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THE ROLE OF THE INDIVIDUAL IN HEALTH SERVICE*

BY

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Last week, in speaking at Eastbourne at another Annual Conference—that of Rotary International—I expressed doubts about the term “Welfare State.” “Welfare” was right, but “State” gave to some people the idea that for everything they desire in welfare men should look to the State and use their votes to get those desires. Some things for welfare, I agreed, must be done by the State, because they would not get done otherwise, but many more things would be done best by private citizens. Welfare requires the free co-operation of the State and the individual, thinking and acting both for himself and for his neighbours. I prefer to speak of “Welfare Society” rather than “Welfare State.”

At Eastbourne, I illustrated this general theme in relation to money rates of benefit under National Insurance. The one completely new thing in the Beveridge Report of 1942 was the proposal that insurance benefits should be enough for subsistence by themselves, should be paid as of right in virtue of contributions, and should not be cut down by any means test. This meant putting up insurance benefits to a different level from before—26s. a week then, as compared with the previous 10s. a week. The object of this proposal was not to give men from the State everything they desired. The object was to set them free to plan their own saving and spending above that subsistence minimum, without discouragement by the State through a means test.

To-day I shall try to illustrate this same general theme of co-operation for welfare between the State and the individual in another field—that of health, the physical basis of all welfare.

Eight years ago the National Health Act was passed, providing medical care for all, broadly at the cost of the State, transferring nearly all hospitals to the State, making the work of the Contributory Schemes (which had been a main feature and financial support of the hospitals when voluntary) appear needless.

The natural inference was that the Contributory Schemes would disappear, and perhaps in any country other than Britain this would have happened. Indeed, many of the Schemes, attached to particular hospitals, had their funds taken over and went out of existence. But the tradition of voluntary action in Britain is too strong to be killed easily. There remained a solid nucleus of Contributory Schemes determined not, in any circumstances, to disappear. Some of them adopted new constitutions to fit the somewhat different work that they would be doing. Others did not worry about their constitutions, but went to their new tasks. The associa-

tion to which they belonged solved all constitutional problems by dissolving itself voluntarily on October 2, 1948, and being born again the same day, with a date added to its title—The British Hospitals Contributory Schemes Association (1948). The Sixth Annual Report of this Association under its new title, the report for 1953-4, has just been published.

Contributory Schemes (1948) on Their Contributory Side

This report shows, at the end of 1953, twenty-nine affiliated and ten unaffiliated Schemes, thirty-nine in all, with more than 3½ million members, paying contributions which range from 1d. to 6d. or more a week, according to the benefits desired, and average nearly 3d. a week. The resulting total income of the Schemes in 1953 was £2,286,460.

The 3½ million members, with their dependants, represent presumably about ten million people—nearly one-fifth of all the people in Britain. The two largest of the Schemes are in London, with about a quarter of the total membership, and on Merseyside. Oddly enough, there appear to be none in Scotland. I understand that there never were more than two or three Contributory Schemes in Scotland, and none of these survived 1948. But before then the tradition of voluntary support for historic hospitals—witness the Edinburgh Royal Infirmary—was even stronger in Scotland than in England, and the tradition is far from dead. The particular device for voluntary action with which we are concerned to-day, of hospital Contributory Schemes, seems to acclimatize better in southern than in northern air; the only large English city which has never had such a scheme is Newcastle-upon-Tyne.

The essence of the Contributory Schemes is that men pay weekly to obtain certain benefits additional to those of the National Health Service when they need them. The most popular of these benefits is a cash allowance when in hospital, helping to make good loss of earnings, and providing income for additional expenses. Next in popularity are maternity benefits additional to that of the State, the use of a convalescent home where no treatment is provided, and where, therefore, the free Health Service cannot come in,* and provision of home helps in sickness.

Several Contributory Schemes administer also under separate constitutions Provident Associations enabling subscribers to insure themselves for private wards in

*An address delivered at the Annual Conference of the British Hospitals Contributory Schemes Association (1948), Bristol, November 5, 1954.

*Under Section 28 of the National Health Insurance Act “recuperative holidays” (a slightly unfortunate term invented by the Ministry of Health) may be arranged by local authorities, who may charge the recipients with anything up to the full cost.

hospitals and nursing homes, and for specialist and consultant fees according to their particular desires.

Contributory Schemes as Organizers of Charitable Aid

The solid basis of the Contributory Schemes and their main activity is the organization of self-help; they are voluntary insurance added to compulsory State insurance. But the Schemes have another side as well. In coming into existence for self-help, they provide a nucleus for the organization of charitable action, for helping others.

Their experience is bound to bring to light from time to time needs which, humanly speaking, should be met somehow, but which are not met by the State's Health Service and do not fall within their direct insurance terms; the needs must be met if at all by charitable spending. So Contributory Schemes are setting themselves more and more to have money at their disposal for charitable spending. Some of them raise this money by special appeals. Some of them have power under their constitutions to allocate money from their contributory income, not to self-help, but to helping those in need. Most of the Schemes, it may be added, cover wide areas and can act as fund-raisers for a number of hospitals and medical charities.

In the six years from the beginning of the Schemes to June, 1954, more than £400,000 was allocated by them for charitable purposes. Self-help leads naturally to helping others.

From Money to Service

So help in money leads naturally to help by service, as by the Leagues of Hospital Friends, which are fostered by many of the Contributory Schemes, or arise independently. The need for personal service as well as money, in addition to everything that the State now does, or is ever likely to do, is beyond question. It was the subject of an interesting editorial in the *Medical Press* last March, which, after pointing out the many purposes for which charitable money to supplement the Health Service was necessary, went on to suggest "that the voluntary workers of the new generation will find their scope rather in giving their personal services than in sending cheques and postal orders."

There are three great social changes of the past 50 years making help by personal service of growing importance. The first of them is the change of family structure, which I described last week in speaking at Eastbourne.

The last fifty years have seen a revolution in the family as well as all the other revolutions. There are on the average many fewer children, and many more old people living longer. In 1901, for every one person of pensionable age there were 10 of working age and five children under 15. To-day, for every one of pensionable age there are less than five of working age and only one and a half children; and the revolution continues. Twenty-five years from now we shall have more pensioners than children, and we shall have only three of working age for every pensioner. That makes security of human care for old people as they get older and less able to care for themselves an acid test of our civilization.

The care needed for children is becoming relatively less. The care needed at the other end of life has grown, and will go on growing. The family will still, I hope, provide the bulk of this care for the old, but it cannot do so nearly as completely in future as it has done in the past. There is a new call for service by neighbours.

The second change is the revolution in the distribution of income. At one time there were many people with large resources that they could, and sometimes did, spend charitably; there are relatively few such people to-day, under modern taxation. Yet the total wealth of the community is greater than before. Somehow or other we have to draw on this surplus in the millions of hands where it rests now. Somehow or other we have to democratize charity as well as government.

The third change is the revolution in distribution of leisure. The old wealthy classes from which so much voluntary action came in the nineteenth century had ample leisure as well as surplus income; the leisure rested mainly on

freedom from household work in any form. Elizabeth Fry, between 1821 and 1842, was able to revolutionize the treatment of prisoners as her public work, while bringing 11 children into the world herself. She could never have done this without a string of nurses and servants, unlimited in number: either the reform of prisons or the starting of a family would have gone to the wall. Actually, for financial reasons, she planted out four of the children for years with uncles and aunts. She could not have done this if the uncles and aunts in turn had not had servants at command. To-day the strings of servants are not there; leisure for good or bad has gone with them. Men of my age, who never did a hand's turn in the house before 65, are proudly learning new arts. We compare with one another our strokes in making beds or washing up rather than our strokes in golf; we vaunt our skill not with mashes but with mincers. Hardly any women, and few men, even if they had ample money, would have the leisure for public service that Elizabeth Fry enjoyed. Yet with reduced hours of work and increased holidays the total of leisure in Britain, like the total of surplus wealth in the community, is greater than ever before. If Britain is not to lose the saving spirit of voluntary action we have somehow to democratize personal service as well as charitable spending and government.

Contributory Schemes and Leagues of Hospital Friends

What are the instruments for doing this? First, there are the Contributory Schemes themselves. The Schemes in most cases cover wide areas, with many hospitals or groups of hospitals. This makes them well suited both for their first business of self-help and for the task that they have added to it of raising money for charitable action. They have many individual members in active contact with the hospitals; these contacts happily are now being encouraged and are growing.

But in so far as the Contributory Schemes as organizations cover often many different hospitals, the business of discovering the needs of the hospitals and their inmates, for voluntary help and in gifts and personal service alike, call naturally for organizations of smaller range connected with single hospitals or groups of similar hospitals. From this have developed as a second type of instrument the Leagues of Hospital Friends. The needs of individual hospitals or groups of hospitals, alike for service and for special gifts for their patients, differ widely. The ideal plan, now in process of execution, is that each hospital, or at least each group, should be served by its own League of Hospital Friends, in intimate friendly contact with the hospital administrators. The key-word of policy for the Leagues is supplementation. This means doing things which the Health Service cannot undertake directly. It means sometimes doing things in relief of the hospital staffs and so setting them free for duties which they alone can perform.

The Contributory Schemes and their association have fostered the establishment of such Leagues of Hospital Friends in every way. The Leagues are individual, but they are associated in a National League of Hospital Friends under the patronage of Her Majesty the Queen Mother. I am happy to be myself the President of this National League, and as such to convey to your conference our thanks and appreciation of all that you have done and are doing to help us.

The needs of individual hospitals and their inmates for help by friends are as wide and as varied as human life itself. A recent list of things and services provided in this way, covering six pages of typescript, runs from altar frontals and aquaria at one end of the alphabet to waiting-rooms and wringers at the other. In between comes everything from billiard tables to birthday cards for lonely patients, books and games of every kind, bulbs for indoors and for gardens, coach outings, fireworks and play-pens for children, library subscriptions for the old, punts for the staff, even sun umbrellas and swimming-pools (no doubt before the present year, 1954!).

The needs are not confined to hospitals concerned with ordinary passing sickness. The mental hospitals call for the same kind of help. Just before I rose to speak to you, one of your delegates told me of two unexpected services which he had just found in urgent demand at a mental hospital which he visited—of hair-drying for old ladies, and television for introvert youths, to take them out of themselves.

The needs calling for voluntary service are not confined to those in hospitals. The organizations which are springing up everywhere for neighbourly help to old people may help the Health Service itself in two ways. By keeping the old people happy they will keep them out of hospital. By organizing homes and care for old people who need some help, but not constant medical attention, they may make possible a more economical use of the hospitals themselves.

Some Health Service Questions

The role of voluntary action in Health Service depends, naturally, on the action of the State; that is to say, on the nature of the Health Service proper. That is now under consideration by the Guillebaud Committee, whose report will not come out till next year. To-day I will comment on three questions only of current importance and related to my special theme.

My first question relates to pay-beds in hospitals. These are a frequent objective of Provident Associations, and their continuance was provided for in the National Health Act of 1946. Within the past few weeks a decision has been announced by the Labour Party Executive to abolish pay-beds completely; a vigorous criticism of this decision has been made by the Minister of Health. For final judgment on this controversy I am prepared to wait for light from the Guillebaud Committee. I can only express the hope that their considered judgment will not lead to the abolition of any of the facilities now open in hospitals. The view of the Labour Party Executive is apparently that people should not be able to get anything in a hospital by payment which they could not get without it. I, on the other hand, should be sorry to see any space for private action narrowed in the interests of equality; liberty and variety are both more important than equality. If it is held as an objection to pay-beds that they enable people to "jump the queue" for hospital treatment, the right remedy is not to abolish the pay-beds but to abolish the queues, by providing more hospital beds or by making more economical use of them. It is not tolerable that there should be a hospital queue at all for people in urgent need of treatment; but, once the queue has been removed, so that anyone can get any essential treatment that he needs without delay and without payment, there is no harm, and maybe some good, in letting individuals, by payment, get these essentials in one place rather than another, or with accompaniments that they find attractive.

My second, and more important, question is that of Health Centres. The establishment of health centres was announced by the Government in 1946 as a main feature of the Health Service scheme, and their provision was made a statutory duty of local authorities. Yet we all know that to-day there are hardly any in existence. They are numbered not in hundreds as seemed the intention in 1946, but are still below 10 in total.

I noticed that last year Professor Brockington, in speaking to you at Norwich, mentioned "a fundamental reluctance of the medical profession" for the establishment of health centres. There did not appear to be any such reluctance when I was engaged in drafting the Beveridge Report and came into consultation with the doctors themselves. The draft interim report of the Medical Planning Commission of the B.M.A. in 1942 devoted seven whole pages to discussion of health centres as a means, among other things, of getting over what they described as "the greatest grievance and disadvantage of the general practitioner"—namely, his sense of isolation.

This argument for health centres was written by doctors before the form of the Health Service was settled in the

Act of 1946. With this form, another argument of overwhelming strength for health centres emerges. Our Health Service, as we have it to-day, is divided into three parts, administered by unconnected authorities: the general practitioners, the hospital and specialist services, and the local authorities services. Whether or not the Guillebaud Committee will come to any conclusion for altering this division, I suggest that the natural and easy way of bringing about the co-ordination of all these different elements is to get the local work of the Health Service done in health centres, where all of them are to be found. That, as Professor Brockington pointed out at Norwich last year and as we all realize, would make the Health Service not only more efficient but more humane, by saving the legs and the time of sick persons in wandering from one place to another. Happily, one of the few health centres in existence in the country is in Bristol, and is daily proving its advantages.

My third question is of how far personal service by Leagues of Hospital Friends and other volunteers can be used not merely to do things outside the Health Service proper, but to help in the work of the Service itself. A number of practical suggestions on this were made by Mr. J. P. Wetenhall at the Norwich conference last year, and this should be pursued in detail as soon as the form of the service is settled after the Guillebaud Committee has reported.

Let This Be a Beginning Only

From this brief excursion to the Health Service let me return to my proper theme of yourselves and your Schemes as the indispensable voluntary allies of all who administer the Service or work in it as doctors, nurses, almoners, and the rest. The National Health Service of 1948 represents a beneficent revolution in our social institutions, a revolution on which there can be no going back. But it leaves plenty for the individual to do. The role of the individual in Health Service is free supplementation, for himself and for others, in money and in service. Your association is the natural organizer of supplementation.

In the study of voluntary action which I completed early in 1948* I spoke of the amazing development of the Contributory Schemes as proof of the driving force that emerges when local feeling can be combined with mutual aid. "It would be disastrous if the spirit that has gone to building up these associations should now be lost. They may continue for special medical treatment. What one would like to see would be that they should explore the possibilities of applying their methods to benevolent purposes generally." The manner in which you and your association have fulfilled these hopes is perhaps even more amazing than what you did before.

The British Hospitals Contributory Schemes (1948) are an outstanding example of voluntary action refusing to be put out of action by a Welfare State. They are an example of self-help leading to help of others. They are an example, directly and through the Leagues of Hospital Friends, which they have done so much to foster and finance, of help to others taking the form of general personal service, not money only. They are democratic in origin and in self-government, and show how democracy can become an aristocracy of public service.

The Contributory Schemes, six years after they had been condemned to death, as it seemed, by the State, have risen again to cover nearly a quarter of the people of England; their future of steady growth is certain. But why one-fourth only of the people in England, not four-fourths? And why not Scotland as much as England?

All of us who believe in the Welfare Society rather than the Welfare State must congratulate you from our hearts on what you have accomplished. All of us must wish you well. Let the first six years be a beginning only. This is no time for sitting back, for anybody. And you, as your record shows, are not men and women who sit back.

**Voluntary Action: A Study of Methods of Social Advance* (Allen and Unwin, 1948), p. 292. See also pp. 115 and 117.