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THE PLACE OF THE HOSPITAL IN A NATIONAL HEALTH SERVICE*

BY

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I must first express my deep gratitude to the President and Censors for doing me the honour of inviting me to deliver the Croonian Lectures this year. I recognize my inadequacy when I see the long line of distinguished men going back for over 200 years who have preceded me in this lectureship. All except one—and he had outstanding qualifications to speak on his subject of “Professional Freedom”—have been eminent clinicians or laboratory research workers. My role has been that of the medical administrator whose main purpose has been to provide the tools, and persuade hard-headed finance committees to provide the money, with which clinicians and laboratory workers could undertake their best work. From that background and my special interest in preventive medicine I shall endeavour to put before you my reflections on some of the problems which confront us in the light of the first five years of the National Health Service and on the relationship of the work done by the hospital and specialist service to the other two pillars of the National Health Service: the general-practitioner service and the miscellaneous services provided by the local health authorities.

Definitions

We must first define our terms. The *O.E.D.*, after referring to the original meaning of “hospital” as a charitable institution for the aged (Chelsea Hospital) and for the education of the young (Christ’s Hospital), says that in the current sense it is “an institution or establishment for the care of the sick or wounded or of those who require medical treatment.” The definition of “hospital” in the National Health Service Act is longer and more specific. It reads that a hospital “means any institution for the reception and treatment of persons suffering from illness or mental defectiveness, any maternity home, and any institution for the reception and treatment of persons during convalescence or persons requiring medical rehabilitation, and includes clinics, dispensaries, and out-patient departments maintained in connexion with any such institution.”

For the definition of “National Health Service” we must go to the preamble of the Act which established it. It simply states that it is an Act “to provide for the establishment of a comprehensive health service for England and Wales and for purposes connected therewith.” This contrasts with the preamble of the first

National Health Insurance Act of 1911, which states that it is “an Act to provide for insurance against loss of health and for the prevention and care of sickness. . . .” I draw attention to the specific reference to prevention in the 1911 Acts and that prevention has been merged in the comprehensiveness of that of 1946.

Origins of Hospitals

An American author well known in this country, General Paul T. Hawley, now Director of the American College of Surgeons (Hawley, 1948), says: “It is scarcely an exaggeration to say that hospitals were set up for the primary purpose of abating a nuisance and that they were operated accordingly for many years. . . . The sick, the crippled, the insane—especially those unable to pay for private care—were public nuisances.” But I am sure that General Hawley would agree that, both in this country and in his, it is probably true to say that purely humanitarian motives have provided the main-spring for the establishment and maintenance of hospitals within, at least, the last century. But the provision of “fever” hospitals was due to a desire to protect the public and to isolate the victims of infectious diseases because of fear of their spreading. Earlier examples were the “leprosaria” of the Middle Ages. Whatever the motives, the hospitals of to-day spring from four main sources.

It is not generally realized that the largest component in the number of beds is the group of hospitals for the mentally disordered and the mentally defective. One, the Royal Bethlem, has just celebrated its 705th anniversary. Along with St. Bartholomew’s and St. Thomas’s, it is among the five “royal” hospitals with whose administration the Corporation of the City of London was, at least until 1948, closely associated. The other mental hospitals were mostly provided by the local authorities or, their predecessors for this purpose, the justices of the peace.

In those days the purpose of mental hospitals was purely “custodial” and for the protection of society and of the lunatics themselves. In fact, it was only in 1930 that the term “lunatic asylum” was replaced by “mental hospital” and “lunatic” by “mental patient.” Special institutions for the care and rehabilitation, where possible, of the mentally defective are a comparatively recent development. The next largest component originated in the sick bays of the “workhouses” or institutions of the boards of guardians. The guardians of the poor

*The first of the Croonian Lectures delivered before the Royal College of Physicians of London on July 7.

had the statutory duty to provide accommodation for the destitute, and in a considerable number of cases the destitution was caused by illness.

Many of the boards of guardians, and later the major local authorities who took over these functions from them in 1930, took their responsibilities for the destitute sick very seriously. Hospitals, some quite first-class, were built to replace the sick bays, and from 1930 many were administered under the Public Health instead of the Poor Law Act, with the result that "any inhabitant of the district" was eligible for admission, though always the "destitute sick" had a prior claim for admission.

The third most numerous group of hospitals, in the number of beds provided, was the then "voluntary" hospital group. Apart from the few ecclesiastical foundations they began to be established about 200 years ago. Many have just celebrated their first centenary. Most of the "cottage" hospitals are of even more recent foundation. The initiative in the establishment of a voluntary hospital usually came from a keen doctor or group of doctors who secured the interest of one or more wealthy laymen whose motives were purely humanitarian and philanthropic. It was felt that the sick poor should not be forced into the Poor Law hospitals or institutions, in many of which the medical services had lagged behind development elsewhere. Also, it was abhorrent to many of the respectable poor to have recourse to the "Poor Law," which at that time still adopted a "deterrent" policy. The voluntary hospitals had the great advantage over the public hospitals that, so long as their committees of management could find the money, they could develop as they wished, and if, as generally happened, the most capable doctors of that locality were on the honorary staff, the lay committees had the best medical advice at their disposal. It was therefore inevitable that when teaching of the science and art of medicine was systematized the voluntary hospitals undertook the training of medical students. There were, however, in 1948 only 23 general teaching hospitals in England and Wales, of which 13 were in London, and one of them, the Hammersmith Hospital for postgraduate teaching, was under municipal management. Many of the rest of the 930 voluntary hospitals were quite small and their financial and medical resources inadequate for the more complicated medical and surgical work. As a further development many voluntary hospitals during the past fifty years provided beds or even separate wings for paying patients. The voluntary hospitals were also pioneers in the training of nurses.

The fourth group of hospitals forming the pre-1930 complement consisted of those provided and administered by the local authorities. Most were hospitals for the acute infectious diseases, and only a few of these were large, well staffed and modern. This group also included a number of sanatoria and maternity hospitals.

Beginnings of a Hospital Service

In 1930, as already mentioned, the former Poor Law hospitals were transferred to the administration of the county and county borough councils, and there were, in effect, from then until 1948, and disregarding the few private profit-making hospitals, clinics, or nursing-homes, only two groups of hospitals: those maintained by public money raised from the rates and the independent voluntary hospitals. Some of the voluntary hospitals received public money from local authorities for "services rendered"—for example, by providing special clinics for venereal disease or for school-children. Before 1930 the only attempts at providing a hospital service were limited to highly specialized fields—

namely, the mental hospitals of three or four large mental hospital authorities and the service of the Metropolitan Asylums Board, which provided fever hospitals, sanatoria, and hospitals for long-stay cases in children.

Even before the outbreak of the second world war in 1939 most voluntary hospitals were finding it hard to make both ends meet, and this would have been impossible had they not received substantial support from hospital contributory schemes.

The larger public authorities had during the period 1930–48 the opportunity of developing a complete hospital service as distinct from an agglomeration of separate and semi-independent units. They were encouraged by the Ministry of Health to dissociate them from the Poor Law, and to administer them under the Public Health Acts, and many did so. This provision of a service ensured that no inhabitant of their district who applied for, and was considered suitable for, treatment failed to obtain it in one or other of the authorities' hospitals. It enabled, also, special units, often of a research type, to be set up. Some of the more progressive authorities took full advantage of these opportunities and, despite the difficulties of the war period, a first-class public hospital service was in process of being developed. On the other hand, some local authorities had neither the resources nor the will to bring about major improvements. Their general hospitals were still being administered under the Poor Law Acts; their patients were mainly in the chronic sick group, and little was done to improve staffing, equipment, or buildings. In all areas, however, the public health and the preventive and hospital services were under the same local administration, and this ensured effective liaison and co-operation between the various services.

The War and its Aftermath: The National Health Service

The war, through the emergency hospital service and the various sector schemes, brought the two separate hospital groups—the local authority and the "voluntary"—more closely together. And the National Health Service Act of 1946, which provided for complete fusion of the local authority and the voluntary non-teaching hospitals, took them completely away from local government and placed them under central government control. The fourteen regional hospital boards nominated by the Minister of Health act as the Minister's agents and under the directions of his Ministry; they are the planning authorities for hospitals and the employers of consultants. The 400 hospital management committees, nominated by the regional hospital boards, are responsible for day-to-day administration of the hospitals within their group, but again subject to regulations made by the Ministry, and their money is obtained through the regional boards.

The teaching hospitals were also nationalized, but remained independent units, separate from the regional board system, and responsible direct to the Ministry of Health, but subject also to control by the regulations made by the Ministry. There are 36 boards of governors of teaching hospitals (14 London postgraduate, 12 London undergraduate, and 10 provincial undergraduate). As London is divided between four regional boards there are no fewer than 30 separate hospital administrative bodies operating within the areas covered by the single executive council for London and by the local health authority—the London County Council. By interchange of membership between boards of governors and regional hospital boards, there is some provision for co-operation between teaching and non-teaching hospitals, but it cannot be regarded as close co-operation such as occurs in Scotland, where the teaching and the non-teaching hospitals alike are administered by the regional hospital boards.

Reversal of Administrative Trends

Thus has come about the reversal of the general trend, which had been for decades to build up the administrative

responsibilities of the major local authorities—that is, the counties and the county boroughs—and to make them responsible for all public health, medical, nursing, and midwifery work, including hospital work, paid for by public money and operating in their areas. The administration of hospitals has been taken out of local government, and the Ministry of Health, to an increasing extent, undertakes executive responsibility and issues directives about the management and staffing of hospitals. This is in substitution, so far as local authority hospitals are concerned, for executive control by the local authorities and their officers. I will not enter into a discussion on which is the more tolerable method of control. There are advantages and disadvantages in each. But we must remind ourselves of the old adage that “whoever pays the piper calls the tune,” and whoever supplies the money, whether the committee, as in former days, of a voluntary hospital or a public authority, whether central or local, must have the last word on how much money is available and how it should be spent. There is no escape from this, though the reins can be held more loosely in some administrations than in others.

It may here be mentioned, as a further illustration of the previous trend, that in 1928 the Royal Commission on National Health Insurance (National Health Insurance, 1928) recommended that the insurance committees responsible for “medical benefit” should be abolished and their work transferred to the county and county borough councils. This was for the purpose of consolidating the administration of all public medical work in the hands of the same local authority; but the 1946 Act disregarded this recommendation, and the executive councils, which have replaced the insurance committees, have even wider powers and authority than the former insurance committees, though by allowing local health authorities to nominate one-third of the committees it has been recognized that the work of the local health authorities and that of the executive councils has much in common and that they should operate over the same areas.

Distribution of Functions Within the National Health Service

There is no clear or logical line of demarcation in the present distribution of function between the three branches of the Service. By and large, preventive work falls to the local health authorities, but Newman pointed out so long ago as 1926 that “preventive and curative medicine are in intimate association,” and “preventive medicine . . . embodies the whole of medicine as regards disease which is preventable especially in its beginnings rather than its end-results.” A recent publication of the Public Assistance Department of Paris (*L'Assistance Publique*, 1953) puts the matter even more strongly. After referring to the important part which a hospital can play in the prevention of illness, and giving examples, it states that preventive and curative medicine should conjugate until they fuse. It continues: “La distinction entre la médecine préventive et la médecine curative apparaît, en effet, de plus en plus arbitraire. En réalité, la médecine est ‘une.’” At the extremes of preventive and curative medicine they, of course, do not intermingle. Vaccination, for example, and immunization are clearly preventive, and the alleviation of symptoms in those afflicted with a mortal disease is neither preventive nor curative but simply remedial. But the early diagnosis and treatment of diseases which are curable, however, often prevent serious disabling or even fatal illness.

The isolation of those suffering from an acute infectious disease was introduced as a measure of preventive medicine for the purpose of preventing the spread of the disease, and in some instances—for example, smallpox—this still has validity, but in many infectious conditions all likely spread has taken place before the diagnosis has been made and the patient removed to hospital. Fever hospitals, therefore, for many years have derived their main value from the treatment given to the patients therein. But the spectacu-

lar reduction in recent years in the incidence of epidemic diseases followed the discovery of their cause and, consequently, of their mode of spread, and the application of that knowledge. Is it too much to hope that, with increasing knowledge of the aetiology of the non-communicable diseases, dissemination and application of that knowledge will have equally happy results?

Tuberculosis—an infectious disease—is another example of the close relationship between preventive and curative medicine. Improvement of living and economic conditions for the individual, as well as for the community as a whole, is undoubtedly in the preventive field. So is educational work on early danger signals which should take the patient to the doctor. The searching for early cases among contacts and others should be regarded as a function of the authority for prevention just as it is in smallpox, but the mass radiography units have been transferred from the local health authorities to the regional hospital boards, presumably because it is they who employ all, or most, specialists in the public service.

An example may be given of a change which is not an improvement and which follows the thesis that hospitals are responsible only for patients for whom treatment is likely to be beneficial, and if no further benefit is likely they become the responsibility of the local health authority. This is a thesis which, though it may follow the statutes, is contrary to the public good. When the taking of steps to reduce the toll taken by tuberculosis was entrusted, before 1948, solely to the local authorities they provided institutional accommodation not only for the tuberculous, for whom treatment was likely to be productive, but also for the ambulant chronic sputum-positive patient who had no suitable home in which he could live. The institutions used were not elaborately equipped or staffed, but they made their patients comfortable and kept them out of harm's way. Very often such people live now in common lodging-houses.

The Metropolitan Regional Hospital Boards, with the concurrence of the Ministry of Health, have declined to admit, and are reluctant to retain, patients who are unlikely to benefit from further treatment, even though they are infectious. The local health authorities are therefore faced with the dilemma of leaving these people in common lodging-houses or providing hostels for them. When hostels are provided, the patients have, under the present law, to make a contribution towards the cost of their maintenance. Before 1948 no charge was made to such patients. As most of them have had free treatment in hospitals and as there is no power to require them to enter, or remain in, a hostel, it is not surprising that such places are difficult to administer and that the patients are reluctant to enter or remain in them.

The thesis that hospitals are to be provided only for those for whom treatment is likely to be beneficial is worthy of a further note. Some thousands of beds are provided by hospital authorities for the mentally defective, for whom the only therapy which can be provided is training and education. It will be remembered that the statutory definition of hospitals specifically mentions the mentally defective. Again, mild cases of smallpox are admitted, without question, to a hospital. No treatment is needed or provided, but only isolation. It seems a pity that, with these precedents, the chronic infectious tuberculous can be excluded unless they need treatment.

The divorce between treatment of the tuberculous and their rehabilitation at colonies such as Papworth and Preston Hall is another example of the difficulties which arise when artificial fences are erected in the course of what should be one process, under the same administration—namely, the restoration of a sick person to the working community. I am limiting my remarks here to the tuberculous, for whom treatment and training are so interlocked.

The working definition of these entitled to hospital care includes those who require constant nursing and regular medical care: this being the line of differentiation between

convalescent homes (hospitals) and recuperative holiday homes (local health authorities) and between the chronic sick (hospitals) and the aged and infirm (local welfare authority).

The Chronic Sick (Hospital Responsibility) and the Aged and Infirm (Welfare Responsibility)

The line of demarcation here also is by no means clear. Those responsible for the institutions to which admission is sought decide whether or not they will accept an individual patient, and there is no appeal to anyone who can give a binding decision when neither authority will have him and maintains that it is the responsibility of the other. There is the further complication that if the hospital authority accepts the patient no charge is made. If the local health or welfare authority does so, the patient is assessed to pay. But, however broad the dividing line, one must be fixed somewhere, as a hospital authority cannot be expected to provide accommodation for the aged and infirm, though when local authorities were responsible for both hospitals and welfare institutions the exact definition was not of great importance. There is much to be said for an arrangement which was common before 1948, but which does not accord with the present statute, under which the hospital provided medical, nursing, and pharmaceutical services for homes for the aged which were then called "public assistance institutions." The same doctor then decided when a patient should be transferred from the hospital to the institution, or vice versa.

With regard to patients at home, for whom the general practitioner has recommended admission to hospital, there always will be difficulty while the number of beds available falls short of the demand. A scheme started by Dr. E. B. Brooke, then of St. Helier Hospital, has much to commend it, though strictly it goes somewhat beyond the statutory provisions. He went to see the case in the patient's own home and met the general practitioner there. He was familiar with the local authority and voluntary services available, and, by appropriate use of them and of the hospital out-patient department facilities, the patient could often be looked after satisfactorily at home. At the Montefiore Hospital in New York City, Dr. E. M. Bluestone has developed a large scheme under which hospital consultant and other staff supervise the treatment of the chronic sick in their own homes. A suggestion has been made by the paediatric department of one London teaching hospital that many child patients could be spared the "psychological trauma" of separation from their mothers if the hospital services, including that of the paediatrician, were taken to the homes instead of the children being taken to the hospital. Any such schemes, however, for home treatment supervised by hospitals bring in the other two branches of the National Health Service, and there are so many different people with whom the matter has to be discussed and agreement reached that progress is slow.

Mention should here be made of the "half-way" houses for patients for whom an acute general hospital can do no more but whose nursing needs are such that they are unsuitable for a welfare home. They are regarded as part of the hospital organization, and so co-operation and selection of patients are easy. But, despite the generosity of the King Edward Fund and of the National Corporation for the Care of Old People in finding the capital for such places, there are not enough of them. In consequence many of these patients are in welfare homes and others remain in hospital. The latter are maintained free, the former have to pay a contribution towards their maintenance and, despite the reduced sickness benefit paid to long-stay hospital cases and to the fact that welfare cases are mostly pensioners—contributory or non-contributory—the patients themselves regard it as an anomaly and resent the differentiation. It is difficult to understand why the recommendation in the Beveridge report that a "hotel charge" should be made to hospital patients was never taken up.

Interlocking of Preventive and Curative Services

As a further example of the interlocking of preventive and curative medicine, the local authorities, 35 years ago, started clinics, mainly in general voluntary hospitals, for the diagnosis and treatment of venereal diseases. The patient was diagnosed, treated, and rendered non-infectious as speedily as possible, and this is probably the most important and effective method of reducing the incidence of these diseases. But education of the public, case-holding, and contact-tracing were also essential parts of the scheme. Except for education of the public, all these functions with their important preventive aspects are now largely in the hands of the hospital boards, which thus carry out important preventive functions. Further, doctors in the clinical field are to an increasing extent giving advice to their patients on how to prevent a recurrence of the illnesses for which they have been consulted. But Dr. Edwin L. Crosby, President of the American Hospital Association (International Hospital Federation, 1953), says, and the same applies to this country, "Education of the patient and his family while he is being treated in the hospital . . . is a relatively unexplored area that merits increasing attention."

I hope that I have made it clear that there can be no clean-cut line of demarcation between the work of hospital and health authorities so far as preventive and curative medicine are concerned. While hospitals may work primarily on the curative side, they carry out important preventive work. On the other hand, health authorities have a vital interest in much of the work of the hospitals, particularly when, as in their child welfare and school health work, they discover children in need of hospital treatment. In consultation with the family doctor, they refer them to hospital and so often prevent a minor condition developing, because of lack of early treatment, into something serious.

Local health authorities have, moreover, many important functions which have no direct concern with preventive medicine, however widely defined. These have been placed upon them because their boundaries are defined, and between them they cover the whole country. When Parliament imposes a duty upon them to provide a service everyone knows where the responsibility lies, and it cannot be evaded. This is very important in some instances, such as, for example, the taking into institutions of persons of disordered mind for whom care is needed for the protection of themselves or others. A duty of the local health authorities is to provide a 24-hour service of "duly authorized officers" who proceed at once to any place where it is alleged that there is a person of unsound mind who is in need of institutional care. In the mental health and mental deficiency services the officers of the local authorities find the patients and the hospital authorities are supposed to find the beds, but, in at least the mental deficiency services, there is a lamentable lack of an adequate number.

The work of the "duly authorized officers" was formerly a duty of the, now abolished, relieving officers. Before 1948 these officers could also require a public hospital to admit any sick person from their area for whom hospital care appeared to be essential. He relied for advice on medical matters on the "poor law medical officer." This power to require admission was possible because the public hospitals then served specified districts. Many think it unfortunate that with the nationalization of the hospitals there is no longer any special obligation on individual hospitals to find room for the sick in their vicinity: nor is there, now, any local official who can require them to make room. I should, however, make it clear that in my experience there is little or no difficulty in finding a bed forthwith for an acute medical or surgical emergency. The difficulties arise in the long-stay or potentially long-stay cases, the tuberculous, the mentally defective, the chronic sick, and the aged. It would appear that the prospect of obtaining a bed decreases materially with advancing age.

Another utilitarian service provided by local health authorities is the ambulance service. The accident ambu-

lance service takes the patients to the hospitals—that is, it provides clients for the casualty or in-patient departments. The reverse occurs in the removal or transport sections of the ambulance service. Here, the hospital or the general practitioner orders the free ambulance or transport and the local health authority has to provide the vehicle and the driver and foot the bill, recovering, however, half from the taxpayers' money distributed by the Ministry of Health.

This criss-cross of administration under which one authority must look to another to carry out some of its functions—and few things can be carried to completion by the same administrative body from initiation to completion—is bound to lead to slowing down of action, increased paper work, and added expense.

Another function of local health authorities is to provide domiciliary nursing. The "ordering" of this, generally, is done by a general practitioner, or, for a patient about to be discharged, by a hospital. A similar service is that of "home" or "domestic" helps, but it is not a statutory duty of local health authorities to provide this service. It is only a "power" which Parliament says the local authorities may exercise if they wish. The local authorities, therefore, can in this service decline to comply with the wish of a general practitioner or a hospital that a home help be provided. In practice, however, it is unusual for such a request to be declined, though there may be difficulty in meeting it fully. From my recent visits to other countries I gather that this type of service under a public authority is unique to this country.

The Maternity Services

It is perhaps in the maternity services that interlocking of function between the three branches of the National Health Service is most pronounced. Hospitals can provide a complete antenatal clinic service for their booked patients, and, though they are asked by the Ministry of Health, following advice given by the Central Health Services Council, only to book patients who need a bed on obstetrical or social grounds—the latter being determined by the local health department—some hospitals accept all comers.

Local health authorities have the duty to provide a service of domiciliary midwives, and they also provide antenatal clinics. Sometimes hospitals send their booked cases to municipal antenatal clinics for intermediate supervision and the clinics send them back at the 36th week, or immediately on the occurrence of any abnormality. Hospitals can also ask the midwives or health visitors of the local authority to look up those who should have attended the hospital antenatal clinic but have defaulted in doing so. Some hospitals which are training schools for midwives have an extern department which is part of the local authority's midwifery scheme and paid for by it. Some expectant mothers still book a domiciliary midwife and leave it to her to call in a doctor, as required by the rules of the Central Midwives Board, should any abnormality occur. In this case the doctor is paid by the local health authority. On the other hand, the patient may book a doctor for the domiciliary confinement, and he may be either a general-practitioner obstetrician on the special list or the patient's own doctor. In either case he is paid by the executive council. The patient in these cases also has the services of a municipal midwife, who, again, may either act as a midwife, if the booked doctor does not attend the actual confinement, or as a maternity nurse if he does.

The patient may receive all her antenatal care from the doctor and the midwife or she may attend the municipal antenatal clinic for educational lectures, blood tests, antenatal exercises, and medical supervision as well. The hospital is concerned in these cases in that they may be sent there if any serious emergency arises, and maternity hospital provision in every area must take account of this contingent liability. Again, if post-partum haemorrhage or other serious mishap occurs, the hospital may be asked to send to the home the "flying squad." The domiciliary doctor also may at any time call in a specialist obtained from,

and paid for by, the hospital board, for a consultation at the patient's home. Those with a liking for tidy administration are horrified by this jumble of authority, but, despite it, the maternal mortality has been reduced spectacularly in recent years, and preventable deaths are very rare.

Almoners and Health Visitors

Another overlapping field concerns the work of hospital almoners and of the health visitors employed by the local health authorities. Now that almoners are no longer concerned with the assessment of means and the collection of money, and now that doctors are more alive to the part played by occupational, environmental, and economic factors in the causation and prognosis of disease, almoners are increasingly called upon by hospital staffs to supply information on these matters. On the other hand, the duties of health visitors as set out in the National Health Service Act, 1946, are: "Giving advice as to the care of young children, or persons suffering from illness, and of expectant and nursing mothers and as to the measures necessary to prevent the spread of infection." The Ministry of Health has expressed the view that, normally, hospital almoners should not pay home visits and that information needed about home conditions should be obtained from health visitors, who should be the family case workers.

Again, local health authorities have responsibilities for aftercare, and some, by agreement with hospitals, follow up in their homes and as helpers of the family doctor cases of gastric and duodenal ulcer and of diabetes discharged from hospital. Some mental hospitals employ their own psychiatric social workers to make home inquiries: others ask the local authorities to do so. Some institutions for the mentally defective have their own staff to supervise their patients out on licence: others use local authority staff.

Local education authorities have statutory responsibilities for safeguarding the health of schoolchildren. They must provide for routine medical examinations, and if treatment is found to be necessary they must see that the child gets it from a general practitioner, at a hospital, or at a school clinic. Yet some hospitals steadfastly refuse to pass information to the school medical officer about schoolchildren under their care, on the grounds either of inadequacy of clerical staff or of a breach of the doctor-patient relationship. All would agree that the parents' consent to the transmission of the information should be obtained, but when it is put to the parents that it is in the interests of the child's education refusal is extremely rare.

The above are only examples of the interlocking of the health and hospital services and of some of the difficulties, actual and potential, met with in the desire to achieve adequate integration. Having regard to the "oneness" of preventive and curative medicine, any attempt to allot only preventive services to local authorities and only curative to hospitals would be doomed to failure.

General Practitioners and the Hospital Service

The Scottish Health Services Council (1952) has recently examined and reported upon the relationship between the general practitioner and the hospital service. It refers to the method of appointment of specialists, and points out that it is now difficult, if not impossible, for the general practitioner, even with the requisite qualifications and experience, to obtain a post as a consultant. It also discusses the use made of the general practitioner in institutional midwifery and the absence of full facilities for the general practitioner to follow his patients into hospital. A fourth point is the difficulty of access by the general practitioner to the ancillary services provided by the hospitals, particularly those of the x-ray and pathological departments.

It recommends that the specialist establishment of a hospital should include provision for doctors who are engaged

partly in general and partly in specialist practice. They commend as part of a long-term policy the establishment of general-practitioner wards or blocks associated with general hospitals and the continuance of existing cottage hospitals. It also recommends direct access of general practitioners to hospital x-ray and pathological departments. A step forward, however, is the new provision by which consultants can be called in for a domiciliary consultation under the Act. This provides that personal contact between consultant and general practitioner which is so desirable.

It may also be mentioned here, with regard to the relationship between general practitioners and the local authority health services, that the Act has, on the whole, tended to make it closer, particularly as compared with the relationship with the hospital service, where the Act has severed the former bonds. The practitioner can be helped materially by several of the local authority services, particularly the home help, the home nursing, and the ambulance sections. There is an interesting development in a few areas where a health visitor is attached to a general practitioner, and this, again, may well forge a link between all the services at the local level. The attendance of the medical officer of health at meetings of the local medical committee has enabled each to understand, and appreciate, the problems of the other. On the hospital side, it would help to close the gap if, to an increasing extent, medical officers of health were co-opted on to the medical staff committees of hospitals.

The National Health Service: A Divided House

It is recognized generally that a weakness of the new service is the division of its administration into three separate compartments, and that it is essential that all who work in it should realize that there is only *one* National Health Service, that all proposals for development and change should be discussed with representatives of the other services, whose own work, in some way or another, is likely to be affected. Professor James M. Mackintosh in an address to the Royal Medical Society at Edinburgh in February, 1951, said: "In the entire Act there is no broad conception of a national health policy, only a fragmentation. It has failed because it has set a gulf between divisions which ought to have been brought together—the hospital, the general practice of medicine, and the public health service." Above all, there must be a regular exchange of information so that all concerned may be aware of what is going on and what is proposed, so that they can put forward their comments before it is too late.

All this means more and more time on paper work and attendance at committee meetings, but it is part of the price we pay for rationalization, nationalization, or whatever word we use for attempting to do things comprehensively and on a nation-wide or large scale. A committee of the Central Health Services Council (1952) spent many months in 1951 considering how the National Health Service could be more closely integrated and function as one service instead of three separate dominions. It gathered much information and it was clear that in some localities valiant attempts are being made to bring together for consultation and discussion representatives of the three branches of the Service. It was felt that this could best be done at the level of the hospital management committees, but this is not easy if the local government area contains several such committees or if the normal gathering-ground of the hospitals in the group covers several local government areas.

A Unified Service

Some may feel that the only logical solution of all these administrative difficulties is to have for each area one, and only one, body responsible for the administration of all three branches. This involves many difficult questions.

In the first place, should the administrative responsibility be in the hands of nominated or elected bodies? It is the general experience that nominated bodies have not the same

sense of financial responsibility as elected ones. Possibly because of this, hospital boards and management committees have been subjected to tighter and tighter control by the Ministry of Health.

Comparisons are sometimes drawn between the hospital service, administered locally by a multitude of boards and committees whose members are unpaid, and corporate bodies like the B.O.A.C., and the Coal, the Gas, and the Electricity Boards. They are reputed to be administered on more business-like lines and are given more financial freedom than are hospital boards. The late Viscount Dawson was attracted by an administration based on that of the B.B.C., and Dr. Stephen Taylor (1951, 1952) would administer the service by small boards of paid directors. Not everyone would agree that the corporate bodies mentioned have the advantages claimed, but the essential difference between the two types of service is that all the corporate bodies are revenue-earning. They all sell something, and, despite the shocks received by the taxpayers when they show a deficit which has to be provided from public funds, they are, at least in theory, supposed to pay their way and to cover their expenditure by revenue. The B.B.C., however, is now an exception, though at first it conformed to the general rule that it should be self-supporting. It does now receive subsidies for its foreign broadcasts, but even this may be regarded as a sale to the Government of services which could not otherwise be provided economically.

Financial Problems

Unless, as is most unlikely, there is a radical change in the basis of our hospital service and, as in the U.S.A. and in certain States of Australia, hospital revenue is derived from contributory schemes—voluntary or compulsory—and from patients direct, hospitals will always be a heavy charge on public funds. It would not be impossible to devise a scheme which would substitute a small nominated body for the Minister of Health and his officers and put it in charge either of the hospital and specialist service alone or of the whole of the National Health Service, give it a global sum which would have to be settled annually by Parliament, and tell it "to get on with the job." But it is extremely doubtful if this would accord with Parliamentary principles as applied to the expenditure of such vast sums of public money. Further, in my view, their stick would be heavier than that of the Ministry and used more often. Also, in my opinion, it would in the long run cost more for administration.

Before 1948 a not unsatisfactory balance was maintained between the aspirations of those who wished to extend and develop hospital services and what could be afforded on hospitals by the fact that the spenders of the money—that is, the hospital boards and committees—had to raise it themselves. In the case of voluntary hospitals the members had to look round for sources of increased revenue, and in the local authority hospitals, where the money came from the ratepayers, they had to subject themselves to the electorate every three years and run the risk of being turned out if they had been either too parsimonious or too extravagant. In any case they were subjected to searching questions about the hospitals at election, and, indeed, at any other time.

It was hoped when this service started that hospitals would be provided by the Ministry with adequate funds, not only for the maintenance but also for the development of the hospital service, and that considerable freedom would be given to hospital boards and committees in the way they were spent. This might well have happened if hospital costs had not risen steeply during the past few years. Incidentally, they have risen just as steeply in other countries. With these rising costs and the amount of money which Parliament can properly vote, having regard to the total national income and the competing claims of other national services, being not unlimited, financial control becomes imperative at least as regards the total bill. The extent to which it needs to be detailed depends on the

importance attached in a national service to all parts of the country being provided with the same type and range of service and to people doing the same job getting the same rate of pay, and having the same conditions of service, and on staffing ratios being reasonably similar in comparable hospitals. Organizations representing staff insist on at least minimum rates of pay negotiated nationally for the same job, and the Ministry, as the paymaster, not unnaturally desires uniformity so that special rates of pay given to a particular individual may not be used as a bargaining-point for a general all-round increase.

Capital expenditure has had to be curtailed because of the licensing system, necessitated by the shortage of money, building materials, and building labour. One last point on finance which I have heard on my travels abroad is that unless rising hospital costs can be curbed, hospitals, except for the most serious illnesses, and then for the shortest possible length of stay, will almost price themselves out of existence, as neither the public nor any private purse will be able to afford them. There is little wonder that increasing attention is being paid everywhere to schemes for keeping people out of hospital and caring for them, whenever possible, at home.

All the above has a bearing on the question I am discussing—namely, should the administration of the three branches of the service be combined and should the local control be in the hands of nominated or elected bodies? If the administration of the three branches is combined—which, as I have indicated, would remove many anomalies—it could function only through nominated bodies if the whole charge were met from Government sources. If the rate-payers' money is involved, then, under our system of local government, elected representatives who are empowered to levy a rate must be included. It should be mentioned here that bodies nominated by the Minister, in effect appointees of the Minister, cannot bring pressure to bear on a Ministerial department to the extent that an independent elected body can, particularly if it is spending its own money and not entirely that of the Minister. There is a stronger case for a nominated body if the hospital service is to remain separate from the other two branches.

Local Government

The removal of the personal health services from local government would, however, be a very serious matter. Speaking quite generally, the local authorities have made a success of their health services, in which they have taken a deep interest. The occasional failure receives the headline; the success goes unnoticed. Another very important branch of local government work is the education service, of which the school health service is an integral part. It also makes a substantial contribution to the health of a very important age group. The school health service is outside the National Health Service, and the removal of the latter service to an independent body, outside local government, would be a major disaster to the education service. The anomaly of separate administrations dealing with the health problems of children under school age and of school-children, against which a Royal Commission reported in 1926, would be revived. It must be remembered that the school health service involves not only the routine medical examination of the children but also the selection of children for special education, and advice on school buildings, school furniture, and school meals.

It is essential also that the new children's departments dealing with orphans and neglected children and the welfare departments dealing with the aged and infirm and with handicapped persons should have expert medical advice readily available. In fact, there are few departments of local authority work which do not call on, from time to time, the medical officer of health for his advice. Sometimes the advice is unpalatable, but it is accepted from their own trusted officer when it might not be if it came from an officer employed, and paid, by the Government. All this is apart from the duties of the local health officer in connexion with the control of epidemics and environmental

hygiene. If the present health services of local authorities were transferred to a new organization of nominated members deriving all their money from Government sources, a major part of the scaffolding of local government would fall and incidentally there would be little or no case for local authorities employing whole-time trained health officers and medical administrators. Even if they did, the scope of the duties would be unattractive compared with other opportunities in the field of medical administration. Further, administrative difficulties which are not quite germane to our subject, and therefore will not be pursued, would arise if the work of the executive councils were transferred to a similar nominated body.

The answer, then, to the question whether the three branches should be combined and administered centrally by the Ministry of Health and locally by nominated bodies is that it would be inadvisable.

Local Administration by Elected Bodies

Next, let us turn to the possibility of their local administration by bodies wholly or partly elected. It will be assumed that there should be nominees of the professional interests concerned, though this is a departure from normal administrative procedure in this country, where, until 1948, professional experts were advisers, and not members, of the body which was in financial control and which determined policy. This is still the procedure at central and local government levels, though most local health authorities co-opt a few professional members on their health committees. It is interesting that the professional groups who insisted, and in the circumstances of the time did so properly, on being represented on every committee dealing with hospital work now complain of the long hours they have to spend attending committees to the detriment of their professional work.

A point against elected bodies for the control of hospitals is that there are invaluable members of hospital boards and committees who belong to no political party, who would decline to submit themselves to the electorate, and who would be unable or unwilling to take part in the general work of local authorities. Provision, therefore, would have to be made for the co-option of at least some of them. There are, on the other hand, many members of local authorities who are intensely interested in hospital and health problems and are prepared to devote much time to committee work. Some of these are giving, under the present organization, active and valuable service to local authorities as elected members, and to hospital boards and committees as nominated members.

Local health authorities now nominate one-third of the members of executive councils. If they were able to nominate a proportion of the members of a new body administering all three branches of the National Health Service, it would help to ensure that local opinion could be expressed by those who had, at least, the confidence of those who had elected them to the local authority. Moreover, it would help to bring the two administrations—local authority and the health services—more into alignment and might lead to the local medical officer of health holding a joint appointment, carrying out for the local authority, as their own officer, the various duties outside the National Health Service which would remain with them and, for the new authority, the duties which would be transferred to it, and which up to then would have been under his direct administration. If the money were not all provided centrally, that portion of the budget represented by services financed, partly or wholly, by the local rates would have to be submitted to the finance committee of the local authority concerned.

The conception of an *ad hoc* body elected specially by popular vote, and with power to precept on local authorities, for the administration of the combined service can be ruled out. The school boards and the boards of guardians, elected on such a basis, have now both disappeared. John Stuart Mill (1861) says "that there should be but one elected body

for all local business, not different bodies for different parts of it. . . . The local, like the national, Parliament has for its proper business to consider the interest of the locality as a whole." Except for later ideas involving two-tier government, as in county council areas, he is probably right.

[The second lecture, together with a list of references, will appear in our next issue.]

STAPHYLOCOCCAL INFECTION OF THE NEWBORN*

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During the neonatal period minor staphylococcal infection is a frequent occurrence. The recorded incidence of such infection depends so much on the criteria adopted and on the care with which minor septic lesions are looked for that a close comparison of published figures is of limited value. The wide variation in recorded neonatal skin and conjunctival sepsis rates in

TABLE I.—*Reported Neonatal Skin and Conjunctival Sepsis Rates in Maternity Units*

Author	Period	Skin Sepsis	Conjunctivitis
Henderson (1943)	1940-1	6.8%	15.9%
Corner (1946)	1944-5	6.58%	13.49%
(2 maternity units)		10.0%	17.6%
Frazer (1948)	1946-7	1.58%	0.61%
Roscoe (1949)	1947-8	2.06%	4.32%
(2 maternity units)		5.4%	6.2%
Gaisford <i>et al.</i> (1951)	1949	4.7%	5.9%
Barber <i>et al.</i> (1949)	1949	3.6%	9.2%
Present series:			
Western General Hospital, 1951	1951	2.3%	4.1%
Eastern General Hospital, 1951	1951	2.3%	4.2%

various maternity units in this country is shown in Table I. These figures do not refer to staphylococcal infection alone, but this is responsible for most of the skin and conjunctival sepsis in the neonatal period. Henderson (1948), for instance, has shown that the incidence of staphylococcal infection in neonatal conjunctivitis is approximately 80%. We have found, from 100 consecutive swabs from septic lesions of the skin and conjunctiva, that where an organism was isolated the incidence of staphylococcal infection was 91%. No growth was obtained from 18 swabs.

In the two main maternity units in our group of hospitals births numbered 1,093 and 1,296 respectively during 1951 and the sepsis rates given are derived from the routine records on the baby charts. An attempt is made to record all septic lesions, no matter how small.

*Based on a paper delivered to the Scottish Paediatric Society on June 13, 1952, by Dr. Forfar.

No deaths from staphylococcal sepsis occurred during the lying-in period, but one baby (Case 3) was re-admitted to hospital and died from staphylococcal infection, almost certainly acquired during his stay in one of the maternity units.

Most neonatal staphylococcal infections are trivial and short-lived, but they are potentially dangerous. A few years ago penicillin provided a weapon with which the severer types could be successfully treated, and its use soon spread to the treatment of minor lesions and even to prophylaxis (Wallace, 1947; Muhl, 1949). In recent years the emergence of resistant strains has rendered penicillin ineffective in the treatment of many staphylococcal lesions. There is a rising incidence of such strains (Barber, 1947; Barber and Rozwadowska-Dowzenko, 1948), particularly in hospitals (Forbes, 1949; Rountree and Thomson, 1949; Barber *et al.*, 1949). The newer antibiotics aureomycin and chloramphenicol have so far provided effective therapy in most resistant infections (Banks, 1952; *Lancet*, 1952).

It is the purpose of this paper to report several cases of serious staphylococcal infection in the newborn in which resistance to antibiotic drugs played an important part, to record a few observations on the background of staphylococcal carriage and infection in one of the maternity units from which some of the cases arose, and to draw attention to some of the problems of diagnosis, of management, and of treatment which such staphylococcal infections raise.

Case 1

A baby girl, born in a nursing-home, birth weight 5 lb. 10 oz. (2.55 kg.), was admitted from her own home to hospital at the age of 4½ weeks with a swelling of the left upper arm of three days' duration. This had been accompanied by pyrexia, and on the day before admission she had been given 200,000 units of penicillin.

On admission a purulent discharge from the left eye was noted. No growth was obtained from an eye swab. No other septic lesions were found. The white-cell count was 6,000 per c.mm. Radiological examination of the affected humerus showed osteomyelitis with patchy destruction of the lower end. Intramuscular penicillin, 100,000 units three-hourly, was given.

On the following day an abscess had formed and was incised, a large amount of pus escaping. On culture a profuse growth of *Staphylococcus aureus* sensitive to penicillin, streptomycin, aureomycin, and chloramphenicol was obtained. Despite the continued administration of penicillin the pyrexia persisted and the child's condition deteriorated. On the third day after admission she developed a cough, rapid shallow respirations, moist sounds at both bases, and a slight haemoptysis. An x-ray film of the chest showed consolidation at both bases. The white-cell count was 19,200 per c.mm. Aureomycin, 250 mg., and chloramphenicol, 125 mg., six-hourly, were begun.

Two days later pus from the wound in the left arm grew on culture a coagulase-positive *Staph. aureus* resistant to penicillin but sensitive to streptomycin, aureomycin, and chloramphenicol. At this time an abscess developed in the left parieto-occipital region. This required incision after 48 hours, and appeared to have arisen from infection of the underlying bone. A coagulase-positive *Staph. aureus* highly sensitive to streptomycin and chloramphenicol, moderately sensitive to aureomycin, and resistant to penicillin, was grown.

Penicillin was given for 17 days after admission. Treatment with aureomycin and chloramphenicol was continued for almost a month on account of several relapses of respiratory infection. After a period of two months the child had