformation in the sixteenth century the religious orders which had nursed the sick in the Middle Ages were swept away, and those sick persons who were destitute were subsequently provided for under the Poor Law, the main hospital and medical services in England and Wales remained almost entirely outside the sphere of public administration until the twentieth century.

The history of modern measures to promote public hygiene begins in the mid-nineteenth century. Town councils had issued elementary sanitary regulations in the Middle Ages, and water supplies were first regulated in the sixteenth century and steps taken to check the spread of plague and other infectious diseases; but by the early part of the nineteenth century the rapid growth of towns as a result of the industrial revolution had created urgent sanitary problems calling for drastic new measures. Outbreaks of cholera and typhus at this time emphasised the total inadequacy of existing arrangements for public health, especially in towns.

The Public Health Act of 1848 is a landmark in public health history, because it attempted to lay down a common minimum of sanitary services. It aimed at creating a comprehensive public health system to include a sound water supply, proper sewerage, improved drainage and cleansing, and street paving, and at bringing these services under unified control by local public health authorities supervised by a central board. As a result of the Act, local authorities for the first time appointed medical officers of health. The Act of 1848 pointed the way for the Public Health Act of 1875, upon which all subsequent legislation has been based. The Public Health Act of 1936 brought up to date and consolidated preceding acts, and constitutes the present basic public health code, for the implementation of which local authorities are mainly responsible. By this and other Acts, local authorities have extensive powers for the making and administration of by-laws (laws of local application) relating to matters of public health.

The local authorities chiefly concerned in England and Wales are the councils of county and non-county boroughs, urban and rural district councils, and, to a limited extent, parish councils.

## WATER SUPPLY AND SEWERAGE

Water supply, sewerage and the prevention of river pollution in England and Wales are among the responsibilities of the Minister of Housing and Local Government. The Water Act, 1945, gives powers for the control of resources, long-term planning of supplies, and the reorganisation of areas of supply. The management of rivers, including the prevention of pollution, is in the hands of the River Boards set up under the River Boards Act, 1948. (The rivers Thames and Lee have older-established Conservancy Boards.) Local authorities are required (by the Water Act, 1945) to ensure that whole-

some water is supplied to every part of their districts where there are houses or schools. The Rural Water Supplies and Sewerage Acts, 1944 to 1955, empower the minister to make grants towards the cost of schemes of water supply and sewerage in rural areas. It is estimated that piped water supplies now reach some 97 per cent of all households in England and Wales and 90 per cent of rural households.

It is the duty of every local authority to provide such public sewers as may be necessary for effectually draining its district and to make provision of effective sewage disposal works. The provision of drains or private sewers for individual properties is primarily a matter for the property owners or developers.

## GOOD HOUSING

Housing is another important aspect of public health for which local authorities have wide responsibilities (mainly, now, under the Housing Act, 1957, but also under the Public Health Act, 1936). They are responsible for securing the repair, maintenance and sanitary condition of houses, the clearance and redevelopment of unhealthy and congested areas, the abatement of overcrowding, and the provision of housing accommodation to meet local needs.[1] Landlords are required by law to keep their house property in a fit state for human habitation, and if they allow it to fall below the prescribed standards the local authority may require them to carry out repairs, or, if the property cannot be rendered fit for habitation, it can be closed and scheduled for demolition.

## CONTROL OF INFECTIOUS DISEASES

Local authorities are responsible to the Minister of Health for recording notifications of the prescribed infectious diseases; they are also responsible for the investigation of outbreaks of infectious diseases by the Medical Officer of Health and for disinfection and other measures advised by the Medical Officer of Health for preventing the spread of infectious diseases in the area.

## HEALTH CONTROL AT SEAPORTS AND AIRPORTS

The Minister of Health also has the general responsibility for supervising the operation of the health control at seaports and airports, the primary object of which is to prevent the introduction of infectious disease into the country. It is operated at the principal seaports by Port Health Authorities specially constituted for the purpose, and at others by the riparian local authorities. At State airports the minister is directly responsible for the control, but he has invariably delegated its operation to the local authority; at other airports the local authority is responsible.

Health control is applied in accordance with the Public Health (Ships) Regulations, 1952, and the Public Health (Aircraft) Regulations, 1952, which, among other things, implement the International Sanitary Regulations adopted by the World Health Assembly in May 1951. At seaports the regulations are applied by the port medical officer, assisted by port health inspectors, rodent officers and others; at airports the airport medical officer

[1] See COI reference pamphlet *Housing in Britain*, for a fuller account of the housing powers and duties of local authorities.

is responsible for applying the Regulations, and where necessary he has lay assistants.

The control in normal circumstances is not onerous, and may consist of a rapid scrutiny of all arriving passengers, with a more detailed examination for special cases or the issue to passengers from certain areas of 'Warning Notices' (to be taken to a doctor if the passenger falls sick within 21 days of landing). In abnormal circumstances—for example, the arrival of a ship with infection on board—more elaborate precautions are taken. Actual or suspected cases of infectious disease can be detained at any time, and contacts can be placed under surveillance.

Apart from this health control certain categories of aliens arriving in the country may be subjected to detailed medical examination under the Aliens Order.

## PURE FOOD

The purity, hygiene, composition and description of food are controlled by legislation now consolidated in the Food and Drugs Act, 1955. The Act and Regulations made under it are, broadly, executed and enforced by 'Food and Drugs authorities' (i.e. county councils, county borough councils and, generally, the larger borough and urban district councils) in relation to composition, adulteration and description, and by local authorities (i.e. county borough, borough, urban district and rural district councils) in relation to purity and hygiene. The Ministry of Health and the Ministry of Agriculture, Fisheries and Food are the central Departments responsible for advising and for making Regulations under the Act.

All premises where food for sale for human consumption is prepared, sold or stored are required to conform to certain hygienic standards. Authorised officers of food and drugs authorities and of local authorities are empowered under the Act to take samples of any food for sale for human consumption, for analysis or for bacteriological or other examination. Special regulations are in force for certain foods such as milk, meat and ice-cream.

## OTHER PUBLIC HEALTH DUTIES

The public health functions of local authorities also include street cleansing and refuse disposal, the provision of burial grounds, the provision of baths and wash-houses, disinfestation and rodent control, and the abatement of smoke and other nuisances, such as those arising from the processes of offensive trades.

Under the Public Health Acts, local authorities have power to regulate the provision of sanitary conveniences in places of work (as well as in houses) and to treat unclean or dangerously overcrowded or ill-ventilated places of work as nuisances, of which the abatement can be enforced. (For other industrial health measures, see Chapter IV.)

II

# THE NATIONAL HEALTH SERVICE

A century's progress in Britain's health and medical services culminated on 5th July, 1948, in the establishment of National Health Services throughout the United Kingdom. Similar services operate in England and Wales, in Scotland and in Northern Ireland, but with administrative differences (see Chapters V and VI).

## SCOPE AND FINANCE

The National Health Service Act, 1946, aimed at promoting 'the establishment in England and Wales of a comprehensive health service, designed to secure improvement in the physical and mental health of the people of England and Wales, and the prevention, diagnosis and treatment of illness'; and through its provisions the Minister of Health was made responsible to Parliament for seeing that health services of every kind, and of the highest possible quality, were available to everyone who needed them. The National Health Service (Scotland) Act, 1947, laid similar responsibilities on the Secretary of State for Scotland.

There was no intention that the introduction of the new health service should mean a complete break with the past. On the contrary, it was clearly understood from the beginning that all that was good in the existing services should be absorbed into the new scheme. What was aimed at was a strengthening and an expansion, so that benefits once available only to insured persons or those who could afford to pay for them, or as a form of charity, should become available to everyone.

The essential freedoms have been safeguarded, for the public is free to use the Service, or any independent part of it, as it pleases. The patient is free to choose his doctor, and to change to another if he wishes to do so. The doctor is free from interference in his clinical judgment, and may make what criticism he wishes of medicine in general or of the Service. He may accept private patients while taking part in the Service.

The former health and medical services were re-grouped in the new Service and entirely new administrative machinery was devised. The Service is constituted in three main parts: the general practitioner (including dental) services, the hospital and specialist services, and the local health authority services (comprising a range of home and clinic services for prevention, treatment or care). The minister's detailed responsibilities are delegated to series of boards and councils. The working of the Service in all its branches is continuously under review, and modifications and improvements are being made as their desirability emerges. Amending Acts were passed in 1949, 1951, 1952 and 1957; and National Health Service Contributions Acts in 1957 and 1958.

All but a very small proportion of the population of Great Britain is using the Service. The great majority of specialists are taking part and about 98 per cent of general practitioners; practically all of the dentists available

for general practice and almost all chemists are taking part. Over 20,000 general practitioners (principals and assistants) in England and Wales are in the Service, and nearly 2,500 general practitioners in Scotland. It is believed that only some 500 or 600 general practitioners remain outside the Service. Of about 11,200 dentists in England and Wales available for general practice, about 10,300 are in the Service, and of 1,300 dentists in Scotland, practically all are in the Scottish Service. Over 900 ophthalmic medical practitioners and over 6,000 opticians in England and Wales, and 70 ophthalmic medical practitioners and 900 opticians in Scotland are engaged in the Eye Services. Chemists in the Service number nearly 16,000 (almost all) in England and Wales, and 2,800 in Scotland. Over 3,000 hospitals are within the Service.

In England and Wales in 1958, the 2,641 hospitals in the Service had 483,000 staffed beds, including about 214,000 beds specially set aside for mental disorder. The nursing and midwifery staff in these hospitals comprised 152,000 full-time and 41,000 part-time nurses and midwives. There were, besides, a small number of hospitals remaining outside the Service for special reasons. Most of these are run by religious orders; some, such as the Italian and French hospitals, serve a special group of patients, and others are maintained for the chronic sick or convalescent by charitable organisations. There are also private nursing homes, which must be registered as such. In Scotland at the end of 1958 there were 400 National Health Service hospitals with about 64,000 staffed beds and a full-time nursing and midwifery staff of about 22,000 and a part-time staff of 5,000.

**Cost and Charges**

The total cost of the National Health Service in the United Kingdom amounts to about 3½ per cent of the total national resources.[1] In 1957–58 the Service accounted for about a quarter of total current public expenditure on social services—a sum similar to that spent on education and equivalent to nearly £13 per head of the population.

The greater part of the cost of the Service falls on the Exchequer (about 77 per cent in 1957–58 and estimated to be about 72 per cent in 1958–59). Other sources of finance are the National Health Service contribution which is paid with the National Insurance contribution (about 9 per cent in 1957–58 and estimated to increase to 14 per cent in 1958–59); payments by patients for those items in the Service for which charges are made (about 5 per cent in 1957–58 and estimated to be the same amount in 1958–59); payments in connection with superannuation schemes (about 5 per cent in 1957–58 and estimated to be the same in 1958–59); and a small part is met from local rates (about 4 per cent in 1957–58 and estimated to be the same in 1958–59). Apart from charges for certain items, the Service is available to all according to medical need. Its availability is not dependent on contributions to National Insurance nor on contributions paid under the National Health Service Contributions Acts.

To help to limit expenditure without reducing the services offered, it was found necessary in 1951, and again in 1952, to introduce charges for certain

[1] For table of National Health Service expenditure and rates of contribution see Appendix I.

items in the Service. Certain exemptions or refunds are made and anyone may apply to the National Assistance Board for help in meeting any of these charges.

There is a charge of 1s. for each item prescribed on a prescription form, and charges are also made for dentures and for spectacles except children's spectacles in standard frames (see p. 15), for elastic hosiery supplied in the family doctor service or hospital out-patients' departments, for certain appliances supplied to out-patients (see p. 17), for treatment in the dental service but not for examination only or for treatment given to persons under 21 or to nursing or expectant mothers (see p. 15), and for some local health authority services, e.g., domestic help and day nurseries.

These various charges are imposed under the National Health Service (Amendment) Act, 1949, and the National Health Service Acts, 1951 and 1952. The 1946 Act allowed for charges for a limited number of hospital beds for patients desiring privacy or private treatment (see p. 17).

In addition to the introduction of charges, several administrative measures have been taken to secure economy in the Health Service without prejudice to the quality of service provided.

A clause in the 1949 Act empowered the minister (or Secretary of State), if he so wished, to make regulations for the recovery of the cost of treatment under the National Health Service from any person normally resident overseas. Immigration authorities were instructed to refuse admission to people who came to Britain only to use the Health Service. This does not mean that a visitor from overseas is not welcome to free treatment, as an act of hospitality, for illness or accident overtaking him during his stay.

The cost of the Service has been under constant review since 1948 and a committee set up in 1953 under the chairmanship of Mr. C. W. Guillebaud, a Cambridge economist, found no opportunity for recommending either new sources of income or substantial reductions in the cost of the Service.[1] During the period 1949–58, in spite of the introduction of charges, the real cost of the Service in Great Britain, after allowing for rising wages and prices, increased by approximately £80 million. At the same time, many of the services provided have been substantially expanded or improved. In order to reduce that part of the cost borne by the Exchequer, the weekly National Health Service contribution was doubled in 1957 under the National Health Service Contributions Act, 1957, and further increased in 1958 under the National Health Service Contributions Act, 1958.

## ORGANISATION IN ENGLAND AND WALES

The Minister of Health has direct responsibility for (*a*) the provision on a national basis of all hospital and specialist services; (*b*) the conduct of research work into matters relating to the prevention, diagnosis and treatment of illness; (*c*) a Public Health Laboratory Service; and (*d*) a Blood Transfusion Service. He has indirect responsibility for the family practitioner services and local health authority services.

The minister discharges his responsibilities under the Act through executive

[1] Report of the Committee of Enquiry into the Cost of the National Health Service, Cmd. 9663, HMSO, 1956, 11s.

councils, regional hospital boards, boards of governors of teaching hospitals, and local health authorities.

**Central Health Services Council**

The minister is advised in the discharge of his responsibilities by the Central Health Services Council, which reviews the general development of the Service and makes a special study of any subject to which, in its view, the minister's attention should be called, and by a number of standing advisory committees, which he has established on the recommendation of the Central Council.[1] These committees at present consist of:

The Medical Committee
The Dental Committee
The Pharmaceutical Committee
The Ophthalmic Committee
The Nursing Committee
The Maternity and Midwifery Committee
The Tuberculosis Committee
The Mental Health Committee, and
The Cancer and Radiotherapy Committee.

The medical, dental, pharmaceutical and ophthalmic committees are professional in character, while the others include lay members and review the whole scope of the services in their particular field.

In addition to the standing advisory committees, the Central Council sets up committees of its own as need arises: these have included a committee on the administration and organisation of the hospital services, on prescribing, on co-operation between hospital, local authority and general practitioner services, on general practice, and on hospital supplies. These committees may include co-opted members from outside the council, and such bodies as the British Medical Association (the doctors' professional association) may be consulted.

**Executive Councils**

The 138 executive councils in England and Wales are responsible for the administration and general management of the family practitioner services. Each has 25 members, 12 of whom have been appointed by the local doctors, dentists and pharmacists. An executive council has other important functions, such as that of co-operation with, for example, the local health authorities (see p. 12), and eight of its members are appointed by the local health authority, the remaining five being appointed by the Minister of Health. Since the work of the councils closely affects members of the medical, dental and pharmaceutical professions, and includes the publication of lists of doctors, dentists and others who are taking part in the public service in their respective areas, each council is assisted in its duties by local committees representative of the various professions concerned.

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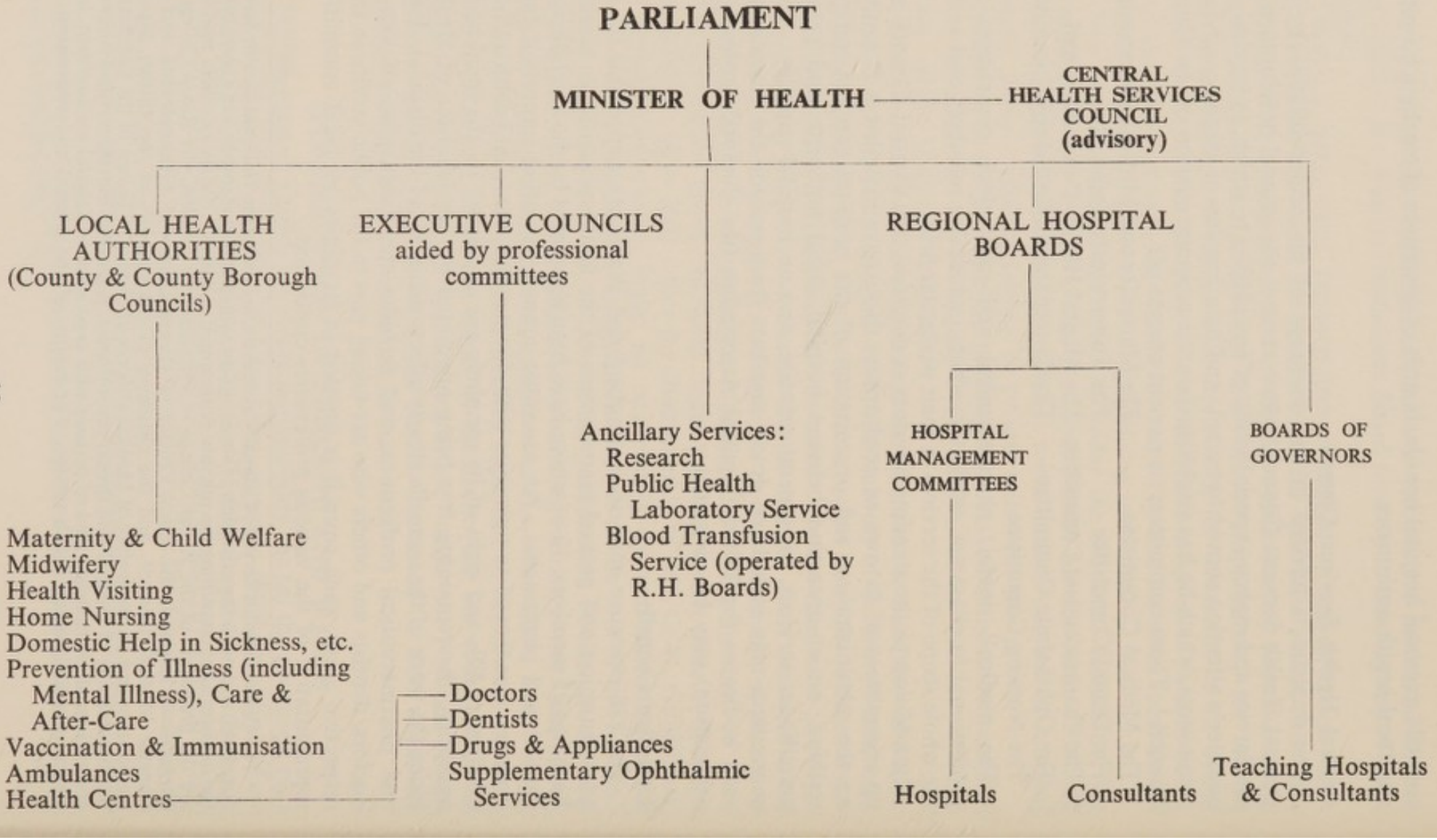
[1] The Central Health Services Council was constituted under the National Health Service Act, 1946, and, with the exception of six *ex officio* members, the members are appointed by the minister after consulting the relevant representative bodies. The six *ex officio* members are the presidents of the Royal College of Physicians of London, the Royal College of Surgeons of England, the Royal College of Obstetricians and Gynæcologists and the General Medical Council, and the chairmen of the councils of the British Medical Association and of the Society of Medical Officers of Health. The rest of the membership is representative of medical and dental practitioners, registered nurses, certified midwives and registered pharmacists, and of persons with experience in hospital management, local government and mental health service. For reports of the council and committees, see p. 50.

## ORGANISATION OF THE NATIONAL HEALTH SERVICE IN ENGLAND AND WALES



Executive councils are required to set up service committees to investigate complaints about the family practitioner services given by doctors, dentists, chemists and opticians. The councils may recommend to the Minister of Health (in Scotland, the Secretary of State) the withholding of money from practitioners who fail to comply with their terms of service, or may take other action against them. A special tribunal decides those cases in which it is proposed that a practitioner's name should be removed from the list of general medical practitioners, pharmacists, dentists, ophthalmic medical practitioners or opticians practising in the National Health Service. There is a right of appeal to the Minister of Health (or the Secretary of State), and also an appeal on a point of law to the High Court against a decision of a tribunal.

**Regional Hospital Boards**

The 15 regional hospital boards, which are in general charge of the hospital and specialist services, operate in areas determined so as to secure, as far as practicable, that these services are conveniently associated with a university having a school of medicine. Each board has a membership of between 22 and 32 persons, appointed by the minister after consultation with universities, local health authorities, bodies representing the medical profession and other bodies such as voluntary associations, employers and trade unions. All appointments are honorary. The term of office is three years, one-third of the board retiring annually and being eligible for reappointment.

**Boards of Governors of Teaching Hospitals**

Hospitals in the Service are under the management of the regional hospital boards, with the exception of those designated as teaching hospitals by the Minister of Health (after consultation with the university concerned) to provide facilities for undergraduate and postgraduate clinical teaching. There are 36 teaching hospitals of which 26 (12 undergraduate and 14 postgraduate) are in London. The ten provincial teaching hospitals provide facilities for both undergraduate and postgraduate teaching. Each teaching hospital has its own board of governors, which is responsible, under the minister alone, for its organisation and control. The members are appointed by the minister, but three-fifths of them are nominated in equal numbers by the university, the teaching staff and the regional hospital board for the area in which the hospital is situated.

Medical and dental schools are university departments. Those in London have their own governing bodies, with a constitution agreed with the University of London.

**Hospital Management Committees**

The detailed internal administrative work connected with individual non-teaching hospitals or groups of hospitals is carried out by 382 hospital management committees, whose members are appointed by the boards in consultation with the local health authorities, the executive councils, the senior doctors and dentists working in the hospitals and other interested bodies. These committees are responsible for the day-to-day running of their hospitals, and for the appointment of all staff except the most senior

officers. Although their powers are delegated from the regional boards, they have complete freedom of action in most respects.

**Local Health Authorities**

The 146 local health authorities, which are the councils of counties and county boroughs (the Isles of Scilly are deemed a local health authority under the Act), are responsible for providing those services, e.g., maternity and child welfare, health visiting, vaccination and immunisation, etc., which have been in operation under local government auspices for many years. They are also responsible for ambulances, home nursing and domestic help schemes, and all other services for the prevention of illness and care and after-care (including cases of mental illness and mental deficiency), and for the maintenance of health centres (see pp. 23-24).

## PRACTITIONER SERVICES

The practitioner services consist of the Family Doctor Service, the Dental Service, the Eye Service, and the Pharmaceutical Service, all of which provide the patient with the individual medical attention that he needs.

**Family Doctor Service**

Through the Family Doctor Service, the professional attention of a family doctor is made available to everyone. Patients may choose the doctor they wish, provided only that he is enrolled in the Service and that he consents to attend them. They may also change their doctor with a minimum of formality. The doctor has a similar freedom to accept or refuse patients as he wishes. He cannot be forced to attend any person against his will, although he has, of course, a general obligation to provide emergency treatment where necessary, nor does his enrolment in the Service preclude him from attending paying patients who have not joined the Service, if he cares to do so.

The doctor in the Family Doctor Service is free to treat his patients exactly as the family doctor treated them in the past. There are no regulations as to what drugs or treatment he may prescribe, although the Chief Medical Officer of the Ministry of Health has asked doctors to consider before prescribing any proprietary preparations whether a standard drug or combination of standard drugs can be prescribed with equal effect, and there is provision for the investigation of improper or excessive prescribing. If a serious illness develops or diagnosis is difficult, he may call in a consultant and secure hospital treatment without reference to any outside authority.

The advent of the Health Service has not harmed the relationship between doctors and their patients; there may even have been some improvement as a result of the removal of the bar to treatment which lack of money imposed, and of increased co-operation among doctors. (This was one of the conclusions reached by the committee of the Central Health Services Council which in 1954 reported on general practice within the National Health Service.[1])

Doctors already practising in an area before 5th July, 1948, were entitled to join the public service in that area and to continue practice as before.

[1] Report of Committee on General Practice within the National Health Service. Central Health Services Council. HMSO, 1954. 2s. 6d.

Any doctor now wishing to take up public practice must first get the consent of the Medical Practices Committee,[1] in case there are a sufficient number of doctors in the area already. It is one of the aims of the National Health Service to improve distribution of doctors, so that everybody may have an equal chance of first-class medical attention; and it is therefore essential to apply some limit to the number of practitioners in any given area.

The maximum permitted number of patients' names to be put on one principal's list is 3,500 (reduced from 4,000 in 1953), and the present average number is just over 2,200. After four and a half years of the Service, the Medical Practices Committee for England and Wales reported an increasing number of doctors in general practice within the Service, and a well-established trend towards a more even distribution of general practitioners. This trend resulted from the provisions of the scheme, but as a natural process from the voluntary choice of doctors and not from direction by any statutory body. No doctor is forced to remove from his existing practice, but he may be prevented from starting practice in a new area if it is already well served, and he will be encouraged to choose one of the areas where doctors are most needed. There still remains a number of comparatively under-doctored areas, especially in the industrial north, but the number of patients living in areas where the average doctor's list is very large continues to fall.

A doctor in public service is remunerated by a capitation payment of 18s. a year for each patient registered with him, with an addition of 12s. for every patient within the range of 501 to 1,500 on his list. This scheme gives an annual remuneration ranging from £450 for a list of 500 patients to £3,750 for a list of 3,500. Supplementary payments are available to certain classes of doctors who for special reasons do not obtain much benefit from the additional payments for patients in the 501 to 1,500 range. Doctors in the service may in addition receive mileage payments for visiting in rural areas, inducement payments for practising in specially difficult or unpopular areas, and grants or fees for special services, such as the treatment of temporary residents and emergency patients, the administration of anæsthetics, the training of assistants, maternity work, hospital duties, and dispensing their own prescriptions. An initial practice allowance may be paid in addition to doctors taking up practice in areas designated as in need of more doctors. The allowance is paid on a descending scale (£780 to £260) for the first three years in the practice concerned, and is subject to conditions which have been agreed with the representatives of the profession.[2]

At present the Family Doctor Service is almost always organised from the doctors' own surgeries, to which patients go for advice and treatment unless the doctor visits them at home. A few doctors work from health centres (see pp. 23-24).

The Committee on General Practice reached the conclusion that many of the advantages both to doctors and to patients which had been urged in

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[1] The Medical Practices Committee is appointed by the minister after consultation with representative professional organisations. It consists of a chairman and eight other members. The chairman and six other members (of whom at least five must be in practice) must be medical practitioners.

[2] The earnings of family doctors were studied by the Royal Commission on Doctors' and Dentists' Remuneration, which reported early in 1960 (Cmnd. 939). Its recommendations are under consideration.

favour of health centres might possibly be more easily secured through the evolution of group practices. In a group practice, as defined by this committee, a group of practitioners, including normally between three and six principals, work from a common centre controlled by themselves and jointly employ ancillary help. They co-operate in providing a round-the-clock service for patients and proper off-duty and holiday relief for themselves, and they consult with each other about their patients while each patient remains the responsibility of his own chosen doctor.

On the basis of the committee's conclusions a scheme was introduced to provide interest-free loans for the acquisition of premises for group practice and a considerable development of group practice has ensued.

A group practice may or may not be organised as a partnership. It is increasingly the custom for family doctors to practise in partnership. Slightly more doctors are working with one partner than are working on their own, and smaller numbers are in large partnerships. To become an assistant to a partnership is a common method of entering general practice.

As to co-operation between the family doctor and the other two main branches of the Health Service, which is one of the Service's continuing problems, the Committee on General Practice noted the efforts that were being made to associate more effectively the work of the general practitioner with that of the officers of the local health authorities (and in particular with health visitors) and made several recommendations for associating general practitioners more closely with the hospitals (for example, by allocating some hospital beds for the use of general practitioners).

**Dental Service**

Through the Dental Service patients are provided with all forms of treatment necessary for the restoration of dental fitness. As in the Family Doctor Service, there is complete freedom of choice by patients of dentists and by dentists of patients; and dentists may take private as well as National Health Service patients if they wish. Patients are not required to register with dentists, and the ordinary practice of visiting by appointment is maintained. Dentists providing treatment in their own surgeries are paid on a prescribed scale of fees according to the items of treatment they have carried out.[1]

All conservative dental treatment (e.g., fillings and root treatment), extractions for the relief of pain, extractions not requiring replacement by dentures, and ordinary denture repairs, may be given without reference to any outside authority; but extensive and prolonged treatment of the gums, gold fillings, inlays, crowns, dentures and special appliances and dental surgery may be given only with the authority of the Dental Estimates Board.[2] Patients wishing for certain treatment or appliances that are more expensive than is clinically necessary may have them with the authority of the Dental Estimates Board if they are prepared to pay the extra cost.

In May 1951, charges were introduced for dentures, whereby the patient

[1] The earnings of dentists were studied by the Royal Commission on Doctors' and Dentists' Remuneration, which reported early in 1960 (Cmnd. 939). Its recommendations are under consideration.

[2] The chairman and a majority of members of the Dental Estimates Board are dental practitioners.

has to pay an amount between £2 and £4 5s., according to whether dentures for one or both jaws are supplied and how many artificial teeth are required. In June 1952, a charge of £1, or the full cost of any treatment if less than £1, was introduced for other types of treatment. No charge is made for the clinical examination of a patient's mouth. Charges for dental treatment (other than the supply or relining of dentures or additions to them) are not made for anyone under 21 years of age, or to expectant mothers, or mothers who have had a child during the preceding 12 months. The National Assistance Board[1] can meet or refund charges in cases of hardship.

When dentures supplied through the Service are lost or damaged, the charge described in the last paragraph is not payable for their replacement; but the patient may be called upon to pay all or part of the cost if the need for replacement is judged to have been due to lack of care on his part.

**Supplementary Ophthalmic Services**

The Supplementary Ophthalmic Services, which form part of the eye services available under the National Health Service, provide for the testing of sight and the supply of glasses only. Anyone found to be in need of treatment or to require one of the more unusual types of glasses, or to be suffering from an abnormal condition of the eyes, is referred to his doctor for introduction, if necessary, to the Hospital Eye Service.

Any ophthalmic medical practitioner or ophthalmic optician who has joined the Service may be consulted and lists of such practitioners and opticians can be seen at post offices or the offices of executive councils. A person using these services for the first time must obtain from his doctor a recommendation that his sight needs testing.

Ophthalmic medical practitioners and ophthalmic opticians are paid prescribed fees for testing sight. Payment to opticians or dispensing opticians for the supply of glasses includes a dispensing fee for professional services, together with the wholesale cost of the glasses, and some addition to cover the risk of breakages.

No charge is made for the testing of sight, but in May 1951 a charge for spectacles was introduced. The charge is 10s. for each lens, plus the actual cost of the frames, i.e. a total charge varying between 24s. 8d. and 42s. 2d. for a pair of spectacles. Additional charges are made for certain special lenses supplied at the applicant's own request. A range of glasses is available for children without charge. Glasses may be repaired or replaced partly at the cost of the Service if the loss or damage is judged not to have been due to the applicant's lack of care.

Help towards the cost of new glasses or frames only can be obtained on grounds of hardship from the National Assistance Board, and for repairs and replacements from the executive council and, in some circumstances, from the board. The Committee on the Cost of the National Health Service recommended that second priority after dental treatment charges should be given to a reduction in the charge for spectacles.

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[1] The National Assistance Board is the body which administers the national scheme of financial assistance for those in need.

**Pharmaceutical Service**

Through the Pharmaceutical Service, everyone receiving treatment under the Family Doctor Service is entitled to drugs, medicines and certain appliances prescribed by his doctor as part of that treatment. Any special appliances not covered by this part of the Service may be supplied through the hospitals. Chemists in the Service are required to be open at all reasonable times so that patients may be sure of getting their medicine without undue delay. There is a charge of one shilling for each item on each prescription form made out by the family doctor and presented to the chemist for dispensing. A charge of 5s. or 10s. per item is made for elastic hosiery. These charges are refunded to war pensioners who need the prescription for an accepted war disability, to National Assistance recipients, and to others for whom payment would cause hardship assessed according to National Assistance Board standards.

## HOSPITAL AND SPECIALIST SERVICES

The hospital and specialist services provide all forms of hospital care and treatment, for both in-patients and out-patients, in every kind of hospital, in maternity homes, tuberculosis sanatoria, infectious disease units, institutions for the chronic sick, convalescent homes and rehabilitation centres.

They also provide specialist opinion and treatment, either in hospitals and clinics or, where this is advised, at the homes of the patients. The domiciliary consultant service has grown rapidly since its introduction at the start of the Service and forms a valuable link between hospitals and general practitioners.

A blood transfusion service and a pathological laboratory service are at the disposal of every hospital as part of the general services.

The hospital and specialist services also provide a certain amount of after-care and convalescence for hospital patients needing regular attention after recovery.

A number of new diagnostic ear clinics have been established in hospitals and hearing aids of the special 'Medresco' type, designed and made for the Service, are supplied to patients referred from the clinics at distribution centres manned by specially trained technicians. These aids are serviced and maintained without charge.

Particular attention is being paid to that part of the hospital and specialist services which provides care and treatment for what may be termed 'socially significant' diseases, e.g., tuberculosis (see also pp. 21-22), venereal disease, and mental defectiveness (see also pp. 24-25). Special regulations ensure confidential treatment for persons attending venereal disease treatment centres, in order that voluntary attendance at clinics, which worked satisfactorily in the past, should be further encouraged and maintained. A standing mental health committee appointed by each regional hospital board advises the board on the running of services within the region; and it has been made illegal to accommodate mentally ill persons in the local authority welfare institutions.

All these services are available to every member of the public and, like the other parts of the National Health Service, without any insurance qualification whatsoever. As a general rule, they are obtained through the patient's family doctor, who makes all arrangements both for the specialist services and advice, and for hospital accommodation where this is necessary.

The Service provides free treatment and free maintenance in hospital. Charges for medicine, dressings and appliances supplied to out-patients were introduced in June 1952. These charges include 1s. on each item on a prescription form for drugs or dressings, charges of 5s. to 10s. each item for elastic hosiery, £1 each for surgical abdominal supports, £3 a pair for surgical footwear (and charges for repairs) and £2 10s. for a wig. Repayment or exemption is allowed to persons in receipt of National Assistance, to war pensioners in respect of treatment for their pensionable disabilities, to patients attending venereal disease clinics in respect of that treatment, and for children under 16 (or over, if in full-time attendance at school).

The majority of patients are accommodated in general wards, but certain hospitals have beds in single rooms or small wards, which, if not required for patients needing privacy on medical grounds, may be made available to patients desiring them as an amenity. In such cases, the hospital makes a charge which is fixed by Regulation; at present the charges are 12s. a day for single rooms and 6s. a day for beds in small wards. There are also a number of pay-beds in which part-time specialists (both physicians and surgeons) taking part in the Service treat privately patients who have decided not to take advantage of the scheme. Such patients are charged for full hospital maintenance as well as for the specialist's fee. In most cases, a maximum limit is prescribed for the fees that may be charged by the specialist to patients occupying private pay-beds.

Scarcity of capital resources seriously limited hospital building in the first seven years of the Service, though some £62 million from Exchequer funds was spent in England and Wales alone on works to improve services and increase ward accommodation. The first new hospital to be built in Britain since the second world war was opened in Scotland in December 1955 (the Vale of Leven General Hospital, Alexandria, Dumbarton). An expanded programme of new hospital building and capital improvements in existing hospitals was begun in 1956. In England and Wales, there are now over 100 major hospital building projects either in progress or at various stages of planning. These include a number of new hospitals, several of which have been begun. Over £31 million a year is to be spent on the programme in 1961–62. Considerable further funds for hospital extensions and improvements are found from voluntary sources, including King Edward's Hospital Fund for London.[1]

**Blood Transfusion**

The National Blood Transfusion Service is administered by the regional

[1] King Edward's Hospital Fund for London was founded in 1897 to commemorate the Diamond Jubilee of Queen Victoria. Until 1948 its primary function was to support and improve London's voluntary hospitals by means of monetary grants, but it has always concerned itself with the efficiency as well as with the financial needs of the hospitals. As a permanent fund with large capital investments (now amounting to between £7 and £8 million) it has been able to continue its work, and even to expand in many directions, since the establishment of the National Health Service. It is now concerned with all types of hospital, inside and outside the Service. The fund makes grants to hospitals and allied institutions for purposes which cannot be met from public funds and initiates as well as supports projects tending to improve hospital services, e.g., it makes and publishes studies in hospital administration; provides a catering advisory service, an emergency bed service and a hospital personal aid service for the elderly; and has established training centres for various types of hospital staff.

hospital boards under the National Health Service. Each region maintains an organisation for collecting blood within the region. The blood is kept in the regional blood bank, or issued to area blood banks which are maintained at general hospitals in each region. Each of the principal hospitals holds a supply of blood for its own needs and also for the small hospitals, nursing homes and general practitioners in its district. The blood is provided free by voluntary donors recruited from the public. There are two central laboratories administered by the Medical Research Council on behalf of the Ministry of Health: the Blood Group Reference Laboratory, which prepares grouping serum and investigates blood grouping problems referred to it, and the Blood Products Laboratory, which prepares dried plasma and plasma fractions.

**Rehabilitation**

The importance of rehabilitation as a facet of medical treatment is firmly established, and today hospital treatment does not stop at relief of pain, or alleviation or cure of pathological conditions, but aims at restoring the individual's functional capacity without delay. Special rehabilitation facilities are provided, for those requiring them, in the departments of physical medicine and occupational therapy at the main hospitals, and in a few special rehabilitation centres which are not attached to any hospital. The work is carried out under the guidance of the appropriate medical specialists by physiotherapists, remedial gymnasts, occupational therapists and social workers, working as a team. Experience has shown that efficient medical rehabilitation reduces the stay in hospital, the incidence of permanent disability and the period of incapacity for full work. The departments work in close association with the Disablement Resettlement Service of the Ministry of Labour. Rehabilitation methods have been applied with advantage in the care of the chronic sick, the aged and the handicapped, and have enabled many to become self-sufficient or to be discharged from hospital and to resume an independent life in their own homes.

**Medico-Social Work**

Many hospitals have an almoner's department staffed by medico-social workers specially trained to apply the principles of social case-work to the problems of the hospital patient. The almoner's main function is to co-operate with the medical staff in their treatment of the patient; to minimise, by social action, the personal anxieties, family difficulties and other problems which arise during illness, and to ensure that after-care and help with adjustment to normal life or continuing disability are available when necessary. Social work in connection with psychiatric clinics and mental hospitals is carried out by another specialised type of social worker, the psychiatric social worker (see pp. 25-26).

## LOCAL HEALTH AUTHORITY SERVICES

The services provided by the 146 major local authorities in England and Wales, working through health committees, consist of the maternity and child welfare services, including welfare centres, maternity care, dental care and day nurseries; the services for the prevention of illness, care and after-

care, including vaccination and immunisation, health visiting, home nursing and domestic help; the ambulance services; and the provision, equipment and maintenance of health centres.

Some of these services were already highly developed before the National Health Service Act came into force; others did not exist, or were narrowly limited in their scope.

**Maternity and Child Welfare Services**

The maternity and child welfare services provide care for expectant and nursing mothers, and advice and general supervision for them and for children under five years of age.

These services are not compulsory, but every effort is made to make them convenient and attractive to mothers, and they are widely used. Specially trained doctors, nurses and midwives are in attendance at the ante-natal and post-natal clinics held at maternity and child welfare centres, while health visitors, working from these centres, call at homes in the district to give advice and help to mothers and to encourage them to attend the welfare centres, which in some areas are also now used by general practitioners, in conjunction with local health authority staff, for medical supervision of expectant and post-natal mothers who have booked with them.

More than three out of four babies born in England and Wales attend the child welfare centres for regular supervision of their progress and development by doctors and health visitors, who are in attendance to advise mothers on matters concerning the health and welfare of their young children and themselves. Such supervision is available until the child is five years of age, by his attendance at regular intervals for routine medical examination and more frequently as necessary. If treatment is required the child is referred to the family doctor, who, if he considers it necessary, will refer him for a specialist's opinion either to consultant sessions in the clinics or to the hospital. Special sessions are held for test feeding, remedial exercises and sunlight treatment. Local health authorities are required to provide free dental care for mothers and young children, and their priority dental services are being expanded as more dentists become available. Where possible, special sessions are arranged for children between two and five years of age.

Mothercraft teaching is a feature of the work at ante-natal clinics, often associated with relaxation classes for expectant mothers. Such teaching continues for mothers who attend the clinics with their young children, in the form of individual consultations, group discussions, demonstrations and special classes, and in some areas evening mothers' or parents' clubs.

**Ante-Natal Care and Arrangements for Confinement**

The expectant mother may arrange to have her baby in hospital or at home according to the advice given her by her doctor or midwife, or according to her own preference if sufficient hospital beds are available over and above those required for priority cases, i.e. where domiciliary confinement is inadvisable for medical or obstetric reasons or because of adverse home conditions. For a home confinement, every mother has available to her the services of either a general practitioner obstetrician or her own family doctor, if he is willing to undertake her maternity care, besides those of a trained

midwife employed in the domiciliary service of the local health authority. The doctor carries out ante-natal and post-natal examinations, attends at the confinement if he thinks it necessary and gives any other medical care required. Routine supervision and advice is provided by the midwife who visits regularly before the confinement for the purpose of examination and to give the mother advice and help generally. In addition, the expectant mother may attend the ante-natal clinic for instruction in the preparation for motherhood and in some cases for interim ante-natal supervision. The midwife delivers the patient (unless the doctor considers it necessary to be present) and continues in attendance for the first 14 days after birth. Midwives work in close touch with the welfare centres in the care of the mother both before and after the birth of the child.

When the midwife ceases to attend a mother, or the mother returns home after confinement in a hospital, the health visitor from the welfare centre begins her regular visits.

Women who are to be confined in hospital normally obtain their ante-natal and post-natal care as hospital out-patients.

**The Care of Premature Infants**

Many local health authorities make special provision for the care of premature babies in their own homes, by lending equipment such as draught-proof cots, warm and suitable clothing, hot-water bottles and special feeding equipment, and by arranging for them to be attended by midwives and health visitors with training in and experience of their special needs.

**Day Nurseries**

The day nurseries run by some local health authorities are staffed by specially trained nursery nurses and nursery assistants. Under the National Health Service Act, 1952, the authorities are given power to make charges for the use of day nurseries. Privately run and factory day nurseries have to be registered with the local health authorities and registration may be refused where premises or management are not considered satisfactory.

**Child Minders**

Persons who provide in their own homes day care for children under five years of age, for payment, must also be registered if they take three or more children from different households. This enables a check to be kept on the conditions in which children are cared for.

**Services for Unmarried Mothers**

All the services mentioned above are available to unmarried mothers and their children and, in addition, there are special forms of help for the unmarried mother. Voluntary associations for moral welfare provide specially trained workers to help the unmarried mother in making plans for herself and her child and many provide hostels for ante-natal and post-natal care. Local health authorities are empowered to make a contribution towards the cost of such work in their areas and most of them do so. A few authorities make their own provision through their Health Department.

### Health Visitors

Before 1948, health visitors had been primarily concerned with the health and general care of mothers, during pregnancy and afterwards, and of their children up to the age of five years. The trend was to make the health visitor also the school nurse, and this is still encouraged. The National Health Service Act, however, widened her role still further to include advice as to the care of any person suffering from illness and as to measures for the prevention of the spread of infection. Many health visitors take part in the care and after-care services, especially in cases of tuberculosis.

A report, published in 1956, on the work and training of health visitors confirms the importance of their health education work, especially with mothers and children of all ages, and recommends the extension of their care and after-care activities as members of the various domiciliary teams concerned with family health and welfare.

### Home Nursing

A home nursing service is provided to attend (under a doctor's orders) people who require nursing in their own homes. Nurses working in this service are employed either directly by the local health authority concerned or by a voluntary organisation acting as the agent of the authority, for before the coming of the National Health Service home nursing was widely organised on a voluntary basis by district nursing associations. Over half of all the nurses' time is devoted to nursing the aged or chronic sick.

### Domestic Help

Local health authorities have the power to make arrangements for providing domestic help in households where it is needed owing to illness, confinement, or the presence of children, old people or mental defectives. This is not one of the free services and authorities are empowered to recover from those assisted such charges as the authorities consider reasonable having regard to the person's means. All authorities provide this service, mainly by the employment of part-time workers, although the extent of the help available varies from area to area. The needs of the aged and the chronic sick make the heaviest demand on this service, with maternity cases next in importance. Many authorities provide a night service for sitting-up with patients or old people where friends and relatives are in need of relief, or where their help is not available.

### The Prevention of Illness: Care and After-Care

Measures for the prevention of tuberculosis, e.g., the tracing of sources of infection, the prevention of its spread, and the removal of the cause of infection, are the responsibility of all the local health authorities. Facilities for diagnosis and treatment are the responsibility of the hospital service and are provided through sanatoria and chest clinics. The chest physicians staffing these clinics are often employed jointly by the regional hospital boards (or boards of governors) and local health authorities to ensure that diagnosis and treatment are properly co-ordinated with prevention and after-care. Among the duties of these officers are those of making recom-

mendations for residential treatment, visiting of homes of patients, and examining and advising 'contacts'. They are assisted in this work by tuberculosis health visitors and nurses. Most local health authorities have statutory or voluntary tuberculosis care committees.

Mass miniature radiography was introduced in 1943 as a means of early diagnosis of tuberculosis. About 75 units now operate under the regional hospital boards in England and Wales in close co-operation with local health authorities, and 10 units in Scotland. They are examining nearly four million persons a year, concentrating increasingly on areas with a bad record for tuberculosis or on specially susceptible groups in the population.

Measures are also taken to protect organised groups of children against the risk of infection by adults suffering from tuberculosis, by arranging for the X-ray examination of those whose employment involves close contact with groups of children.

Care and after-care of patients is supplemented by general advice and assistance given to households in which the patients live. This includes supplying chalets for erection in the patient's own garden, beds and bedding to enable the patient to sleep alone, and nursing requisites; helping the family to find better housing accommodation; making arrangements for boarding-out the children of infected parents; helping to find extra food and clothing; and other similar matters.

Local health authorities send suitable patients to the village settlements for tuberculous persons run by voluntary bodies or by local health authorities in other areas, and training for employment is carried out in conjunction with the training and resettlement schemes of the Ministry of Labour.

Care and after-care arrangements are made by all local health authorities for other types of illness, including mental illness or mental defectiveness. As part of their preventive work, local health authorities may give help and advice to families which may be in difficulties and in danger of breaking up.

A charge may be made for some of these services, if the person or persons wishing to make use of them can reasonably be expected to contribute towards their cost.

### Welfare Services

Under the National Assistance Act, 1948, local authorities (county and county borough councils) have the power, in accordance with schemes approved by the minister, to provide welfare services for persons who are blind, deaf or dumb, or permanently and substantially handicapped by illness, injury or congenital deformity; this power, in relation to the blind, was made a duty in 1948 by direction of the minister. The Act also empowers local authorities to use registered voluntary organisations as their agents in the provision of welfare services and to make contributions to their funds.

### Social Workers in Local Authority Health and Welfare Services

Local authorities employ a large number of social workers in their health and welfare services, including professionally trained medico-social workers (almoners) and psychiatric social workers. A Working Party appointed by the Minister of Health and the Secretary of State for Scotland reported in

1959[1] on the functions, recruitment and training of social workers at all levels in these services. The main recommendation in the report is for a new general training in social work to be provided outside the universities, in addition to existing professional courses. There are also recommendations to attract more trained workers and to reduce the present degree of specialisation within the health and welfare services.

**Vaccination and Immunisation**

Arrangements for vaccination against smallpox and immunisation against diphtheria, without charge, as part of the National Health Service, are made by all local health authorities; in addition, most authorities have similar arrangements for immunisation against whooping-cough and a small number have power to provide for immunisation against tetanus.

Vaccination against poliomyelitis, which was introduced for children in 1956 and made available to some adults in 1957, was extended in 1958 to all persons up to the age of 25 as well as to certain others and in 1960 to all persons up to age 40. Under a scheme launched in 1949, all local health authorities provide BCG vaccination for people known to have been in contact with tuberculosis. In 1953 this scheme was extended so as to provide for BCG vaccination of school-children between their thirteenth and fourteenth birthdays.

**Ambulance Service**

Free conveyance by ambulance between home and hospital or clinic is provided, where necessary, by local health authorities, either directly or by arrangement with voluntary organisations. The Hospital Car Service (organised by the St. John Ambulance Brigade, the British Red Cross Society, and the Women's Voluntary Services) provides transport in many areas for patients, e.g., sitting cases who need special transport but who do not require an ambulance; such patients are conveyed in private cars whose owners volunteer to give this service, and the authorities make a mileage payment to the volunteers to cover their expenses.

**Health Centres**

Local health authorities are empowered, with the approval of the minister, to provide, equip and maintain health centres to afford facilities under a common roof for all or some of the following services:

(*a*) the Practitioner Services, i.e. (by arrangement with the Local Executive Council) the Family Doctor Service, the Dental Service and the Pharmaceutical Service;
(*b*) the specialist services (by arrangement with the regional hospital board);
(*c*) the local health authority clinic services and services for health education.

Health centres were established in some places in 1948 in existing premises and a few new centres have been built. Scarcity of resources has prevented the building of centres on a large scale and it is now felt that the extensive provision of health centres should wait on the experience to be gained from

[1] Report of the Working Party on Social Workers in the Local Authority Health and Welfare Services. HMSO, 1959. 15s.

the use of a limited number of experimental centres and developments in group practice (see p. 14). Centres already built or planned vary widely in their size and scope, from a pair of council houses adapted for group practice to the large centre built for the London County Council at Woodberry Down, Stoke Newington. A few experimental centres have been set up independently by non-statutory bodies.

## MENTAL CARE

The National Health Service Act, 1946, brought mental and physical health together for the first time in one comprehensive service. The Minister of Health, as central authority in England and Wales for mental health, is now responsible for providing:

(*a*) hospital and institutional accommodation and all services, including nursing, for mentally ill or mentally defective persons, free of charge (subject to payment only for those received as private patients)[1]; and

(*b*) services of specialists (free of charge) for mentally ill or mentally defective people.

### Duties of Local Health Authorities

The local health authorities are now responsible for the community care of mental defectives and for the initial care and, if necessary, conveyance to hospital of patients suffering from mental illness, and also for after-care so far as this is not provided by the hospital services.

The 1946 Act required each local health authority to establish a statutory health committee, and the minister recommended that it should appoint a mental health sub-committee to which would be assigned the responsibility for providing and controlling mental health services for the area, whether under the National Health Service Act or the Lunacy and Mental Treatment or Mental Deficiency Acts.

The officers employed by the local health authorities for the work are mainly mental health workers who work under the direction of the Medical Officer of Health. Some authorities have an assistant medical officer with special duties in mental health: some have available the advice of a hospital specialist. As regards mental defectives, the mental health workers are chiefly concerned with their ascertainment and supervision. The duties relating to mental illness are often combined with this work.

### Institutional and Community Care

The majority of mental defectives are brought to the notice of the local health authority through the schools, but others are referred from such sources as the courts, probation officers, infant welfare clinics, hospitals, the family doctor, parents or friends. On being reported to the authority, the individual, whether child or adult, is first examined by a medical officer of the authority (and in case of doubt referred for specialist's opinion). If the patient is found to be defective, the social worker then visits his home and makes contact with him and his parents or relatives. With the help of the

[1] Institutions carried on for private profit—i.e. houses licensed under the Lunacy Act, 1890, and the majority of approved homes for defectives under the Mental Deficiency Act, 1913—were not transferred under the Act.

social worker's report, the medical officer and the mental health committee determine whether the defective is 'subject to be dealt with' under the Mental Deficiency Acts and, if so, what form of care is needed: whether it is to be supervision, guardianship or hospital care. Since January 1958, it has been permissible within the existing legislation to admit patients to mental deficiency hospitals on an informal basis. This change of procedure does not affect the local health authorities' duties in respect of mentally defective persons, but it is hoped that it will be the normal method of admission in the future.

The defective under supervision remains in his own home and receives periodic visits from the social worker, who gives such advice and help as will enable him to live a stable life in ordinary family surroundings. Alternatively, if he is fit to live in the community but closer control is needed, a judicial order may be obtained placing him under the guardianship either of a parent or, more often, of a foster parent. The effect of the order is to give the guardian the control a parent would have over a child of 14 and to require the guardian to undertake corresponding responsibilities. The local health authority is responsible for seeing that the defective under guardianship is properly maintained. A defective may also be placed under the guardianship of an officer employed by a local health authority and allowed to reside elsewhere; this enables suitable defectives capable of employment to be placed in carefully selected lodgings.

Training and occupation for the defectives living in the community are provided in occupation centres, where most of those who attend are children. There are also recreational and craft classes for mentally defective adults. The number of centres is growing, but in rural and thinly populated areas it is often not practicable to establish a centre, and some local health authorities are developing home teaching schemes. Under these, the teacher visits the home of the defective. Instruction given is chiefly in handicrafts, but valuable advice is given to parents. In a few areas, defectives who cannot go to a centre are gathered at the home of one of them or other suitable place where the home teacher can visit more often.

Many of the defectives sent to institutions become suitable, after a period of training, for return on licence to their own homes, or for placing in residential employment. They continue to be under supervision, either by the social worker attached to the institution, if this is practicable, or by the local authority's worker, unless and until they are discharged. They may then have the friendly help of the local health authority and a form of after-care.

The local health authority service for the care and after-care of the mentally ill or neurotic (shared in practice with the hospitals) is growing. The function of the social workers, working with the hospitals and the family doctor, is to reassure the patient and see that he obtains the form of help most suited to his needs, including medical and hospital care. In a few places special clubs, often associated with a hospital, have been set up for psychiatric cases. In hospital a variety of treatments—physical, psychological, electrical, occupational, etc.—is available. The psychiatrists are assisted by mental health workers called psychiatric social workers. These workers report on the social history and development of the illness and maintain close contact with patients and relatives throughout the hospital

period, and continue to support the patient through the process of readjustment after discharge from hospital (unless he is, instead, visited by a social worker employed by the local health authority). The demand for trained social workers in the mental health services at present far exceeds the supply.

**Mental Service Statistics**

Of 483,083 National Health Service beds in England and Wales at 31st December, 1958, 148,083 were designated for the reception of patients under the Lunacy and Mental Treatment Acts, 8,246 were for the treatment of the mentally ill outside the provisions of those Acts, and 57,670 were for mental defectives.

At the same date there were 141,680 persons under care in accordance with the provisions of the Lunacy and Mental Treatment Acts, and, of these, 139,429 were accommodated in National Health Service hospitals. The average daily number during 1958 of mentally ill patients receiving treatment in National Health Service hospitals other than under these Acts was 5,031.

The rate of admission to mental hospitals and the rate of discharge have both greatly increased in recent years. This development is due to the fact that the public is becoming more aware of the value of early treatment, to the acceptance of patients in mental hospitals on a voluntary basis (since 6th October, 1959, patients may be admitted informally without recourse to any of the statutory procedures) and to improved methods of treatment. Rather than being kept in hospital continuously for a long time, patients are being admitted several times for short periods. For instance, the average duration of stay during 1958 in the non-designated beds was 90 days, and of the patients admitted to designated National Health Service accommodation during 1956, 80 per cent were discharged within 12 months.

In 1958, there were 95,968 direct admissions to all the designated accommodation, of these 85 per cent were voluntary and at the end of the year 44 per cent of all patients under care were voluntary patients. Of the 83,629 patients who were discharged during 1958, 21 per cent had recovered and in a further 68 per cent of the cases the illness was relieved.

At the end of 1958 there were 61,396 mentally defective patients in institutions, 27,166 of whom had been received informally and 34,230 under the Mental Deficiency Acts, 1913–38. There were also 2,181 mental defectives under guardianship or notified, 60,144 under statutory supervision, and 18,898 under voluntary supervision. Of the defectives in institutional care, 95 per cent were in institutions and homes in the National Health Service.

## THE PUBLIC HEALTH LABORATORY SERVICE

The Public Health Laboratory Service provides a network of bacteriological and virological laboratories throughout England and Wales which conduct research and assist in the diagnosis, prevention and control of epidemic diseases. Its largest establishment is the Central Public Health Laboratory at Colindale, in North-West London, which includes the National Collection of Type Cultures, the Standards Laboratory for Serological Reagents, the Food Hygiene Laboratory, the Epidemiological Research Laboratory, and reference laboratories specialising in the identification of

infective micro-organisms. In addition to the Central Laboratory, there are eight regional laboratories at university centres, and 51 area laboratories.

In Scotland and Northern Ireland there is no separate public health laboratory service; bacteriological work is mainly done in hospital laboratories.

## VOLUNTARY AID

A number of voluntary organisations provide extensive welfare services of various kinds for sick and handicapped persons in co-operation with, or supplementary to, the provision made by central and local authorities. Many convalescent homes and homes for the infirm and others specially handicapped have been provided by voluntary effort. Some of these are now absorbed in the National Health Service, others receive some aid from public funds. In many areas invalid children and others needing care in their own homes are visited and helped by voluntary organisations. Though the need for material aid from private sources becomes less as public provision extends, many special forms of help to meet individual needs that would not otherwise be met are given by voluntary agencies. Their most valuable role is probably to provide personal service and the continued personal interest that can contribute so much to the welfare of the sick and infirm. These voluntary agencies usually depend largely on the work, part-time or full-time, of unpaid volunteers.

A great deal of voluntary help is given to hospitals by voluntary bodies and individual voluntary helpers. A majority of the hospitals in England and Wales have their own 'Leagues of Friends' or similar bodies of voluntary workers who organise and undertake a variety of services for their hospitals. Many hospitals also have help from the British Red Cross Society, the Order of St. John, the Women's Voluntary Services, or a similar organisation. The operation of canteens for out-patients and trolley-shops and library services for in-patients, visiting in the wards, receiving new patients, and mending linen are amongst the tasks commonly undertaken.

## PROBLEMS OF THE HEALTH SERVICE

The National Health Service has still many problems to face. There are administrative problems, for there must inevitably for some time be room for adjustment in so large and complicated a piece of new machinery, and there are problems of priority between competing claims on the limited total resources of the Service.

The largest administrative problem is that of securing maximum co-operation between the different branches of the Service (i.e. the local authority, practitioner and hospital services), especially with regard to such matters as maternity care and the prevention and treatment of tuberculosis, where an integrated service taking account of the whole field is of particular importance. Another administrative question is whether the most satisfactory distribution of responsibility between the different levels of management in the hospital service has been achieved.

The ideal of making the Service available to meet every medical need involves obvious dangers to economy. For example, the free transport provided for patients was at first too freely used, and steps had to be taken to limit this service to cases in which it was essential. The number and type of staff needed to administer a co-ordinated hospital system with efficiency

and economy must necessarily be to some extent the subject of experiment, and the question of hospital staffing is kept under constant review.

Every part of the Service is now more readily available than it was in the first phase, without a prolonged wait for spectacles, dental treatment or hospital bed; but there are still deficiencies. The capacity of the hospital service has more than kept pace with an increasing demand for hospital treatment, but the larger nursing staff still falls short of the needs of the Service, especially in mental hospitals. There has been a marked advance in methods of treating the aged sick, but provision for their care cannot be made adequate until the Service can devote more resources to them.

The general and particular problems of the Service are the subject of continual inquiry—by the organisation and methods unit of the Ministry of Health, by the standing and *ad hoc* committees of the Central Health Services Council and the Scottish Health Services Council, by other official committees and by independent bodies. A Royal Commission was appointed in 1957 to consider the remuneration of doctors and dentists and reported early in 1960. Its recommendations are under consideration. Other aspects of the Service which have come under examination by official committees recently include the costs of prescribing, the organisation and control of the maternity services and provision for convalescent treatment. The voluntary trusts such as King Edward's Hospital Fund (see p. 17) and the Nuffield Provincial Hospitals Trust[1] are also active in inquiring into the working of the Service and pointing out directions in which improvement might be made. King Edward's Hospital Fund, for example, has sponsored a study of voluntary service in the State hospitals and the Nuffield Provincial Hospitals Trust has undertaken investigations into the functions and design of hospitals and other subjects, a job-analysis of nursing, and an experiment in hospital costing. A group of management consultants has undertaken at its own expense a series of work studies in hospitals.

The committee on the cost of the National Health Service reached the general conclusion that it would be premature to make any fundamental alteration in the structure of the Service. To quote from the committee's report (published at the beginning of 1956):

> 'the structure of the National Health Service laid down in the Acts of 1946 and 1947 was framed broadly on sound lines, having regard to the historical pattern of the medical and social services of this country. It is very true that it suffers from many defects as a result of the division of functions between the different authorities, and that there is a lack of co-ordination between the different parts of the Service. But . . . even now, after only seven years of operation, the Service works much better in practice than it looks on paper. That it should be possible to say this, is a remarkable tribute to the sense of responsibility and devoted efforts of the vast majority of all those engaged in the Service, and also to their determination to make the system work'.

[1] The Nuffield Provincial Hospitals Trust was founded by Lord Nuffield in 1939 with an endowment of one million share units in Morris Motors Ltd. for 'the co-ordination on a regional basis of hospital and medical services throughout the provinces . . .'. The Trust is now mainly concerned with studies, experiments and demonstrations, of a kind that cannot easily be financed from public funds and undertaken with a view to practical testing and demonstration of possible improvements in the service to the patient.

III

# THE SCHOOL HEALTH SERVICE

The School Health Service is in no way intended as a substitute for the National Health Service; and parents of school-children are as free as any other citizens to avail themselves, on behalf of their children, of all that the latter has to offer. At the same time the State recognises (and has recognised for over 50 years) that special medical care, both preventive and curative, is essential to the welfare of growing children, and that a School Health Service is the best means of providing it. Therefore, although the School Health Service has been closely co-ordinated with the National Health Service, it continues as a separate entity organised by the local education authorities and designed to develop and maintain the physical and mental well-being of children who are being educated at publicly maintained schools. All the medical and dental services provided through the School Health Service are free of charge.

## MEDICAL INSPECTION AND TREATMENT

Through the School Health Service, every child attending a publicly maintained school undergoes a number of general medical and dental inspections during his school career and such other inspections as are found to be necessary or advisable. A dental inspection must be carried out as soon as possible after admission to school. Parents are encouraged to be present, and for the medical examination of school entrants almost 100 per cent attendances are common. Medical and dental records are kept in an approved form, and these records follow the child when he moves from one area to another.

### Medical Treatment

Minor ailments are normally dealt with by the school nurses under the general supervision of the school doctors. Children found at periodic medical inspections to need detailed investigation, or whose parents require further advice about care or management, are invited to attend clinics where more time can be given to them. Consultative and specialist services are also provided at these clinics, usually by arrangement with the National Health Service. Fully qualified speech therapists are employed to treat speech defects.

### Dental Service

It is the aim of the school dental service that every child should be dentally inspected at intervals of not more than a year and offered whatever treatment may be found to be necessary. Inspection is usually carried out at the schools, the pupils then being referred for treatment to the nearest clinic.

### Child Guidance

Child guidance clinics for the treatment of maladjusted children are provided by most local education authorities under the School Health Service

and also by many large hospitals and a few voluntary organisations. There are over 300 clinics in England and Wales, though not all are full-time. The service is being extended as rapidly as circumstances permit. Child guidance clinics are normally staffed by teams consisting of a psychiatrist, an educational psychologist and psychiatric social workers.

## EDUCATION OF HANDICAPPED CHILDREN

It is normally through examinations carried out in the School Health Service that local education authorities become aware of children suffering from disabilities of mind or body which necessitate special educational treatment. Authorities have a duty under the 1944 Education Act to provide special educational treatment for these children. This may be given in the ordinary schools, or in special schools for those children who are more seriously handicapped.

Special schools exist for the following 10 categories of handicapped pupils:

| | |
|---|---|
| Blind | Epileptic |
| Partially sighted | Maladjusted |
| Deaf | Physically handicapped |
| Partially deaf | Pupils suffering from speech defects |
| Educationally subnormal | Delicate. |

There are day and boarding special schools for children in each category, except that blind children, on account of their small numbers, must always be boarders.

Local education authorities are also responsible for providing education for children undergoing treatment in hospital. Either a hospital special school is established or individual tuition is given, dependent upon the number of child patients in a particular hospital and the length of their stay. Home teaching is available for severely handicapped children who on account of their disability are unable to attend any kind of school.

All forms of special educational treatment provided by local education authorities are free of cost to the parents.

## SCHOOL MEALS AND MILK

Milk (one-third of a pint a day) is given free to all children in school who wish to have it, and the School Meals Service provides a daily dinner at a subsidised price (remitted where there is need) to nearly half the pupils in schools maintained by local education authorities. The school dinner is planned on a high nutritional standard so as to be the child's main meal of the day. The School Meals Service may also supply other meals, such as breakfasts or teas, as required.

IV

# INDUSTRIAL HEALTH

Industrial health services are essentially preventive and include first-aid treatment for cases of accident or sickness. The present industrial health services have grown from two principal sources: the State and the employer. The State has appointed inspectors, including medical inspectors, to advise on and enforce the increasing volume of enactments concerned with the health of the workers particularly in the mining, manufacturing, construction and power supply industries and in agriculture. Employers have a general responsibility not to endanger the life and health of their employees and many have made arrangements, including the engagement of doctors and nurses, both to help them to comply with the statutory requirements and also in a spirit of enlightened management. Although much of the protective legislation that applies to employment in mines, factories and industrial workplaces is necessarily in general terms, the benefits to health that derive from provisions above the minimum legal standards are well recognised.[1]

## MINES AND QUARRIES

For mines and quarries, provision is made for dealing with such matters as ventilation, dust suppression, rescue work, first aid, and the initial medical examination of certain new entrants by official doctors. There are many detailed requirements for the safe conduct of operations. The employment of women and children underground has been forbidden since 1842. Legislative provision has been revised and consolidated in the Mines and Quarries Act, 1954, and Regulations and Orders, etc., made and re-enacted thereunder. The Ministry of Power is generally responsible for the administration of these statutory requirements, while the Mines and Quarries Inspectorate, which is part of that ministry, is directly responsible for their enforcement throughout Great Britain.

Since 1947, the National Coal Board has developed its own industrial medical service which, broadly, has the following functions:

(*a*) the medical care of the mineworker in terms of a comprehensive industrial medical service;

(*b*) the conduct of medical research within the industry.

At the end of 1959 the strength of full-time doctors in this Service was 75, comprising a chief medical officer and his assistant, 9 divisional medical officers, 45 area medical officers, with 8 assistants, 7 doctors engaged in radiological services research, and 4 doctors engaged on medical research. The Service also includes a number of non-medical scientists, e.g., statisticians, together with a small supporting administrative staff.

At 364 of the larger collieries, medical treatment centres had been provided, each comprising at least a treatment room, a doctor's/nurse's room, a waiting room and storage space, with modern equipment. Almost all of them are

[1] For further information see COI reference pamphlet RF.P. 3814, *Labour Relations and Working Conditions in Britain.*

staffed by State registered nurses under the supervision of doctors. A medical unit is normally provided at collieries where a medical centre is not available.

## THE FACTORIES ACTS

Most other industrial premises in Great Britain come under the Factories Acts, 1937 and 1948, which are administered by the Ministry of Labour and enforced by the Factory Inspectorate which is part of that ministry.[1]

A Factory Inspectorate appointed and paid by the central government was first created by the Factories Act, 1833. The number of inspectors of factories has risen from 4 inspectors and 14 sub-inspectors during the first ten years to about 400 in all at the present time. The number of premises subject to inspection has risen in the same time from just over 4,000 to a quarter of a million. The present Acts lay down general requirements with regard to safety and health, such as the fencing and proper maintenance of machinery, lifting appliances, steam boilers and other pressure vessels; sound construction and proper maintenance of floors, passages and stairs and safe means of access to working-places; and the prevention of escape of dangerous fumes and dust into the workroom. They also prescribe general standards to safeguard health and welfare, e.g., with regard to cleanliness, the provision of sanitary accommodation, cubic space per worker, temperature, ventilation, lighting, washing facilities, accommodation for outdoor clothing, drinking-water, provision of seats, and arrangements for first aid.[2]

Any person intending to use premises as a factory has to notify the Inspector of Factories of his intention not less than one month before he begins to occupy them. On entry to and on change of employment in factories, at docks, or at building operations all young persons under 18 years of age must be medically examined for fitness for employment by doctors appointed by the Chief Inspector of Factories and they are re-examined according to circumstances but not less frequently than annually. The hours which may be worked by women and young persons between the ages of 16 and 18 are limited to 48 in a week and 9 in a day, although some overtime is allowed (up to six hours a week for not more than 100 hours a year). Young persons under 16 are limited to 44 hours of work a week. Adequate intervals for meals must be arranged for women and young persons and the employment of women and young persons by night is, in general, prohibited. No one under 15 years old may be employed on industrial premises.

These general requirements for safety, health and welfare are supplemented or modified by regulations dealing with special risks or conditions in particular industries, processes, establishments or machines.

## INDUSTRIAL MEDICAL SERVICES

The industrial medical services provided either on a statutory basis or voluntarily may be classified under four heads: medical inspectors of

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[1] For the duties of local health authorities with regard to places of work see p. 5.

[2] At the *Industrial Health and Safety Centre* in Horseferry Road, London, there is a permanent public exhibition for promoting the safety, health and welfare of industrial workers. Examples of good and bad methods and appliances are shown and there are sections dealing with, for instance, chemical hazards, eye protection, protective clothing, industrial diseases, ventilation, first aid and washing facilities.

factories, appointed factory doctors, industrial medical officers, and industrial nurses.

**Medical Inspectors of Factories**

There are at present 18 medical inspectors of factories in the Factory Inspectorate of the Ministry of Labour. Their duties include special investigations in connection with questions of industrial hygiene, the investigation of industrial conditions in so far as they affect the health of the workers, and inquiries into cases of industrial disease and processes directly dangerous to health. The medical inspectorate keeps in touch with and advises the appointed factory doctors.

**Appointed Factory Doctors**

Appointed factory doctors are appointed by the Chief Inspector of Factories to carry out the statutory medical examinations required in factories; they are also required to investigate cases of notifiable industrial disease and certain accidents. Each factory doctor usually serves a particular district and the whole of Great Britain is covered by the service. Most of the doctors are in general practice and in addition to their statutory duties, the demands of which vary considerably from one district to another, they often undertake part-time voluntary medical supervision in factories.

**Industrial Medical Officers**

In addition to the above two services covering all factories, industrial medical officers have been appointed by some employers for the medical supervision of their workers. The duties of each medical officer vary from factory to factory but the following examples indicate the range of their work:

General advisory services on industrial hygiene, including advice on the design and layout of processes and buildings, on dangerous hazards, on the study of sickness, absenteeism, and questions of personnel and group morale, and on the prevention of industrial disease and accidents.

Examination of individual workers, e.g., of workers who are exposed to occupational hazards or who have returned to work after illness or injury, with a view to advising managements as to their conditions of employment.

Supervision of first-aid and nursing services.

Promotion of the education of workpeople in matters of general and personal hygiene.

A Committee on Industrial Health Services which reported in 1951 found that there were at that time about 230 doctors engaged whole-time on factory work and that, including whole-time doctors, there were 1,287 doctors taking part in factory medical services, in addition to 1,789 appointed factory doctors.[1] There are now about 400 full-time industrial medical officers and the number of doctors engaged on part-time work in industry has also risen.

**Industrial Nurses**

The Committee on Industrial Health Services estimated that in 1951 there were about 2,600 State registered nurses and 1,400 other nursing staff

[1] Report of Committee on the Industrial Health Services, Cmd. 8170. HMSO, 1951. 1s. 3d.

employed in factories; again there is evidence that the numbers have increased in recent years.

## AGRICULTURE

The safety, health and welfare of agricultural workers is safeguarded by separate legislation and supervised by a special Inspectorate.

## SHOPS

The Shops Act, 1950, which consolidated earlier Shops Acts, requires local authorities to ensure that all shops in their areas observe the requirements of the Act with regard to Sunday employment, weekly half-holidays and meal intervals. It also requires shops to provide proper ventilation, temperature, lighting, and sanitary and washing facilities. The central authority responsible for the Act is the Home Office.

The larger stores employ medical officers and make other voluntary provision for the health of the staff employed by them.

## RESEARCH AND ADVISORY BODIES

There is a standing Industrial Health Advisory Committee to advise the Minister of Labour, and a number of other official and voluntary bodies help to supply the research, advice and assistance necessary for promoting industrial health and welfare. These bodies include, besides the Factory and the Mines and Quarries Inspectorates, such government agencies as the Medical Research Council, the Department of Scientific and Industrial Research (including the National Physical Laboratory), the Radiological Protection Service and the Government Chemist; the departments of industrial health and social medicine of the universities; such voluntary bodies as the Central Council for Health Education and the Industrial Welfare Society; and the research and personnel departments of various large industrial concerns. Co-ordination is provided by a number of general and special committees.

There are also advisory panels of experts set up by the Minister of Labour to advise him on special problems, e.g., dermatological, ophthalmological and radiological questions in industry.

V

# HEALTH SERVICES IN SCOTLAND

The health services in Scotland had the same origin and their development has followed much the same course as the health services in England and Wales. In both countries the services have evolved during the past hundred years from measures for the prevention of the outbreak and spread of pestilence into measures for community welfare and for the care of the individual.

## PUBLIC HEALTH SERVICES

The development of the Public Health Services in Scotland has been largely on the same lines as in England, although these services have been based on separate Acts, and different authorities are responsible for the various services. In Scotland the basis is the Public Health (Scotland) Act, 1897, and the Burgh Police (Scotland) Act, 1892.

The local authorities concerned in Scotland are the councils of counties and burghs. The county councils and large burghs (i.e. burghs with a population of twenty thousand or more) have since 1930 been the public health local authorities for all the major public health services. The county councils are also responsible for these services in the small burghs, but certain functions may be delegated to the burghs. The small burghs are responsible for local sanitary services, housing, etc.

Powers similar to those exercised by the Minister of Housing and Local Government under the Water Act, 1945, are conferred on the Secretary of State for Scotland by the Water (Scotland) Acts, 1946 and 1949. The local authorities concerned in Scotland with water supply (local water authorities) are county councils, the town councils of all burghs and joint water boards, i.e. combinations of local authorities. The local authorities for sewerage purposes are the county councils and the town councils of all burghs.

Local authorities in Scotland have responsibilities for housing similar to those of the English authorities. Their powers are derived from the Housing (Scotland) Acts, 1950–1959.

In Scotland port health control is operated by all county councils and large burghs with seaboards, who are the responsible authorities. There is only one specially constituted port local authority.

The Secretary of State for Scotland is concerned in the central administration of the legislation relating to foods.

## THE NATIONAL HEALTH SERVICE

The National Health Service (Scotland) Act, which received the Royal Assent on 21st May, 1947, and came into force on 5th July, 1948, is very closely akin to the corresponding Act for England and Wales, although there are some administrative differences due to the somewhat different background against which the service must operate.

Central responsibility for the National Health Service as a whole rests with the Secretary of State for Scotland, who is assisted by the Scottish Health Services Council with members drawn from all relevant fields of experience. Standing committees of that council have been set up in connection with particular parts of the service; these include the additional members necessary to cover particular subdivisions of the expert field.

### General Practitioner Services

The General Practitioner Services are administered, as in England and Wales, by executive councils, five-sixths of whose members have been nominated locally by the authorities and professions in the locality. The same safeguards as to freedom of choice exist, and there are the same regulations governing the sale of practices and controlling the entry of doctors into practice in areas already well served in this respect.

### Hospital and Specialist Services

Responsibility for the hospital and allied services rests with the Secretary of State, to whom all existing hospitals were transferred on 5th July, 1948. Regional boards, as agents of the Secretary of State, undertake the general administration of the hospital service in their areas; and boards of management in turn, as agents of the regional boards, control and manage particular hospitals. In Scotland, teaching hospitals are included in the regional ambit and do not, as in England and Wales, have their own separate boards of governors responsible to the central authority alone. A regional board, in drawing up its scheme for the constitution of boards of management, was required to consult the university concerned so that the teaching hospitals might be agreed upon, and university nominees are included in the membership of the boards of management of these hospitals. There is also a medical education committee in each region, consisting of nominees of the university, the regional board and the Secretary of State, to advise the regional board on the need for facilities for clinical teaching.

The endowments of voluntary hospitals, instead of being pooled and re-allocated by the minister as in England, were left with the boards of management but have been re-allocated since by a Hospital Endowments Commission to an extent sufficient to ensure that no hospital is without an endowment fund giving a minimum annual income of £2 per bed. In addition, the commission allocated a proportion of these endowments to a Scottish Hospital Endowments Research Trust to assist medical research in Scotland.

The Scottish National Blood Transfusion Association organises the blood transfusion service on behalf of the Secretary of State.

### Local Authority Services

Responsibility for the local services, e.g., maternity and child welfare services, home nursing service, preventive and after-care services, domestic help service, etc., rests with the major local authorities, that is with the county councils and the town councils of large burghs.

**Ambulance Service**

The duty of providing ambulances, which falls upon the local health authorities in England and Wales, is undertaken in Scotland by the Secretary of State, working through the Scottish Ambulance Service (the St. Andrew's Ambulance Association and the Scottish Branch of the British Red Cross Society).

**Health Centres**

Health centres come immediately under the control of the Secretary of State, and not of the local authorities as in England and Wales, for Scotland, being smaller, is more easily managed as a unit. The first health centre to be built in Scotland was opened in May 1953 in a suburb of Edinburgh, and another—for a rural area—was opened two years later at Stranraer, in south-west Scotland.

**Mental Care**

The arrangements for mental care and treatment in Scotland are very similar to those in England and Wales. The main differences are:

1. The Secretary of State, and not the local health authority, is responsible for the conveyance of mental patients to hospital.
2. The boarding-out system, which has always been a notable feature of the mental health service in Scotland, provides the advantages of family care and useful occupation both for the mentally ill and for mental defectives.
3. In addition to the usual medical and lay visitation, these boarded-out patients, and also those absent on probation or licence from mental hospitals and mental deficiency institutions, are visited regularly by the deputy medical commissioners of the General Board of Control for Scotland.

At the end of 1959 there were in Scotland 27,323 hospital beds for the mentally ill and mentally defective, compared with 38,478 for all other types of illness.

About 80 per cent of admissions to mental hospitals are now of voluntary patients (in some hospitals the proportion is over 90 per cent). At the end of 1959, 32 per cent of all patients in mental hospitals were voluntary patients.

## THE SCHOOL HEALTH SERVICE

The School Health Service in Scotland operates under the provisions of the Education (Scotland) Act, 1946. The Act imposes upon each education authority the duty of providing for the medical inspection, supervision and treatment (including the supply of appliances) of all pupils in attendance at schools and junior colleges under the authority's management and of all pupils under 18 in attendance at other State educational establishments. It also (1) empowers each authority to provide for the medical inspection, etc., of all pupils over 18 at other educational establishments under its management; (2) authorises arrangements, by agreement with the managers, for the inspection of pupils at privately run schools and colleges; and (3) gives each authority the necessary powers to ensure the cleanliness of the bodies and clothing of pupils attending schools and other educational establishments under its management.

VI

# HEALTH SERVICES IN NORTHERN IRELAND

In general, the Health Services Act for Northern Ireland, which received the Royal Assent on 4th February, 1948, follows the lines of the corresponding Act in England and Wales. The benefits and services provided in Northern Ireland are similar to those provided in England and Wales—such differences as exist are mainly in administration, their effect being to minimise centralisation and government direction in Northern Ireland. The services began to operate on 5th July, 1948, the same day as the National Health Service. The services in Northern Ireland are financed as in the rest of the United Kingdom.

The Minister of Health and Local Government does not administer any of the services directly. This responsibility rests with three main agencies, each of which exercises wide powers:

The Northern Ireland Hospitals Authority;
The Northern Ireland General Health Services Board; and
Local Health Authorities, which are the councils of counties and county boroughs.

The minister is given power to set up health advisory committees from time to time.

## PUBLIC HEALTH SERVICES

The central authority in Northern Ireland responsible for the administration of the law relating to public health is the Ministry of Health and Local Government. Local administration is mainly the responsibility of the county and county borough councils acting as health authorities, but for certain functions related to communal hygiene the urban and rural district councils are the appropriate authorities.

Local health authorities have also been made responsible for the enforcement of the Sale of Food and Drugs Acts, and for the notification and prevention of infectious diseases under the Infectious Diseases (Notification) Act, 1889, and the Infectious Diseases (Prevention) Act, 1890.

Medical and sanitary staff for the discharge of these public health functions are appointed by the health authority. There is a Medical Officer of Health for each county and county borough, as well as a County Sanitary Officer, and in the case of county boroughs, an Executive Sanitary Officer. In a county health authority there are also divisional medical and sanitary officers, and these appointments are made in consultation with the local sanitary authority in whose area the officer is to undertake duties. The officer is responsible to the local sanitary authority for the discharge of the duties remaining with that authority, and to the county health authority for the discharge of the public health duties now entrusted to it.

## HOSPITAL AND SPECIALIST SERVICES

Responsibility for planning and administering the hospital and specialist service, including the hospital and specialist tuberculosis service (since

1st April, 1959) is placed upon the Northern Ireland Hospitals Authority. Hospital property is transferred to the Hospitals Authority.

The functions of the Hospitals Authority are wide. It undertakes the building of new hospitals; the provision of a consultant and specialist service, including a mass radiography service, and of facilities for medical education and research in consultation with the Queen's University; the organisation of an ambulance service (to include suitable transport for expectant or nursing mothers), a bacteriological service, a pathological service and a blood transfusion service, not only for hospitals but for health services generally.

The management of hospitals is placed in the hands of local management committees, appointed by the Hospitals Authority after consultations with previously existing hospital authorities, hospital medical staffs, local health authorities, etc. Every hospital keeps its endowments, and special endowments continue to be used for the purposes for which they were intended.

The Northern Ireland Act provides for the preservation and continuance of the tradition of each hospital. It was made the duty of the authority to consult with management committees and to draw up a management scheme for each hospital or group of hospitals, setting out the manner in which the hospital concerned would function and the part it would play in the hospital and specialist service as a whole. Hospital management committees act within the schemes as approved; they are corporate bodies and carry on the tradition of the hospital, having regard to its character and associations.

**Mental Health Services**

The Mental Health Services are administered by the Northern Ireland Hospitals Authority as part of the comprehensive hospital and specialist services provided under the Health Services Act and the Mental Health Act (Northern Ireland), 1948. There are six mental hospitals, and four institutions for the reception and care of persons suffering from arrested or incomplete development of mind; and, in addition, the Hospitals Authority is responsible for the community aspects of mental health work.

## GENERAL HEALTH SERVICES

In addition to making arrangements for general practitioner, general dental, pharmaceutical and supplementary eye services, the General Health Services Board has certain other duties, for example, the responsibility for providing health centres where these are considered necessary. The board may also supplement and reinforce the work of the individual practitioners by educating the public in the essentials of good health and by arranging courses of study for the doctors, dentists, chemists, and opticians taking part in the scheme. It also falls to the board to control the rate of admission of new doctors to participate in general medical services.

## HEALTH AUTHORITY SERVICES

The services provided by county and county borough health authorities include maternity and child welfare, vaccination against smallpox and poliomyelitis, immunisation against diphtheria and other diseases, home

nursing and health visiting. The health authorities are also responsible for health education and for care and after-care services. These services are available to all members of the community.

## SCHOOL HEALTH SERVICE

In Northern Ireland the School Health Service is administered by the county and county borough health authorities. One of the principal objects of this arrangement is to secure the fullest integration of the School Health and Child Welfare Services. In day-to-day administration of the School Health Service, however, there is no substantial difference from the arrangements in operation in Great Britain. Local education authorities are responsible for the School Meals Service, and milk is supplied free for the pupils of all schools.

## INDUSTRIAL HEALTH

The health and welfare of industrial workers in Northern Ireland are safeguarded by arrangements similar to those obtaining in Great Britain, with comparable legislation and inspectorates. The Northern Ireland Departments responsible are the Ministry of Labour and National Insurance, for factory welfare, and the Ministry of Commerce, for welfare in mines and quarries.

VII

# MEDICAL RESEARCH

Medical research in universities, hospitals and other institutions has for many years been recognised by the United Kingdom Government as of paramount importance in maintaining and improving the standard of medical practice. The main organisation directly engaged in this work is the Medical Research Council, which is responsible to the Committee of the Privy Council for Medical Research, under the chairmanship of the Minister for Science. Under the National Health Service Act, 1946 (Section 16), the Minister of Health (in England and Wales) is also able to initiate and maintain research work, and similar powers were given to the Secretary of State for Scotland under the corresponding Scottish Act.

In the financial year 1959–60 the sum specifically allocated by parliament for medical research in Great Britain totals over £3½ million: £3,518,250 for the work of the Medical Research Council and £124,300 for expenditure by the Health Departments on special research projects and services. These sums take no account of the considerable amount of research undertaken by the hospital authorities out of non-Exchequer funds or carried out in the normal course of hospital treatment.

Medical research is also undertaken in most relevant university and medical school departments, supported primarily out of the grant provided by the University Grants Committee. An important contribution to research in particular branches of medicine is made by private organisations, such as the British Empire Cancer Campaign and the Nuffield Foundation; there is close co-operation between the Medical Research Council and these other organisations to ensure the best allocation of their resources.

## THE MEDICAL RESEARCH COUNCIL

The Medical Research Council has the duty within the United Kingdom of promoting all forms of medical research, including research which requires direct access to patients and the use of the clinical facilities which, by virtue of the National Health Service Acts, are under the jurisdiction of the Minister of Health and the Secretary of State for Scotland. The council also undertakes medical research overseas and, with additional support from the United Kingdom Colonial Development and Welfare funds, maintains laboratories in the Gambia and smaller units in Uganda and Jamaica.

The Medical Research Council is composed of 12 members, who are appointed by the Committee of the Privy Council and who retire in rotation at regular intervals. Of these 12, 9 are appointed for their scientific qualifications in different branches of curative and preventive medicine, after consultation with the President of the Royal Society and the Medical Research Council itself. The remaining 3—at least 1 of whom must be a member of the House of Lords and another a member of the House of Commons—are appointed for general rather than for scientific qualifications.

The council, by its constitution, has full liberty to pursue an independent scientific policy, to control all its own work and to appoint its own staff. It is financed by a grant-in-aid which is the subject of a Vote in the Civil

Estimates,[1] and by funds accruing to it through grants or gifts from public bodies or private benefactors.

The Medical Research Council supports and subsidises medical research in three main ways:

1. By employing a scientific and technical staff of its own. This numbers about 1,600, of whom some 680 are scientific staff. Of these latter about a third are medically qualified.
2. By making temporary grants for research projects directly to independent workers in universities, hospitals and elsewhere.
3. By awarding fellowships and scholarships to enable promising young graduates to be trained, under suitable direction, in research methods.

The council's own research activities are mainly undertaken in the National Institute for Medical Research at Mill Hill and at Hampstead (both in North-West London) and in over 70 smaller establishments, generally known as Research Units or Groups, which are attached in most cases to universities and hospitals (see Appendix II). Since 1951–52 the council has assumed the major financial responsibility for the Institute of Cancer Research, which has continued to receive substantial support from the British Empire Cancer Campaign.

The programme of research work undertaken by the council is planned in accordance with both need and opportunity, and individual items are therefore constantly changing. In general, however, the programme includes:

(1) fundamental studies of the structure and natural processes of the body and other organisms which may be associated with it, to provide a basis for the better understanding of problems of health and disease, e.g., studies in physiology, biochemistry, biophysics, nutrition, genetics;

(2) clinical and laboratory studies of disease; its nature and causes, and methods for its prevention, diagnosis and treatment, e.g., studies in cardiovascular, sensory, mental, alimentary, dental and skin disorders, pædiatrics, malignant diseases, epidemics, tuberculosis, tropical diseases, wound infections;

(3) the development and evaluation of special methods of treatment and also of prophylaxis and diagnosis, e.g., studies in chemotherapy, radiotherapy, immunology and bacteriology, blood transfusion, anaesthesia, electrical methods for the diagnosis of disease, pharmacology; and

(4) the study of social and occupational factors affecting health and the efficiency of body and mind, e.g., studies in social medicine, environmental and occupational physiology, occupational psychology, occupational diseases.

In planning and carrying out its research programme, the council may be assisted by technical committees, which it appoints to advise on special subjects. These include the Clinical Research Board, set up in consultation with the Health Departments to assist in the development of clinical research in the National Health Service.

The results of the great majority of investigations supported by the council are reported by the workers concerned in papers contributed to medical and other scientific journals. In addition, the council publishes a series of special reports, a series of memoranda, and its annual report to Parliament.

[1] Vote 6 (Medical Research Council) in Class V (Health, Housing, and Local Government)

VIII

# PROFESSIONAL QUALIFICATIONS AND TRAINING

Professional standards in the medical and allied professions are maintained in Britain by the practice of registration. Registration carries with it certain privileges for the registered practitioner and constitutes a guarantee of competence to intending patients; in some professions, e.g., dentistry, it is a prerequisite for practice. The right and duty of maintaining registers of qualified practitioners is entrusted to the different registering bodies by statutes which govern their composition and procedure, lay down the appropriate training and experience required for admission to the register, and prescribe penalties for persons falsely representing themselves to be registered practitioners. The first registering body to be set up was the General Medical Council, established just over a century ago by the Medical Act, 1858, and it has served as a model for later bodies. The latest council to be set up is the General Optical Council, established under the Opticians Act, 1958, and legislation was introduced in 1959 to provide for the registration of a number of professions supplementary to medicine including chiropody and occupational therapy.

## MEDICINE

The current provisions governing the constitution and activities of the General Medical Council are contained in the Medical Act, 1956. Under the Act, the General Medical Council consists of 47 members—8 members nominated by the Crown (of whom 3 are laymen), 11 elected members (8 from England and Wales, 2 from Scotland and 1 from Ireland), and 28 members chosen by the universities and by such bodies as the Royal College of Physicians of London, the Royal College of Physicians of Edinburgh, the Royal College of Surgeons of England and the Royal College of Surgeons of Edinburgh.

In order to become fully registered under the Medical Act, a person must both obtain the qualifications awarded by a university or other body specified in the Act, and also spend a year gaining practical experience under supervision in an approved post in hospital or an institution. A doctor has therefore had 6 to 7 years' training in medical school and hospital before he is fully registered. Only fully registered doctors may engage in general practice in the National Health Service.

There are 18 universities in Great Britain and Ireland which grant degrees in Medicine and Surgery, and diplomas recognised as qualifications for registration under the Act are granted by such bodies as the Royal Colleges of Physicians and of Surgeons. Examples of higher qualifications obtainable after of original degree or diploma are: university degrees of Doctor of Medicine (MD) and Master of Surgery (MS); Membership or Fellowship of one of the Royal Colleges of Physicians (MRCP, FRCP); Fellowship of one of the Royal Colleges of Surgeons (FRCS). Diplomas are awarded by the appropriate examining bodies for aptitude in special subjects, e.g., the

Diploma in Public Health (DPH) and the Diploma in Psychological Medicine (DPM).

There are in all about 140 hospitals in Great Britain with medical teaching facilities. The 26 London teaching hospitals are in fact groups of hospitals, and include over 60 individual hospitals, while the 10 teaching hospitals in Wales or provincial centres cover over 40 institutions. Each of the 12 undergraduate medical schools of London is linked with one of the teaching hospitals—St. Bartholomew's ('Bart's'), St. Thomas's, St. Mary's, St. George's, the London, the Middlesex, Westminster, the Royal Free, University College, King's College, Guy's, or Charing Cross. These hospitals are used for postgraduate as well as undergraduate training but the other 14 London teaching hospitals are reserved for postgraduate study. The British Postgraduate Medical Federation is a School of the University of London, and comprises the Postgraduate Medical School at Hammersmith Hospital and institutes in the various clinical branches of medicine and surgery associated with the special postgraduate teaching hospitals. The 10 teaching hospitals in Wales or provincial centres comprise Birmingham, Bristol, Cambridge, Leeds, Liverpool, Manchester, Newcastle (associated with Durham University), Oxford, Sheffield, and the United Hospitals of Cardiff.

## DENTISTRY

The dental profession is governed by the General Dental Council set up under the Dentists Act, 1957.

There are 12 universities granting degrees in Dental Surgery (BDS) and diplomas as Licentiate of Dental Surgery (LDS). Over and above these, diplomas are granted by the Royal College of Surgeons of England, the Royal College of Surgeons in Ireland, the Royal College of Surgeons of Edinburgh, and the Royal Faculty of Physicians and Surgeons of Glasgow.

Higher qualifications obtainable after initial qualification are: Master of Dental Surgery (MDS); Master of Surgery (Dental Surgery) (MS (Dent.)); Doctor of Dental Surgery (DDS); Fellowship in Dental Surgery (FDS); Higher Dental Diploma (HDD).

The General Dental Council consists of 37 members: 3 dentists and 3 laymen nominated by the Crown, 1 layman nominated by the Governor of Northern Ireland, 19 dentists nominated by the authorities granting diplomas in dental surgery or dentistry, and 11 dentists elected by registered dentists (7 for England, 1 for Wales, 2 for Scotland and 1 for Ireland). In addition, 6 members of the General Medical Council act and vote as members of the General Dental Council, but only in connection with dental education and examinations.

## OTHER PROFESSIONS

The minimum period of hospital training required to qualify for registration as a nurse is three years, except in the case of fever nurses, for whom the minimum period of hospital training is two years. The theoretical work required for the examinations is done either at the same time as the practical nursing or, in some hospitals, in intermittent periods of full-time study. The registered nurse trained in general nursing is entitled to use the letters SRN

(State Registered Nurse) after her name, or in Scotland RGN (Registered General Nurse).

The minimum period of training required to qualify for certification as a midwife (SCM) is one year for registered nurses trained in general or sick children's nursing (who now constitute 94 per cent of all pupils) and two years for others. Part I of the training is taken in hospital and Part II partly in hospital and partly in domiciliary practice, or, in some areas, wholly in the latter.

Pharmacy is regulated by the Pharmacy Act, 1954, and by-laws made thereunder. Only registered pharmaceutical chemists may describe themselves, or practise, as pharmacists, and qualifications requiring about five years' academic study and practical training are necessary for registration. Medicines may be dispensed only by a pharmacist or under the supervision of a pharmacist. The governing body of the profession, responsible for keeping the register, is the Pharmaceutical Society of Great Britain.

There are two types of optician—ophthalmic opticians who usually both test sight and supply glasses, and dispensing opticians who only supply glasses. Training as a dispensing optician is mainly part-time. Training as an ophthalmic optician consists mainly of three years' full-time study, followed by a year under supervision. The profession is regulated by the General Optical Council, set up under the Opticians Act, 1958, and ultimately only registered ophthalmic opticians (or registered medical practitioners) will be allowed to test sight.

Almoners, chiropodists, dietitians, laboratory technicians, occupational therapists, psychiatric social workers, physiotherapists, radiographers and speech therapists generally require two to three years' professional training, in addition to a good general education, to obtain the qualifications for their professions. The training for remedial gymnasts is shorter. With the exception of almoners and psychiatric social workers, the qualifications required for employment in the National Health Service are covered by the National Health Service (Medical Auxiliaries) Regulations, 1954. Almoners are expected to be on the register of the Institute of Almoners, psychiatric social workers to have the qualification of the Association of Psychiatric Social Workers, and legislation was introduced in 1959 to provide for the registration of members of the other professions ancillary to medicine.

# APPENDIX I

## COST OF THE NATIONAL HEALTH SERVICE IN THE UNITED KINGDOM

1st April, 1958 — 31st March, 1959

£ *million* (*estimated*)

| | England and Wales | Scotland | Northern Ireland | United Kingdom |
|---|---|---|---|---|
| *Gross Exchequer Expenditure:* | | | | |
| TOTAL .. .. .. .. .. | 604·2 | 73·5 | 19·5 | 697·2 |
| Hospital, Specialist and Ancillary Services | 385·6 | 49·1 | 12·8 | 447·5 |
| General Medical Services .. .. | 64·2 | 8·0 | 2·2 | 74·4 |
| Pharmaceutical Services (*a*) .. .. | 55·9 | 6·1 | 2·2 | 64·2 |
| General Dental Services (*a*) .. .. | 37·1 | 3·9 | 0·9 | 41·9 |
| Supplementary Ophthalmic Services (*a*) | 9·8 | 0·9 | 0·3 | 11·0 |
| Grants to Local Health Authorities (*b*) | 28·3 | 2·5 | 0·6 | 31·4 |
| Superannuation .. .. .. .. | 10·8 | 1·2 | 0·3 | 12·3 |
| Civil Defence (medical services) .. .. | 0·6 | 0·05 | 0·01 | 0·7 |
| Other Expenditure .. .. .. | 11·9 | 1·7 | 0·2 | 13·8 |
| *Receipts:* | | | | |
| TOTAL .. .. .. .. .. | 131·7 | 15·2 | 3·5 | 150·4 |
| National Health Service Contributions (*c*) | 94·5 | 10·5 | 2·3 | 107·3 |
| Superannuation Contributions, etc. .. | 32·2 | 4·0 | 1·0 | 37·2 |
| Recoveries from Hospital Patients .. | 5·0 | 0·8 | 0·2 | 6·0 |
| Estimated Net Exchequer Expenditure .. | 472·5 | 58·3 | 16·0 | 546·8 |

(*a*) In addition to patients' payments for these three services amounting together to £28·8 million for the United Kingdom (England and Wales £25·6 million, Scotland £2·6 million and Northern Ireland £0·6 million).

(*b*) These grants represent 50 per cent of the cost of Local Health Services, the balance being met from local rates.

(*c*) The weekly contribution rates were increased in July 1958 from 1s. 8d. for a man and 1s. 4d. for a woman to 2s. 4d. for an employed man (of which sum the employer pays 5½d.), 1s. 10d. for an employed woman (including 5½d. from employer), 2s. 2d. for a self-employed or non-employed man and 1s. 8d. for a self-employed or non-employed woman. There are lower rates of contribution for boys and girls under 18 years of age.

# APPENDIX II

## MEDICAL RESEARCH COUNCIL ESTABLISHMENTS

**Research Establishments**

Air Hygiene Laboratory, Central Public Health Laboratory, Colindale, London.
Antibiotics Research Station, Clevedon, Somerset.
Applied Psychology Research Unit, Cambridge.
Betatron Research Group, Christie Hospital and Holt Radium Institute, Manchester.
Biophysics Research Unit, King's College, London.
Blood Coagulation Research Unit, Churchill Hospital, Oxford.
Blood Group Reference Laboratory (administered by the Council on behalf of the Ministry of Health), Lister Institute of Preventive Medicine, London.
Blood Group Research Unit, Lister Institute of Preventive Medicine, London.
Carcinogenic Substances Research Group, Exeter.
Cell Metabolism Research Unit, Department of Biochemistry, Oxford.
Chemical Microbiology Research Unit, Department of Biochemistry, Cambridge.
Climate and Working Efficiency Research Unit, Department of Human Anatomy, University Museum, Oxford.
Clinical Chemotherapeutic Research Unit, Western Infirmary, Glasgow.
Clinical Endocrinology Research Unit, Edinburgh.
Clinical Genetics Research Unit, Great Ormond Street Hospital for Sick Children, London.
Clinical Psychiatry Research Group, Graylingwell Hospital, Chichester, Sussex.
Common Cold Research Unit, Harvard Hospital, Salisbury, Wilts.
Department of Clinical Research, University College Hospital Medical School, London.
Department of Experimental Medicine, Cambridge.
Department for Research in Industrial Medicine, The London Hospital.
Dunn Nutritional Laboratory, Cambridge.
Environmental Radiation Research Group, Department of Medical Physics, University of Leeds.
Experimental Hæmatology Research Unit, St. Mary's Hospital Medical School, London.
Experimental Radiopathology Research Unit, Hammersmith Hospital, London.
Group for the Experimental Investigation of Behaviour, University College, London.
Group for Experimental Research in Inherited Diseases, Department of Genetics, University College, London.
Group for Research on Occupational Aspects of Ageing, Department of Psychology, Liverpool.
Group for Research on Atmospheric Pollution, St. Bartholomew's Hospital, London.
Group for Research on Bilharzia Disease, St. Albans, Herts.
Group for Research on Body Temperature Regulation, The Radcliffe Infirmary, Oxford.
Group for Research on Bone-seeking Isotopes, Churchill Hospital, Oxford.
Group for Research on the Chemical Pathology of Steroids, Jessop Hospital for Women, Sheffield.
Group for Research in Chemotherapy, Molteno Institute, Cambridge.
Group for Research on Drug Sensitivity in Tuberculosis, Postgraduate Medical School of London.
Group for Research on the General Effects of Radiation, Western General Hospital, Edinburgh.
Human Nutrition Research Unit, Nutrition Building, National Institute for Medical Research, The Ridgeway, Mill Hill, London.
Industrial Injuries and Burns Research Unit, Birmingham Accident Hospital.
Industrial Psychology Research Group, University College, London.
Infantile Malnutrition Research Unit, Mulago Hospital, Kampala, Uganda.
Laboratory Animals Centre, MRC Laboratories, Carshalton, Surrey.
Medical Research Council Laboratories, Fajara, Bathurst, Gambia.
Metabolic Disturbances in Surgery Research Unit, The General Infirmary, Leeds.
Microbial Genetics Research Unit, Hammersmith Hospital, London.
Molecular Biology Research Unit, Cavendish Laboratory, Cambridge.
Mutagenesis Research Group, Institute of Animal Genetics, Edinburgh.
National Institute for Medical Research, Mill Hill, London.
Neurological Research Unit, National Hospital for Nervous Diseases, London.
Neuropharmacology Research Group, Department of Experimental Psychiatry, The Medical School, Birmingham.
Neuropsychiatric Research Unit, Whitchurch Hospital, Cardiff.
Obstetric Medicine Research Unit, Royal Infirmary, Aberdeen.

Ophthalmological Research Unit, Institute of Ophthalmology, London.
Otological Research Unit, National Hospital for Nervous Diseases, London.
Pneumoconiosis Research Unit, Llandough Hospital, Penarth, Glamorganshire.
Population Genetics Research Unit, The Warneford Hospital, Oxford.
Radiobiological Research Unit, Atomic Energy Research Establishment, Harwell, Berks.
Radiological Protection Service (jointly with the Ministry of Health), Clifton Avenue, Belmont, Sutton, Surrey.
Radiotherapeutic Research Unit, Hammersmith Hospital, London.
Rheumatism Research Unit, Canadian Red Cross Memorial Hospital, Taplow, Berks.
Social Medicine Research Unit, The London Hospital.
Social Psychiatry Research Unit, Maudsley Hospital, London.
Statistical Research Unit, London School of Hygiene and Tropical Medicine.
Toxicology Research Unit, MRC Laboratories, Carshalton, Surrey.
Trachoma Research Group, MRC Laboratories, Gambia *and* Lister Institute, London.
Tropical Metabolism Research Unit, University College of The West Indies, Mona, St. Andrew, Jamaica.
Tuberculosis Research Unit, MRC Laboratories, Hampstead, London.
Unit for Research on the Experimental Pathology of the Skin, Department of Experimental Pathology, Birmingham.
Virus Culture Laboratory, MRC Laboratories, Carshalton, Surrey.
Virus Research Group, London School of Hygiene and Tropical Medicine.
Wernher Group for Research in Ophthalmological Genetics, Royal College of Surgeons, London.
Wernher Research Unit on Deafness, King's College Hospital Medical School, London.

# APPENDIX III

## READING LIST

### GOVERNMENT PUBLICATIONS

*(obtainable from H.M. Stationery Office, London, and its agents, unless otherwise stated)*

**Statutes**

PUBLIC HEALTH

Public Health Act 1936. 6s.
Public Health and Local Government (Administrative Provisions) Act (Northern Ireland) 1946. *HMSO, Belfast.* 6d.
Public Health (Tuberculosis) Act (Northern Ireland) 1946. *HMSO, Belfast.* 6d.
Water Act 1945. 3s.
Water Act 1948. 4d.
River Boards Act 1948. 1s. 3d.
Rural Water Supplies and Sewerage Act 1944. 4d.
Rural Water Supplies and Sewerage Act 1955. 2d.
Housing Act 1957. 4s. 6d.
Housing (Scotland) Act 1950. 4s. 6d.
Food and Drugs Act 1955. 4s. 6d.

NATIONAL HEALTH SERVICE

National Health Service Act 1946. 3s. 6d.
National Health Service Act 1951. 6d.
National Health Service Act 1952. 4d.
National Health Service (Amendment) Act 1949. 1s. 3d.
National Health Service Contributions Act 1957. 9d.
National Health Service Contributions Act 1958. 4d.
National Health Service (Scotland) Act 1947. 1s. 6d.
Health Services Act (Northern Ireland) 1948. *HMSO, Belfast.* 2s.
Health Services Acts Amendment Act (Northern Ireland) 1950. *HMSO, Belfast.* 2d.
Health Services (Temporary Provisions) Act (Northern Ireland) 1950. *HMSO, Belfast.* 2d.
Health Services (Administrative Provisions) Act (Northern Ireland) 1952. *HMSO, Belfast.* 4d.
Health Services Act (Northern Ireland) 1953. *HMSO, Belfast.* 1s.
Health Services (Administrative Amendments) Act (Northern Ireland) 1955. *HMSO, Belfast.* 4d.
Mental Deficiency Act 1913. 1s. 3d.
Mental Treatment Act 1930. 1s.
Mental Health Act (Northern Ireland) 1948. *HMSO, Belfast.* 2s. 3d.
Mental Health Act 1959. 8s.

INDUSTRIAL HEALTH

Factories Act 1937. 4s. 6d.
Factories Act 1948. 9d.
Factories Act 1959. 1s. 3d.
Factories Act (Northern Ireland) 1938. *HMSO, Belfast.* 2s. 6d.
Factories Act (Northern Ireland) 1949. *HMSO, Belfast.* 6d.
Mines and Quarries Act 1954. 3s. 9d.
Agriculture (Safety, Health and Welfare Provisions) Act 1956. 1s.
Shops Act 1950. 1s. 6d.

MEDICAL AND ALLIED PROFESSIONS

Medical Act 1956. 2s.
Medical Act 1956 (Amendment) Act 1958. 6d.
Dentists Act 1957. 1s. 9d.
Opticians Act 1958. 1s. 6d.
Nurses Act 1957. 1s. 3d.
Nurses Agencies Act 1957. 8d.
Nurses (Scotland) Act 1949. 6d.
Nurses (Scotland) Act 1951. 1s.
Nurses Registration (Ireland) Act 1919.
Joint Nursing and Midwives Council Act (Northern Ireland) 1922. *HMSO, Belfast.* 2d.
Nurses Act (Northern Ireland) 1946. *HMSO, Belfast.* 6d.
Midwives Act 1951. 9d.
Midwives (Scotland) Act 1951. 9d.
Pharmacy Acts 1852 to 1954.

**Annual Reports of the**

Board of Control (Lunacy and Mental Treatment). For 1958. 1959. 9d.
Central Health Services Council. For 1958. 1959. 1s. 9d.
Chief Inspector of Factories on Industrial Health. For 1958. Cmnd. 811. 1959. 3s. 6d.
Chief Inspector of Factories (Northern Ireland). For 1958. Cmnd. 405. *HMSO, Belfast.* 1959. 1s. 6d.
Chief Medical Officer of the Ministry of Education: The Health of the School Child. For 1954 and 1955. 1956. 6s.
Department of Health for Scotland. For 1958. Cmnd. 697. 1959. 5s. 6d.
General Board of Control for Scotland. For 1958. Cmnd. 892. 1959. 2s. 6d.
Medical Research Council. For 1957–58. Cmnd. 792. 1959. 13s.
Ministry of Education. For 1958. Cmnd. 777. 1959. 12s.
Ministry of Health. For 1958, Part I, National Health Service, etc. Cmnd. 806. 1959. 15s. 6d. Part II, On the State of the Public Health. Cmnd. 871. 1959. 12s.
Ministry of Health and Local Government, Northern Ireland: Health and Local Government Administration in Northern Ireland. For 1957. Cmd. 387. *HMSO, Belfast.* 1958. 6s.
Ministry of Labour and National Service. For 1958. Cmnd. 745. 1959. 8s.

**Annual Statistics, etc.**

Analysis of Running Costs of Hospitals for Scotland. For 1956–57. 1957. 10s. 6d.
Hospital Costing Returns. For 1958–59. 1959. 35s.
Summarised Accounts of Regional Hospital Boards, Boards of Governors of Teaching Hospitals, Hospital Management Committees, Executive Councils and the Dental Estimates Boards for England and Wales. For 1957–58. 1959. 3s.
Summarised Accounts of Regional Hospital Boards, etc., for Scotland. For 1957–58. 1959. 1s. 6d.
Summaries of Health Service Accounts, Northern Ireland. For 1956–57. Part I, General Health Services Board. *HMSO, Belfast.* 1958. 1s. Part II, Hospitals Authority and Hospital Management Committees. *HMSO, Belfast.* 1958. 1s. 3d. Tuberculosis Authority. *HMSO, Belfast.* 1958. 1s.
Scottish Health Statistics. 1958. *HMSO.* 12s. 6d.

**Reports on National Health Service**

A National Health Service. Cmd. 6502. Reprinted 1951. 3s.
Northern Ireland Health Service. Report of a Committee of Inquiry. Cmd. 334. *HMSO, Belfast.* 1955. 3s.
Clinical Research in Relation to the National Health Service. 1953. 9d.
Development of Consultant Services. 1950. 9d.
Report of Committee of Enquiry into the Cost of the National Health Service (Guillebaud Committee). Cmd. 9663. 1956. 11s.
Report of Committee on Co-operation between Hospital, Local Authority and General Practitioner Services. Central Health Services Council. 1952. 1s. 6d.
Report of Committee on General Practice within the National Health Service. Central Health Services Council. 1954. 2s. 6d.
Report on the Grading Structure of Administrative and Clerical Staff in the Health Service. 1957. 2s. 6d.
Report of Committee on Costs of Prescribing (Final). 1959. 6s.
Report of the Scottish Committee on Prescribing Costs. 1959. 3s.
Report of the Maternity Services Committee. 1959. 6s. 6*d.*
Report of the Working Party on Convalescent Treatment. 1959. 3s.
Report of the Royal Commission on Doctors' and Dentists' Remuneration. Cmnd. 939. 1960. 15s.

**Reports, etc., on Hospitals**

Out-Patient Waiting Time. Hospital O. and M. Service Reports No. 1. 1958. 1s. 3d.
Medical Records. Hospital O. and M. Service Reports No. 2. 1959. 2s.
Chest Clinics. Hospital O. and M. Service Reports No. 3. 1960. 1s. 9d.
Reception and Welfare of In-Patients in Hospitals. Central Health Services Council. 1953. 9d.
Report of Committee on Internal Administration of Hospitals. Central Health Services Council. 1954. 6d.
Report on Hospital Laundry Arrangements. Central Health Services Council. 1960. 1s. 3d.
Report of Standing Nursing Advisory Committee on the Position of the Enrolled Assistant Nurse within the National Health Service. 1954. 6d.
Report of Working Party on Hospital Costing. 1955. 2s. 6d.
Scottish Hospitals Directory. 1960. 2s. 6d.
Report on the Hospital Pharmaceutical Service. 1955. 2s.

**Reports on Mental Health Services**

Mental Deficiency in Scotland. Scottish Health Services Council. 1957. 1s.

Mental Health Legislation. Report by a committee appointed by the Scottish Health Services Council. 1958. 1s.

Report of Committee on Welfare Needs of Mentally Handicapped Persons. Scottish Advisory Council on the Welfare of Handicapped Persons. 1957. 1s. 3d.

Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency. Cmnd. 169. 1957. 10s. 6d.

Mental Health Legislation. Second Report by a Committee appointed by the Scottish Health Services Council. 1959. 1s.

**Reports on Industrial Health and Safety**

Report of Committee on Industrial Health Services. Cmd. 8170. 1951. 1s. 3d.

Report of the Industrial Safety Sub-Committee of the National Joint Advisory Council. 1956. 1s. 6d.

Short Guide to the Factories Acts, 1937 and 1948. 1949. 8d.

Short Guide to the Factories Acts (Northern Ireland), 1938 and 1949. *HMSO, Belfast.* 1956. 1s. 6d.

**Other Reports, etc.**

Education of the Handicapped Pupil 1945–1955. (Ministry of Education Pamphlet No. 30.) 1956. 2s.

Report of Committee on the Rehabilitation, Training and Resettlement of Disabled Persons (Piercy Committee). Cmd. 9883. 1956. 5s. 6d.

Survey of Services available to the Chronic Sick and Elderly, 1954–1955. 1957. 3s.

Third Report of the Standing Committee on the Rehabilitation and Resettlement of Disabled Persons. 1958. 1s. 3d.

What Local Authorities can do to Promote Health and Prevent Disease. Scottish Health Services Council. 1951. 6d.

Maternity Services in Scotland. Scottish Health Services Council. 1959. 3s. 6d.

**Reports on Recruitment and Training**

Report of the Committee on Nurse Tutors. 1954. 1s.

Report of the Committee on Recruitment to the Dental Profession. Cmd. 9861. 1956. 3s.

Report of the Committee on Social Workers in the Mental Health Services. Cmd. 8260. 1951. 1s. 6d.

Report of the Inter-Departmental Committee on Medical Schools. 1944. 4s. 6d.

Report of the Inter-Departmental Committee on Statutory Registration of Opticians. Cmd. 8531. 1952. 1s. 3d.

Report of the Working Party on District Nurses. 1955. 1s. 3d.

Report of the Working Party on Health Visiting. 1956. 6s. 6d.

Report of the Working Party on Midwives. 1949. 2s. 6d.

Report of the Working Party on Nurses. 1947. 2s. 6d.

—— Minority Report. 1948. 1s. 6d.

Report of the Working Party on Sanitary Inspectors. 1953. 4s. 6d.

Reports of the Committees on Medical Auxiliaries. Cmd. 8188. 1951. 5s.

Report of the Working Party on Social Workers in the Local Authority Health and Welfare Services. 1959. 15s.

## OTHER PUBLICATIONS

**On Public Health**

CLARKE, J. J. Introduction to Public Health Law. *Cleaver-Hume Press.* 1949. 12s. 6d.

MACKINTOSH, J. M. Trends of Opinion about the Public Health 1901–1951. *Oxford University Press.* 1953. 12s. 6d.

**On National Health Service**

ABEL-SMITH, B., and TITMUSS, R. M. The Cost of the National Health Service in England and Wales. *Cambridge University Press.* 1956. 27s. 6d.

ACTON SOCIETY TRUST. Hospitals and the State: Hospital Organisation and Administration under the National Health Service. *The Trust.*

No. 1. Background and Blueprint. 1955. 4s.

No. 2. The Impact of the Change. 1956. 4s.

ECKSTEIN, H. The English Health Service. (*Harvard University Press.*) *Oxford University Press.* 1959. 30s.

HAYNES, A. H. The Practitioner's Handbook to the Social Services. *John Wright and Sons, Bristol.* 1955. 9s. 6d.

HILL, Dr. Charles, and WOODCOCK, John. The National Health Service. *Christopher Johnson*. 1949. 16s.
ORMROD, R., and WALKER, H. The National Health Service. *Butterworth*. 1950. 30s.
ROSS, *Sir* James Stirling. The National Health Service in Great Britain. *Oxford University Press*. 1952. 35s.

**By King Edward's Hospital Fund for London**

Annual Reports.
Voluntary Service and the State, 1952. 1952. 2s. 6d
Hospital Library Services. 1959. 2s. 6d.

**By the Nuffield Provincial Hospitals Trust**

Fourth Report 1955–58. 1958.
Good General Practice—Report of a Survey by Dr. Stephen Taylor. *Oxford University Press*. 1954. 12s. 6d.
Studies in the Functions and Design of Hospitals. *Oxford University Press*. 1955. 63s.
The Work of Nurses in Hospital Wards—Report of a Job-Analysis. *The Trust*. 1953. 6s.

**By the Institute of Hospital Administrators**

Hospitals Year Book, 1960. 59s. 6d.

**COI Reference Pamphlets (RF.P.) and Papers (R.) on Allied Subjects**

Education in Britain. Reference Pamphlet RF.P.3798. *HMSO*. 1958 (under revision). 3s. 6d. (free overseas).
Housing in Britain. Reference Pamphlet RF.P.2797. 1954 (under revision).
Labour Relations and Working Conditions in Britain. Reference Pamphlet RF.P.3814. *HMSO*. 1958. 3s. 6d. (free overseas).
Local Government in Britain. Reference Pamphlet RF.P.4154. 1959. *HMSO*. 2s. 6d. (free overseas).
Rehabilitation and Care of the Disabled in Britain. Reference Paper R.4274. 1959 (free overseas).

Publications for which no price is given are known to be out of print

# APPENDIX IV

## HEALTH DEPARTMENTS AND ORGANISATIONS

**Government Departments and Official Bodies**

Ministry of Health, Savile Row, London, W.1.
Ministry of Agriculture, Fisheries and Food, 3, Whitehall Place, London, S.W.1.
Ministry of Power, 7, Millbank, London, S.W.1.
Ministry of Housing and Local Government, Whitehall, London, S.W.1.
Department of Health for Scotland, St. Andrew's House, Edinburgh.
Ministry of Health and Local Government, Stormont, Belfast.
Ministry of Labour, 8, St. James's Square, London, S.W.1.
Ministry of Labour and National Insurance, Stormont, Belfast.
Ministry of Education, Curzon Street, London, W.1.
Scottish Education Department, St. Andrew's House, Edinburgh.
Ministry of Education, Stormont, Belfast.
Board of Control, Savile Row, London, W.1.
General Board of Control for Scotland, St. Andrew's House, Edinburgh.
General Dental Council, 44, Hallam Street, London, W.1.
General Medical Council, 44, Hallam Street, London, W.1.
General Optical Council, Apothecaries Hall, Blackfriars Lane, London, E.C.4.
General Register Office, Somerset House, Strand, London, W.C.2, and New Register House, Edinburgh, 1.
Medical Research Council, 38, Old Queen Street, London, S.W.1.

**Professional Bodies**

Apothecaries Society of London, Apothecaries Hall, Blackfriars Lane, London, E.C.4.
Association of Dispensing Opticians, 50, Nottingham Place, London, W.1.
Association of Industrial Medical Officers, c/o Peek Frean & Co., Keeton's Road, London, S.E.16.
Association of Mental Health Workers, c/o N.A.M.H., 39, Queen Anne Street, London, W.1.
Association of Occupational Therapists, 251, Brompton Road, London, S.W.3.
Association of Optical Practitioners, 65, Brook Street, London, W.1.
Association of Psychiatric Social Workers, 1, Park Crescent, London, W.1.
Association of Public Health Inspectors, 19, Grosvenor Place, London, S.W.1.
Board of Registration of Medical Auxiliaries, B.M.A. House, Tavistock Square, London, W.C.1.
British Dental Association, 13, Hill Street, London, W.1.
British Dietetic Association, 251, Brompton Road, London, S.W.3.
British Medical Association, B.M.A. House, Tavistock Square, London, W.C.1.
British Optical Association, 65, Brook Street, London, W.1.
British Orthopædic Association, 45, Lincoln's Inn Fields, London, W.C.2.
British Orthoptic Society, Tavistock House (North), Tavistock Square, London, W.C.1.
British Pædiatric Association, The Institute of Child Health, The Hospital for Sick Children, Great Ormond Street, London, W.C.1.
British Tuberculosis Association, 59, Portland Place, London, W.1.
Chartered Society of Physiotherapy, Tavistock House, Tavistock Square, London, W.C.1.
College of General Practitioners, 41, Cadogan Gardens, London, S.W.3.
College of Speech Therapists, 68, Queen's Gardens, London, W.2.
Institute of Almoners, 42, Bedford Square, London, W.C.1.
Institute of Home Help Organisers, 53, Jedburgh Street, London, S.W.11.
Institute of Hospital Administrators, 75, Portland Place, London, W.1.
Institute of Medical Laboratory Technology, 9, Harley Street, London, W.1.
Institute of Personnel Management, Management House, Hill Street, London, W.1.
Institute of Welfare Officers (*Industrial*), 14, Dominion Street, London, E.C.2.
Moral Welfare Workers' Association, Church House, Dean's Yard, London, S.W.1.
Pharmaceutical Society of Great Britain, 17, Bloomsbury Square, London, W.C.1.
Queen's Institute of District Nursing, 57, Lower Belgrave Street, London, S.W.1.
Royal College of Midwives, 15, Mansfield Street, London, W.1.
Royal College of Nursing, 1A, Henrietta Place, London, W.1.
Royal College of Obstetricians and Gynæcologists, Sussex Place, London, N.W.1.
Royal College of Physicians, 12, Pall Mall East, London, S.W.1.
Royal College of Physicians, 9, Queen Street, Edinburgh, 2.
Royal College of Surgeons of Edinburgh, Nicolson Street, Edinburgh, 8.
Royal College of Surgeons of England, Lincoln's Inn Fields, London, W.C.2.

Royal Institute of Public Health and Hygiene, 28, Portland Place, London, W.1.
Royal Society for the Promotion of Health, 90, Buckingham Palace Road, London, S.W.1.
Royal Society of Medicine, 1, Wimpole Street, London, W.1.
Society of Chiropodists, 8, Wimpole Street, London, W.1.
Society of Medical Officers of Health, Tavistock House, Tavistock Square, London, W.C.1.
Society of Radiographers, 32, Welbeck Street, London, W.1.
Women Public Health Officers' Association, 36, Eccleston Square, London, S.W.1.

**Other Bodies**

British Council for Rehabilitation, Tavistock House, Tavistock Square, London, W.C.1.
British Council for the Welfare of Spastics, 13, Suffolk Street, London, S.W.1.
British Diabetic Association, 152, Harley Street, London, W.1.
British Empire Cancer Campaign, 11, Grosvenor Crescent, London, S.W.1.
British Epilepsy Association, 27, Nassau Street, London, W.1.
British Hospitals Contributory Schemes Association, Royal London House, Queen Charlotte Street, Bristol, 1.
British Red Cross Society, 12, Grosvenor Crescent, London, S.W.1.
British Rheumatic Association, 11, Beaumont Street, London, W.1.
British Social Biology Council, Tavistock House, Tavistock Square, London, W.C.1.
Central Council for the Care of Cripples, 34, Eccleston Square, London, S.W.1.
Central Council for Health Education, Tavistock House, Tavistock Square, London, W.C.1.
Central Council of Physical Recreation, 6, Bedford Square, London, W.C.1.
Chest and Heart Association, Tavistock House (North), Tavistock Square, London, W.C.1.
Family Planning Association, 64, Sloane Street, London, S.W.1.
Industrial Welfare Society, 48, Bryanston Square, London, W.1.
Infantile Paralysis Fellowship, Rugby Chambers, Great James Street, London, W.C.1.
Invalid Children's Aid Association, 4, Palace Gate, London, W.8.
King Edward's Hospital Fund for London, 34, King Street, London, E.C.2.
Mental After Care Association, 110, Jermyn Street, London, S.W.1.
Multiple Sclerosis Society, 10, Stratford Road, London, W.8.
National Association for Maternal and Child Welfare, BMA House, Tavistock Square, London, W.C.1.
National Association for Mental Health, 39, Queen Anne Street, London, W.1.
National Association for the Paralysed, 1, York Street, London, W.1.
National Council for the Unmarried Mother and Her Child, 21, Coram Street, London, W.C.1.
National Institute for the Deaf, 105, Gower Street, London, W.C.1.
National Institute of Industrial Psychology, 14, Welbeck Street, London, W.1.
National League of Hospital Friends, 23, Knightsbridge, London, S.W.1.
National Society for Epileptics, Chalfont Colony, Chalfont St. Peter, Bucks.
National Society for Mentally Handicapped Children, 162A, Strand, London, W.C.2.
National Society of Children's Nurseries, 45, Russell Square, London, W.C.1.
National Spastics Society, 28, Fitzroy Square, London, W.1.
Nuffield Provincial Hospitals Trust, Nuffield Lodge, Regent's Park, London, N.W.1.
Order of St. John, St. John's Gate, London, E.C.1.
Royal National Institute for the Blind, 224, Great Portland Street, London, W.1.
Royal Society for the Prevention of Accidents, 52, Grosvenor Gardens, London, S.W.1.
St. Andrew's Ambulance Association, 98–108, North Street, Charing Cross, Glasgow, C.3.
St. Dunstan's (*for war-blinded*), 191, Marylebone Road, London, W.1.
Scottish Association for the Deaf, 85, Queen Victoria Drive, Scotstoun, Glasgow, W.1.
Scottish Association for Mental Health, 57, Melville Street, Edinburgh, 3.
Scottish Association of Parents of Handicapped Children, 226, St. Vincent Street, Glasgow, C.2.
Scottish Council for the Care of Spastics, Westerlea, Ellersley Road, Edinburgh, 12.
Scottish Council for Health Education, 16, York Place, Edinburgh, 1.
Scottish Council for the Unmarried Mother and Her Child, 30, Castle Street, Edinburgh, 2.
Scottish Council of Physical Recreation, 4, Queensferry Street, Edinburgh, 2.
Scottish Epilepsy Association, 24, St. Vincent Place, Glasgow, C.1.
Scottish National Federation for the Welfare of the Blind, 4, Coates Crescent, Edinburgh, 3.
Scottish National Institution for the War Blinded, Gillespie Crescent, Edinburgh, 10.
Shaftesbury Society (*cripple care*), 32, John Street, London, W.C.1.
Women's Voluntary Services, 41, Tothill Street, London, S.W.1.

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