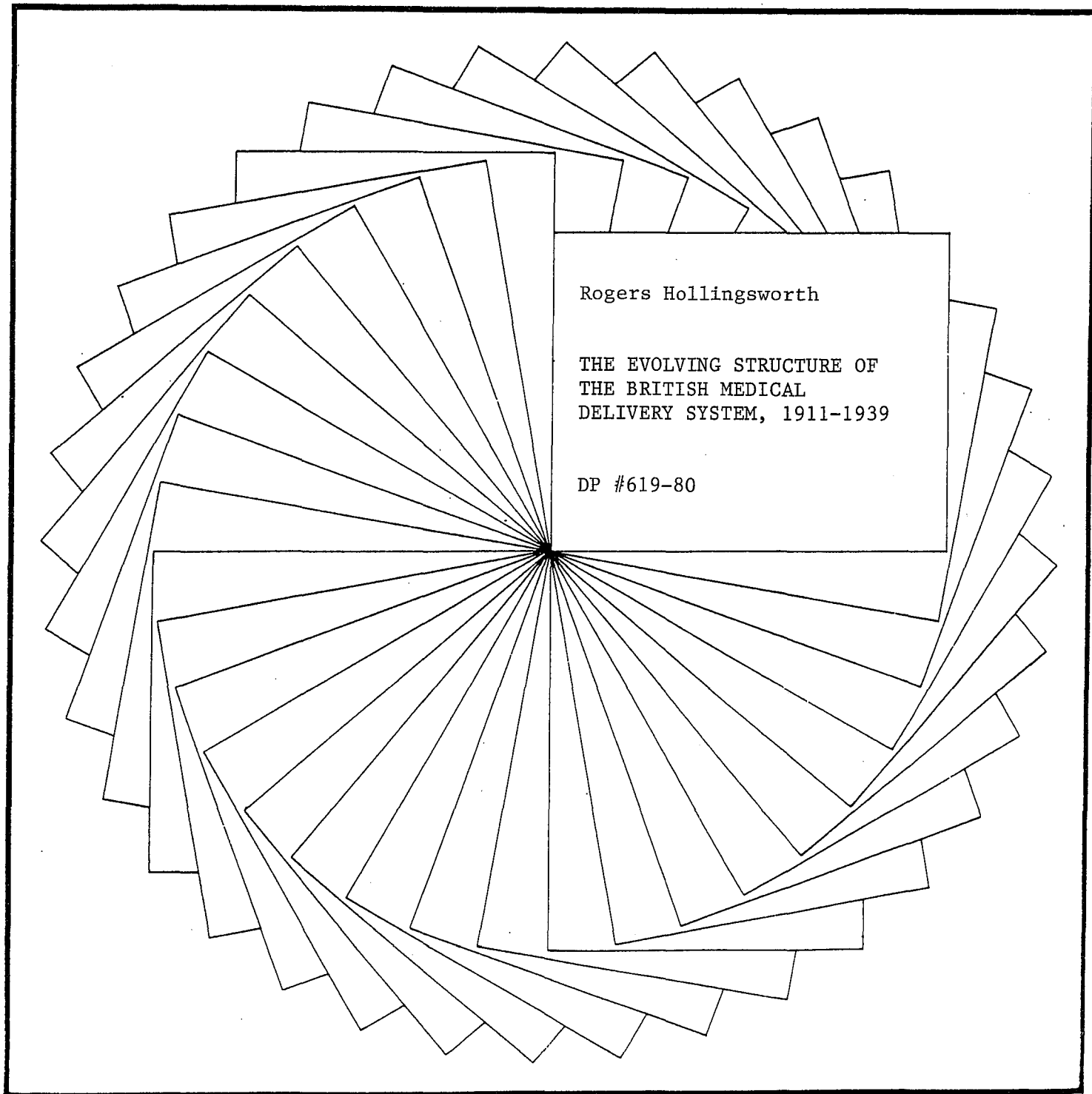




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The Evolving Structure of the British
Medical Delivery System, 1911-1939

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ABSTRACT

Relative to Great Britain, the United States has a much higher proportion of its medical profession who are specialists as distinct from general practitioners, spends a much higher portion of its G.N.P. on medical care, and has a medical delivery system that is more inegalitarian. Much of the explanation for these differences must be found in the variation in the historical evolution of the two systems. This paper demonstrates that part of the reason for the British pattern has resulted from the following:

(1) British consumers historically were much better organized into labor unions and friendly societies than their American counterparts, and thus played a significant role in shaping the nature of medical services. (2) In those countries, of which Britain was one, where national health insurance occurred before the existence of a complex historical technology, the state established an administrative and financial structure which encouraged large numbers of practitioners to engage in general practice. On the other hand, in those countries that developed national health insurance late (e.g., Sweden and Canada) or not at all (e.g., the United States), the governments did not have the financial and administrative structure which provided the incentive for a large proportion of its profession to engage in non-hospital-based, general practice. It is this historical process which helps to explain why such a large portion of the British medical profession practices exclusively outside the hospital.

While it is true that differences between the public and voluntary sectors continued to exist prior to World War II, the history of the British medical delivery system suggests that technology alters structure, for once there was a technology which was believed to be efficacious, the behavior of the private and public sectors began to converge.

The Evolving Structure of the British Medical Delivery System, 1911-1939

The medical delivery system in Britain prior to the Second World War continued to have serious inequities in access across regions and across social classes. There was one type of service for the poor, elderly, and infirm, another for the working classes, and a separate one for the upper middle class and the wealthy. As a result of separate services for different social strata, there was duplication and overlapping of services throughout much of the country, while in many areas there were gross inadequacies in medical facilities.

The system was decentralized and fragmented in both the public and private sectors. And yet, one of the important features of this period was the fact that the distinctions between the public and private sectors became increasingly blurred. As medical technology became more efficacious, complex, and expensive, different sectors of the society demanded similar types of care, causing the various competing health institutions to become more alike. Perhaps the medical facilities in the public and private sectors would have converged more quickly had not the rigid class structure in Britain acted as a constraint on the speed with which different strata had access to similar services.

As medical care became more expensive and as the demand for it increased, the financing of medical care became the most important public health issue facing the nation. Changes in medical technology and their consequences for the financing of medical care were the driving forces for altering the

British medical system during this period. The time was ripe for the development of the National Health Insurance plan.

1. THE NATIONAL HEALTH INSURANCE PLAN

The National Health Insurance plan--primarily a scheme for financing medical care and sickness benefits--did much to shape the medical delivery system for a sizeable segment of the British public. It resolved problems concerning the financing and accessibility of medical care for almost a third of the population. To comprehend why the National Health Insurance Act emerged in 1911, it is necessary to focus on the role of three organized interest groups--the friendly societies, the insurance companies, and the doctors--for the legislation which was adopted tended to reflect the power and concerns of these major interests. In Britain, unlike in the United States, the friendly societies reflected the fact that there was a sizeable segment of the consuming public that was already organized to deliver medical and sickness benefits. In the United States, where industrialization developed somewhat later and where there was considerable racial and ethnic hostility among the population, trade unions and consumer groups which might have shaped medical legislation were much weaker; thus the doctors, who were somewhat better organized and did not have the intense cleavages evidenced in Britain between hospital and non-hospital-based doctors, were in a strategic position to dictate the conditions under which medical care would be provided. In Britain, however, there was considerable consumer power already organized on the subject of medical care, and this fact, combined

with the cleavages within the medical profession, does much to explain the difference in the historical development of health delivery in the two countries.

It was Britain's friendly societies rather than its trade unions that shaped the specific provisions of the National Health Insurance Act. The power of the trade unions was fragmented into many different organizations, and their concerns were primarily with wages and the conditions of employment. Issues involving the financing of medical care received much less attention among trade union leaders and their followers. At the turn of the century, many British trade unionists were not members of friendly societies and did not receive the type of medical benefits which the friendly societies provided for their members. True, most trade unionists desired the benefits which friendly societies received, even if they were unable to finance them, and for this reason, the trade unions operated as a lobby of some modest consequence for the National Health Insurance program, but the demands of the trade unions were so poorly articulated and their power so fragmented that without the pressures exerted by the friendly societies, the National Health Insurance system would not have emerged in 1911.

In contrast to the trade unions, the concerns of the friendly societies were much more narrowly focused and much better articulated. The friendly societies were essentially a consumer group with narrow interests, a major concern of which focused on many medical benefits. Whereas the trade unions at the turn of the century had approximately 1.6 million members, the friendly societies had a membership of more than 5 million (Gilbert, 1966,

pp. 162, 177). Even though the power of the friendly societies was quite fragmented (there being more than 20,000 different societies or branches), the societies had numerous assets, aside from their size, that provided them with enormous political clout. First, because the issues around which the friendly societies were organized were quite specific, they were able to mobilize far more of their political resources than would have been the case had their concerns focused on many different policy sectors. Second, the friendly societies derived an element of strength from the fact that they had long been organized. Their long history provided them with considerable legitimacy, gave them the opportunity to develop extensive political contacts with other groups in British society, and permitted them to generate considerable support among their membership. Third, the long history and extensive membership of the societies made them a highly visible force in British politics, which in itself was an element of power.

By the time that Lloyd George returned from studying the national health insurance system in Germany in 1908, the British friendly societies were facing serious financial problems. Many of the societies were paying out more in medical and sickness benefits than they were receiving from their members and were thus on the verge of bankruptcy. When Lloyd George proposed his system of national health insurance, he had potential allies as long as he satisfied the concerns of the friendly societies. They were very much opposed to a highly centralized, state-owned and -operated system of medical insurance. Rather, they wanted a state mandated medical insurance scheme which they would administer, for they believed that way they could gain millions of additional members. Moreover, they believed that it was essential that they continue to control the circumstances under which the doctors

provided their services, for they feared that if they could not control the doctors they might lose control over their funds--and ultimately lose control over the management of the system. Their leaders argued that a national health insurance system must not be administered for monetary profit but by nonprofit organizations (which the friendly societies were), and that these organizations must be subject to the tight control of their members.

In many respects, the pressures of the friendly societies were decisive in shaping the provisions of the national health insurance legislation. Although they were not successful in shaping all of its provisions, the friendly societies, along with the insurance companies and the doctors, were the key actors. And without the support of each, there would not have been a national health insurance program at that time.

However, a number of the concerns of the friendly societies ran counter to the interests of the various insurance companies, a very powerful interest group. Whereas the friendly societies had been primarily concerned with keeping their members out of the poorhouse and with providing a death benefit, thus securing their members from a pauper's burial, the insurance companies had approximately 30 million death benefit policies in effect and were understandably anxious that the government not provide a death benefit as part of a national health insurance program, as this would undermine much of the industry's business. While there were approximately seventy-five industrial insurance organizations, twelve dominated the industry. The industry was powerful, not only because of the almost £300 million of insurance in force which its thirty million customers had purchased, but also because it employed almost 100,000 men, 70,000 of whom were door-to-door sales agents who had weekly contact with almost every working class home in the country.

In effect, the industry's sales force constituted a small army with considerable potential political clout with their customers, a force which the Liberal Party did not wish to antagonize as it witnessed its overwhelming majority of 1906 diminish.

Not only did the insurance companies successfully prevent the inclusion of a funeral benefit in the National Health Insurance plan, but they also demanded that they, along with the friendly societies, become the agents for administering a substantial portion of the health insurance program. Ultimately, the insurance companies were successful in being able to participate in the program on a nonprofit basis. Once this was achieved, their legion of agents, having obtained a foot in the door of millions of people who were insured under the government's health insurance program, were able to continue the selling of death benefits on a for-profit basis. With this type of participation in the plan assured, the insurance industry's sales force of tens of thousands strongly endorsed the government's insurance plan, while the management of the insurance industry helped to legitimate the scheme among the nation's economic elites. (For a discussion of the insurance industry, see Gilbert, 1966, pp. 289-447.)

But without the support of the nation's doctors, the National Health Insurance plan had no hope of success. Understandably, the doctors were not prepared to support just any type of government-sponsored medical insurance program. Many general practitioners had long worked for friendly societies by contract, being compensated on a capitation basis, and as professionals are generally tolerant to the method of payment with which they have had experience, the doctors who had engaged in this type of practice were willing to continue being compensated on a capitation basis. As the financial problems of the friendly societies became more acute, however, the

conditions of the doctors' contracts with the friendly societies became increasingly objectionable to much of the medical profession. As a result, for several years after 1905 the British Medical Association published a number of reports, sponsored meetings, and generated a great deal of discussion about the undesirable conditions under which general practitioners worked for friendly societies. In fact, it was the B.M.A. campaign which did much to solidify the opinion of doctors against friendly societies and to shape the drafting of the national health insurance legislation (McCleary, 1932, pp. 73-83).

The British Medical Association, founded in 1832, had little to do with political matters in its early years, concerning itself primarily with medical research, the publishing of medical papers, and medical ethics. When the state became involved with matters of health via the poor laws and sanitation policies, however, the B.M.A. began to broaden its range of concerns, so that by 1900, it had become quite outspoken on matters involving a broad range of medical services. Even so, the elite of the British medical profession identified most strongly with their Royal Colleges, and only weakly with the B.M.A. As a result, by the turn of the century the British Medical Association had become primarily a professional organization for defending the interests "of the average, often underprivileged, general practitioner" (Stevens, 1966, p. 22). Approximately 55 percent of the doctors on the medical register were members of the British Medical Association in 1910, though very few members were consultants or specialists (Eckstein, 1960, pp. 44-45; Little, 1932).

The doctors demanded that several cardinal points be incorporated into the National Health Insurance plan. First, reacting to their conflicts with the friendly societies, they demanded that patients be permitted to choose their own doctor and that the doctor have the right of refusing

service to a patient. This of course was in contrast to the practice of the friendly societies, whereby the doctor was required to treat all patients covered by a contract. Second, the doctors demanded that there be an upper income limit placed on those who were entitled to medical benefits. The doctors were dissatisfied that many people had received benefits from the friendly societies, hospital outpatient clinics, and provident associations at bargain prices, though they could afford to pay for medical services independently of these organizations. Because these tendencies placed restrictions on the income of the medical profession, the British Medical Association argued that they should be discontinued. Third, the doctors argued that the medical benefits under a national health insurance scheme should not be administered by the friendly societies but by local insurance committees, which the doctors hoped to dominate. Furthermore, the doctors insisted that they should have adequate representation in the administration of all other aspects of the program (Levy, 1944, p. 17). In sum, the general practitioners viewed the National Health Insurance program as a means of enhancing their professional autonomy and of increasing their income.

As professionals are generally fearful of being compensated in a manner which departs from their past experience, the hospital-based doctors--especially the consultants--insisted that the national health insurance scheme not apply to hospital care, for they were anxious to maintain their traditional privileges and status, and feared that the government might end up regulating admissions to hospitals and the type of care administered to patients. From the perspective of the 1970s, it may appear strange that a national health insurance system should provide coverage for outpatient

care but not for hospital care, for it is in the hospitals that so much of the expenditures for modern medical care occur. But in the early part of the twentieth century, most people did not anticipate or fear that they might some day be hospitalized. Furthermore, paid beds in hospitals were still the exception--especially in large cities--rather than the rule, with only about ten percent of the voluntary hospital income being derived from patient payments.

The hospital-based consultants were also concerned that if the hospital patient load increased there would be more hospital-based doctors and a decline in the monopoly position which the "honorarys" exercised in the hospital. As the high fees which consultants charged the upper middle and upper class patients for a private office were legitimated by the high status which they held in the hospitals, the consultants were predictably unwilling to advocate a change in the financing of medical care which would undermine their privileged position. Moreover, the social elite who served on the hospital governing boards were opposed to the hospitals being covered by a national insurance plan, for they believed that charitable contributions to the hospitals would then decline, thus jeopardizing the basic character of the voluntary hospitals. In sum, the hospital-based physician and general practitioners responded very differently to the idea of a national health insurance program.

Although Lloyd George attempted to be responsive to the concerns of each of these organized interests, he had some strong views of his own, some of which had widespread support. His concerns stemmed largely from several published findings of the Poor Law Commission of 1909. The commission reports--both majority and minority--recognized that Poor Law relief

had not been able to do much to minimize the effects of illness on the number of people who were driven to seek poor relief. As a result, the commission recommended that some form of cash and medical assistance, organized on a provident basis, should be available to individuals when they were incapacitated (*ibid.*, p. 3).

Lloyd George, like the majority of the commission, was not motivated to improve the general level of health of the British population, and this fact is of great importance in assisting us in understanding many of the major inadequacies of the National Health Insurance system. His main goal was to improve the standard of living for the British population. Because he believed that sickness led to pauperism, Lloyd George wanted a mechanism which would provide medical and cash benefits to workers who were ill so that they would not become paupers. For this reason, the National Health Insurance plan was more of a social than a medical program, and this is why Lloyd George did not plan for a program which would provide medical benefits for the dependents of workers. If the breadwinner in a family remained healthy, Lloyd George believed that the well-being of the entire population would improve. The aim of the plan, in short, was to get the breadwinner back into the labor force as quickly as possible, and thus it reflected little concern with hospital care. In this sense, the issue of the economic efficiency and productivity of the working class--which increasingly was a concern of Britain's economic elite--set real limits on the type of health insurance scheme which Parliament enacted in 1911.

The National Health Insurance plan provided two broad types of benefits--medical and cash--and although it was state regulated and mandated, it was administered primarily in the private nonprofit sector.

Parliament reflected an amazing success in incorporating into legislation the major views of each of the powerfully organized groups which had lobbied on the issues. Because the scheme ultimately evolved into and placed constraints on the nature of the National Health Service, that came into existence in 1948, some discussion of its organizational structure is desirable (see Figure 1).

The machinery to administer the program was quite cumbersome, as cash and medical benefits were administered separately. The cash benefits were administered by what was called an approved society, and the medical benefits by local insurance committees. By law, all manual workers between the ages of 16 and 65 and nonmanual workers--with a few exceptions--earning below £160 annually were required to participate (the maximum salary scale was raised to £250 in 1919). Contributions were made on a flat rate, with workers paying four-ninths, employers three-ninths, and the state two-ninths, a payment scheme that was quite common in Europe during the interwar years (McCleary, 1932).

Excepting a small percentage of the people participating in NHI, each newly insured person was expected to join an approved society. Trade unions, friendly societies, and insurance companies organized most of the approved societies, which by law were to be nonprofit and democratically administered organizations. Thousands of agents were necessary to administer the approved societies, for no insured individual was to pay money directly to the societies. Individuals paid their money to the Post Office, the money then circulated to the Ministry of Health, and the cash benefits then circulated to insured individuals via the approved societies.

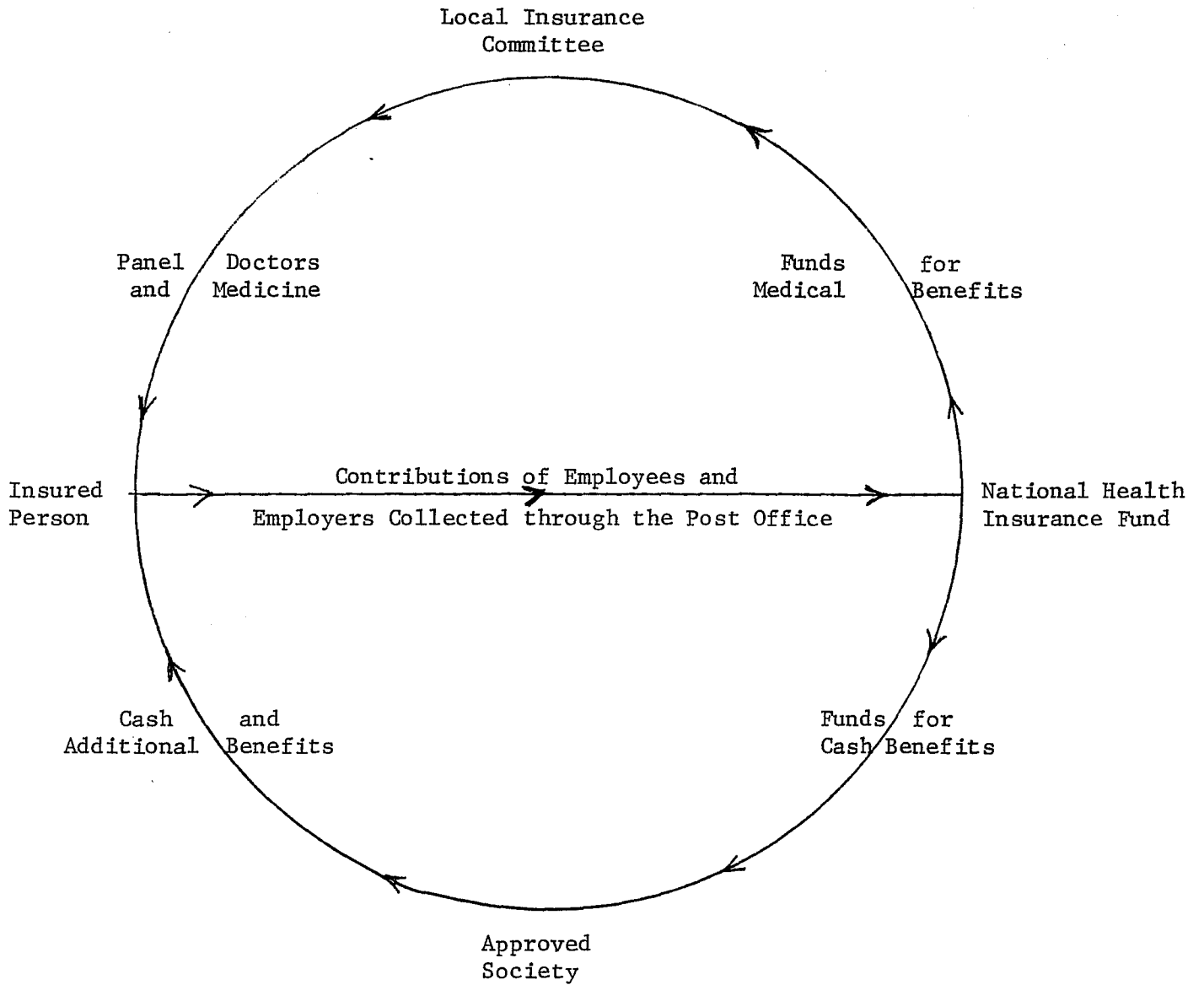


Figure 1. Operation of the National Health Insurance Plan
(Modified from Herbert, 1939, p. 91)

The Ministry of Health was charged with regulating the program, which proved to be highly competitive and uncoordinated (Lindsey, 1962, p. 10).

The ordinary benefits of the approved societies were to be cash benefits for sickness, disablement, and maternity, and were to be the same for all individuals regardless of their level of income. Unlike compulsory insurance plans in many countries in which contributions and payments were based on an individual's earnings, the cash payment was a flat rate. Cash benefits were paid periodically during illness for a specified period of time. When the sickness benefit ended, one could then collect disability payments. Additional benefits were available from approved societies, but on an irregular basis. And although there was a flat rate for each individual, some approved societies managed to have a surplus of funds following a quinquennial audit of the various societies. As these were to be nonprofit organizations, those with a surplus, by statute, could provide additional benefits such as dental care, ophthalmic services, convalescent and hospital care, and home nursing. Over time, approved societies became extremely competitive in terms of the additional benefits which they provided their members.

Meantime, the administration of the medical benefits was equally complex. The doctors, wishing to become independent of the friendly societies and trade unions, but not wishing to be under the control of the central government, had demanded that medical benefits be administered through local committees. As a result, local insurance committees were established in every county or county borough, and it was through this type of private and decentralized mechanism that medical services were

dispensed. The committees varied in size from twenty to forty members. By statute, three-fifths of a committee's members represented insured persons (technically these were representatives of the approved societies), and one-fifth were appointed by the county or county borough councils. The remaining members were representatives of the medical profession, "chemists" (pharmacists), or women. This arrangement represented a compromise, which freed the doctors from the direct control of the approved societies (dominated by trade unions), friendly societies, and insurance companies. At the same time, the plan prohibited the doctors from controlling the local medical insurance committees. Significantly, the system was designed to permit the power of consumer representatives to be dominant in the local insurance committees. And it was the provision of the consuming public with some authority over the administering of medical benefits which did much to differentiate the British and American medical delivery systems.

Every insured person was entitled to the services of a general practitioner in any part of Great Britain. Individuals were free to choose any doctor, and doctors in turn were free to refuse to serve any individual. Participating doctors received compensation on a capitation basis, just as the doctors who had earlier entered into a contract arrangement with the friendly societies. Free drugs were also a statutory benefit for the insured, as each participating doctor was at liberty to prescribe medication (*ibid.*, p. 11).

Although the system was called National Health Insurance, it was very much a private system. The traditional friendly society system of providing benefits had been significantly expanded, thus permitting industrial insurance companies to participate in the scheme. The central government

regulated the scheme, but in practice it was administered in the private sector. Although over time, the government was involved in the program through the Ministry of Health, the Department of Health for Scotland, the Welsh Board of Health, and the Treasury which audited the insurance funds, these agencies were involved only in a supervisory capacity, for the real administration of the program was conducted by the approved societies and the insurance committees.

Because the Act provided insurance coverage for almost one-third of the population, its influence on medical delivery was considerable. Its inadequacies generated a great deal of dissatisfaction and caused people to search for alternatives, which eventually led to the implementation of the National Health Service in 1948. Perhaps the most important inadequacies were inequities in access to the system and in its benefits. Because the basic goal of the system was to prevent pauperism rather than to improve the general health of the population, it did not cover most of the population. True, the National Health Insurance plan, once enacted, suddenly provided benefits for more than ten million people who previously were without them from either trade unions or friendly societies, but the system covered less than half the British population. With the exception of a £2 maternity benefit on the confinement of the wife of an insured man, the plan did not provide coverage for dependents. Nor did it provide coverage for the country's middle and upper classes, an omission that was eventually to become politically important as the demands for the costs of medical care increased (McCleary, 1932).

Among those who were insured, the benefits were distributed in a very inequitable fashion. People on the same street or even in the same home

often received different benefits (Levy, 1944, p. 254). Some approved societies paid out all of their income in the form of cash benefits to sick members and therefore had no surplus income to provide additional benefits. However, although in 1938 80 percent of the insured received some extra benefit via their approved society, most of the additional benefits were negligible in monetary terms (ibid., p. 242; Lindsey, 1962, pp. 11-12). But because it was very difficult, if not impossible, for the public to learn much about the previous performance of approved societies, most individuals chose their society on the basis of incomplete information, thus encouraging poorly managed approved societies to persist with resulting inequities (Levy, 1944, p. 26).

With so many types of approved societies, perhaps it was inevitable that there would be inequities in their benefits. Most approved societies were dominated by one of the following: friendly societies, trade unions, insurance companies, or employers' provident funds. By 1926, when the Royal Commission on National Health Insurance (pp. 93-94) issued its report, there were 926 different approved societies in England and Wales; but some had numerous branches, with the actual number of units administering the approved societies at well over 7,000. Moreover, the membership of the approved societies varied from less than 50 to more than 2,000,000. In England, for example, there were 70 societies with fewer than 100 members and 24 with memberships in excess of 50,000. Vast variation in size and social makeup of approved societies caused the quality of management and benefits to vary greatly from society to society.

For those who were covered by NHI, the types of available medical technology and services were very limited. Most of the medical services

were those of the general practitioner on an outpatient basis. In this sense, the British system was unlike national health insurance in Germany at the same time, where all types of medical service were provided the insured and where well over 80 percent of the doctors participated (McCleary, 1932, p. 54). In Britain, however, there was no general feature for surgery or any other type of treatment in hospitals or for convalescent or nursing home care, even though the demand for hospital care increased dramatically during the interwar period. The program also did not provide for ambulatory specialist diagnosis or treatment. Moreover, there was no provision for diagnostic techniques involving X-ray, urinalysis, and blood examination. If a patient were seen by a physician or surgeon in a hospital, there was hardly any arrangement for communication or cooperation between the general practitioner and the hospital-based doctors. In other words, the National Health Insurance scheme extended the number of people covered, but it did not significantly alter the type of benefits which trade unions and friendly societies had traditionally provided in their contracts with the doctors (ibid.).

The provision regarding the treatment for tuberculosis was an exception to this, however (Political and Economic Planning, 1937, p. 195). In an effort to improve medical care for tuberculosis patients, NHI provided for funds from the national insurance scheme and for grants directly from the central government. The grants were to assist local authorities in constructing tuberculosis sanatoria and dispensaries, while funds were set aside for local insurance committees to aid in paying sanatorium benefits. And finally, grants from the Local Government Board were available to assist

the dependents of tubercular patients. Aside from this provision, however, NHI did not provide directly for hospital benefits (Abel-Smith, 1964, p. 239).

One major change that the health insurance plan did bring about was greater autonomy for the general practitioners in their treatment of patients. Unlike the former contract system with friendly societies which provided for no freedom of choice between patient and practitioner, both now had freedom to reject one another.

With a state mandated system covering so many people and with so many practitioners participating, the system obviously placed limits on and shaped the nature of the practice of general practitioners. By 1938, there were almost 17 million people covered by the insurance plan, with approximately 16,000 doctors active in the plan. The number of insurance patients on each doctor's list varied considerably. Though the largest number of persons a practitioner could have on his panel was 2,500, 65 percent of the general practitioners had fewer than 1,200 people on their panel, and only 14 percent had more than 2,000 (Levy, 1944, p. 131). Those private practitioners who did not participate in the scheme generally limited their practice to the well-to-do. On the other hand, those doctors who practiced in the working class districts of large industrial areas often treated as many insurance patients as the scheme permitted, and there were reliable reports of some doctors who even had 4,000 insured persons on their lists (*ibid.*, p. 123; Brend, 1917, 179). In many towns, approximately one-fifth of the doctors would attend to almost one-half of the insured persons.

It is obviously difficult to evaluate the quality of care provided by the National Health Insurance plan. Overall, the system meant better care for the entire nation, for at least ten million people were now covered who previously were not and who were generally toward the lower end of Britain's pay scale. However, there were many recorded instances of slipshod treatment, indicating considerable variation in the quality of care.

The economic incentive of the practitioner was an important factor for quality of care. Some doctors used their NHI involvement as a means of gaining the dependents of their insured patients for their practice. If the insured could afford to pay medical fees for his family, there was an incentive for the practitioner to take considerable care with his patients, as with panel patients who insisted on paying the doctor an additional fee. William Brend conducted a full-scale study of health insurance in 1917 and was appalled by the inadequacies of much panel practice. He was especially disturbed by the "lightning" practice of doctors who would see up to seventy patients within a period of three hours. An example of this type of practice was provided by one doctor who described his practice in one of the medical journals in 1914:

I often see from 60 to 70 patients in an evening between 6:30 and 9, i.e., an average of one every two minutes. And yet it is very simple. Every patient upon entering the surgery is presented with a numbered ticket by my nurse. This, I may say, is much appreciated and prevents confusion and waste of time. I have already seen, during the past week, nine-tenths of my to-rights' visitors. To my question, "How are you getting on?" the answer as a rule is, "Very well, but I think another bottle would help me more." The prescription is ready as they utter the last word. A number want documents signed, leaving me plenty of time to thoroughly examine the seven new patients. "But they are all trivial cases," I think I hear some one say. Is not almost every deviation from the path of health trivial? [quoted in Brend, 1917, p. 181].

Because of the crowded circumstances under which many general practitioners practiced--especially in working class districts--it is not surprising that doctors often made mistakes. There are few indicators for measuring the quality of care, but one set of records covers 27,746 patients with fairly serious illnesses who were referred by general practitioners to the hospitals maintained by London's Metropolitan Asylums Board. In approximately 10 percent of the cases, the illness had been wrongly diagnosed by the panel doctor. Unfortunately, there is no method for comparing this performance with the diagnoses of nonpanel patients. However, the record is abundantly clear that the diagnostic procedures for outpatients were very crude, and examinations by X-ray and of blood, urinalysis, and excretions were almost nonexistent to panel patients except by payment of fees (*ibid.*, p. 187).

A frequent charge levelled against the general practitioner paid by the capitation system, whether during the period of the National Health Insurance plan or later under the National Health Service, is that doctors avoided as much work as possible and sent too many patients unnecessarily to a specialist. Supporting this claim, an informed spokesman for the British Hospitals Association informed the Royal Commission on Workmen's Compensation that "the panel doctor passes on to the hospital as much work as he can" (Levy, 1944, p. 127). Moreover a 1929 report by the British Medical Association (British Medical Journal, 1929) was quite alarmed by this tendency and observed the cost increases that were taking place concurrently with the rise in the number of outpatient attendances in London hospitals.

The introduction of the National Health Insurance system should have led to a considerable decrease, if not in the number of outpatients, certainly in the number of outpatient attendances. . . . Unfortunately there is a body of testimony from members of the staffs of large hospitals that considerable numbers of insured and other contract patients are sent to outpatient departments for services well within the competence of practitioners sending them; not for the purpose of getting a second opinion so much as in the hope that the patient will be taken off the doctor's hands. [p. 134]

Technically, the practice of doctors participating in the insurance scheme was supervised by the state, and each insured person had an opportunity to request that official investigations be conducted when the panel doctor provided inadequate care. Official statistics concerning complaints and disciplinary procedures indicate that the system worked extremely well. For example, in 1938 (not an atypical year), there were only 84 disciplinary proceedings under the system, and in only 11 were there findings of negligence. On the other hand, there were many complaints filed and many people did change panel doctors. However, the machinery for carrying out official investigations was complex, thus deterring much official monitoring or investigating of panel practice. Moreover, an insured person was required to file a complaint within six weeks after the occurrence of an event giving rise to the cause of the complaint, but many problems undoubtedly came to the attention of patients only after considerably more time had passed.

Despite all of these shortcomings, however, the overall effect of the National Health Insurance system was quite positive. Although the NHI program did not have a substantial impact on the health of the society because of the lack of insurance coverage for family members of the insured and the failure of the program to provide for systematic hospital care, it

did help protect the lower classes against destitution resulting from ill health. Under the plan, several million people who would have gone without medical attention otherwise received it. Moreover, the program encouraged doctors to locate in some of the more densely populated areas of industrial cities, areas which had previously been underserved; thus the system not only provided more equitable access to care, but easier access. Finally, there is considerable evidence that the quality of care was generally superior to that provided by doctors under contract to friendly societies and other types of medical clubs. Even if some doctors' offices were overcrowded under the insurance plan, this was also true under the former friendly society contract system, and occasionally true for doctors who practiced under a fee-for-service basis. On the other hand, the decentralized and very fragmented National Health Insurance system was somewhat inefficient. In 1933, the International Labor Office revealed that 17 percent of the costs of the British NHI system were spent on administering the program, whereas in Germany, Sweden, Switzerland, and France administrative costs ranged between 7 and 10 percent of the total program. Because NHI doctors relied heavily on assistance from the voluntary sector--especially the voluntary hospitals--it is apparent that had the NHI provided hospital services also, the administrative costs would have been even greater. Given that the British National Health Insurance system basically provided a modest cash and a very limited medical benefit, its decentralized structure was one of the world's most expensive governmental insurance programs to administer (Levy, 1944, pp. 289-301; Royal Commission on National Health Insurance, 1926).

2. PRIVATE OUTPATIENT CARE

Types of Private Practice

The medical doctors who provided outpatient care in the private sector may be classified into several groups, each reflecting the class-based nature of British medicine. There were first, the doctors who practiced in working class neighborhoods and whose practices were confined almost exclusively to those covered by the National Health Insurance plan.

There were next, the practitioners who served mostly the middle class who were not covered by the NHI, though in small towns and rural areas these doctors provided service to a mixture of working class patients as well. Middle class patients would normally see the doctor by appointment, have a private conference with the doctor, and would usually enter the doctor's office by the front door, and if any waiting was necessary, there would be a pleasant reception room. The working class panel patient would generally enter by a different door without an appointment, wait for a considerable period of time--usually in an uncomfortable waiting room--and finally see the doctor for a couple of minutes. However, there is substantial evidence that paying patients tended to receive a somewhat higher quality of care than that received by panel patients (Political and Economic Planning, 1937, p. 143; Levy, 1944, p. 136).

Third, there was the "Mayfair" general practitioner who practiced in the fashionable area of the West End of London or in the well-to-do areas of other cities. As his patients were very wealthy, his was a lucrative practice, though a somewhat competitive one which he shared with the

specialists and consultants who spent much of their time in the voluntary hospitals, but who nevertheless saw private patients in their well furnished offices on Harley Street.

Throughout the interwar period, however, the specialists and consultants continued to be the elite of the medical profession. Yet the terms consultant and specialist were ambiguous, having no precise meaning. A doctor may have been acting as a "consultant" when he met a colleague and consulted about a patient. The British Medical Association in 1930 defined a specialist as someone who had received special academic training in a subject and was recognized by his colleagues as having special proficiency in an area of medicine, whereas a consultant was someone who generally had a hospital appointment which was largely confined to consultation work (Political and Economic Planning, 1973, p. 159). Most consultants at voluntary hospitals continued to do their hospital work with virtually no compensation, behavior which conveyed to the public the idea that the consultant was a charitable person, a practitioner whose motives were not primarily pecuniary, a doctor who had reached the height of his profession.

The high public esteem in which the specialists and consultants were held perpetually led to tension between them and the general practitioner. When the general practitioner referred a patient to the specialist or consultant, there was often fear that the patient would be stolen, and this concern intensified the cleavage which already existed as a result of most general practitioners being denied access to practice in the large general hospitals. In an effort to regulate the relationship between these two groups of practitioners, the British Medical Association, dominated by the general practitioners, established a strict code of

ethics. Even so the cleavages between the general practitioners and their hospital-based colleagues remained serious throughout the interwar period.

Apart from the National Health Insurance plan, there were other insurance arrangements which provided for private outpatient care. Many friendly societies continued after 1911 as approved societies which provided contract medical services for people who were not covered by National Health Insurance--generally the dependents of those who were. Although the relations between the B.M.A. and the friendly societies did not continue as strained as before 1911, the B.M.A. nevertheless remained hostile to the idea that a consumer cooperative could, through contracts with doctors, dictate the conditions under which medical care would be provided. Even so, the friendly society contract service remained fairly widespread throughout the interwar period and helped broaden the base of organized consumer participation in the medical care area.

A different type of scheme was the work contracts which existed in the North and Midlands of England. They were generally local plans, organized and managed by an employer who deducted from the wages of employees a sum sufficient to provide general practitioner services for the dependents of employees. Unlike those covered by friendly society contract, the insured in this plan were free to choose any doctor in the community.

The private insurance plan that was most strongly endorsed by the British Medical Association was a scheme organized by the doctors for the uninsured population of a community. The plan was open to all registered

medical doctors practicing in an area. From the viewpoint of the British Medical Association, this scheme had the important advantage of medical control and management by the doctors. Equally important, from the viewpoint of the doctors, this scheme preserved the principle of free choice of the doctor by the patient. Indeed, the idea that organized consumer power could control and manage the terms of medical care, as in friendly societies, has been abhorrent to both the British and American medical professions throughout the twentieth century. But because consumers have been much better organized in Britain than in America, where industrialization developed later and ethnic and racial hostility prevented trade unions and consumer groups from becoming a strong unified force, the British practitioners have had to be more accommodating than their American counterparts to organized consumer power.

And finally, there was the type of private medical insurance scheme which became widespread in the United States before and after World War II, whereby individuals purchased insurance policies which would pay for outpatient care up to a specified amount. Because the insured had free choice of doctor and the system was not managed as a medical consumer cooperative, this scheme also had the endorsement of the B.M.A. By the end of the 1930s, this arrangement covered approximately 1.4 million people, mostly through the National Deposit Friendly Society and the Teachers' Provident Society.

Private Outpatient Clinics

Following the introduction of the National Health Insurance plan, there was initially a decrease in the number of people treated in the

outpatient clinics of the voluntary hospitals. But as the voluntary hospitals resorted to charging more and more patients for their care hospital insurance became rather widespread, with more than 300 different programs in effect by 1930 (Abel-Smith, 1964, pp. 327, 333). In turn as the number of hospital insured increased, many people believed that they had a right to attend a hospital, either as an inpatient or outpatient, and this attitude by 1920 led to an increase in the number of people who attended the outpatient clinics. This led to serious problems between the British Medical Association and the voluntary hospitals over the question of the type of medical practitioner who should have access to the hospital outpatient clinics.

The nonhospital-based doctor took the view that the more patients there were attending the hospital outpatient clinics, the less money there would be for the private practitioners. For the one-third of the population covered by National Health Insurance, there was no income lost to the private practitioner when his patients went to the hospital outpatient clinic, for he had already received his capitation fee. As suggested above, many hospital-based practitioners referred too many patients to the outpatient clinics as a means of reducing their work load. But the G.P.s were concerned about the other two-thirds of the population who were not covered by national insurance: the dependents of the insured, the aged, and those whose income was too high to qualify for national insurance. To prevent these people from being treated in the hospital outpatient departments, the B.M.A. tried unsuccessfully to place an upper limit on the income of those who could purchase hospital insurance. When this failed, the B.M.A. vigorously attempted to limit the hospital outpatient

clinics to those who were referred there by a private practitioner. The hospitals, in contrast, were in financial difficulty and wished to increase their number of hospital insurance policyholders. As a result, hospital outpatient departments increased the number of patients throughout the interwar years, causing an intense dispute to linger between the general practitioners and the doctors practicing in the hospital. The outside practitioner accused the hospitals of caring little for the well-being of patients, but only wishing to have their money; in turn, the hospitals blamed the G.P.s for unnecessarily referring NHI patients to the outpatient clinics.

Eventually the B.M.A. attempted to win over the hospital-based consultants by arguing that they too were losing some of their outside practice to the outpatient clinics. This failed to bring the desired results, however, for in response the consultants entered into agreements with the hospitals whereby they could treat some of their private patients on ordinary outpatient days in a room provided by the hospital (Abel-Smith, 1964, p. 392). This practice, over time, became quite widespread, and eventually was to lead to serious political problems during the National Health Service when salaried, hospital-based doctors insisted that they should have a right to treat their private paying patients in the nation's hospitals. In terms of total volume of patients seen, however, the consultants continued to see most patients in the outpatient clinics without compensation. In other words, their "honorary" status was not seriously compromised.

Another form of private clinic during the interwar years was the provident dispensary, though with the passage of time its importance declined. The financing for most of these clinics came from voluntary insurance payments on a capitation basis, as well as from donations and legacies. By 1937, however, there were still approximately 40 such dispensaries in the London area, with dozens more scattered throughout the country. In most, the insured had a free choice of doctor, and in a few there were specialist doctors attached to the staff. The patients were usually dependents of those insured by the National Health Insurance plan, and rarely were the upper income or pauper classes treated by this type of institution. In some respects, the financial structure of these dispensaries resembled the Health Maintenance Organizations which were later to become popular in America, though these rarely provided any hospital-based services. In Scotland, these dispensaries provided rather high quality care and were often used by the medical schools for instruction purposes.

As a result of the increasing belief in the efficaciousness of medical technology, the institutional competition between the outpatient clinics of the voluntary hospitals and the provident dispensaries caused them to become increasingly similar in the sources of their financing (e.g., insurance payments), the social background of their clientele, types of illness treated, and methods of treatment. No longer were the outpatient clinics of the voluntary hospitals primarily for the deserving poor. The increasing costs of medical technology had encouraged the outpatient clinics of the voluntary hospitals and dispensaries to cater to the middle

class paying patient, despite the almost unanimous opposition of the nonhospital-based medical profession and its spokesman, the B.M.A.

3. PUBLIC OUTPATIENT TREATMENT

Prior to the Second World War the general practitioners might have provided some coordination of medical services had they more effectively played the role of family doctor, but the fragmented and specialized nature of outpatient care, in both public and private sectors, discouraged this. Symptomatic of the fragmented care was the fact that each of the following services was usually served by separate practitioners, yet each often provided benefits for a separate person within a family: the National Health Insurance (1921-1948), with its services restricted to insured workers; the public medical services for expectant and nursing mothers, infants, and school children; and the Poor Law service (Titmuss, 1958, p. 173). Not only were these services uncoordinated, but the activities of each placed severe constraints on the activities of the others.

Perhaps nowhere is this more clearly demonstrated than with the impact that the National Health Insurance plan had on Poor Law outdoor medical assistance. (See Hollingsworth, 1980, for a discussion of Poor Law outdoor medical relief.) Before the passage of the National Health Insurance Act, the amount of Poor Law outdoor medical relief fluctuated mildly around the level which it had attained by 1895, with modest shifts occurring because of changes in the nation's economy and level of sickness. When the National Health Insurance Act was implemented, however, the numbers of

people receiving outdoor medical relief dropped substantially. Because of the availability of NHI, adult males of employable age fell less frequently into the pauper class whose medical aid was limited to Poor Law services. When unemployment and other economic problems increased in the late twenties, however, the number of adult males receiving outdoor medical relief for sickness did increase. In other words, the economic depression during the 1930s demonstrated that NHI provided inadequate medical services to people of employable age during periods of high unemployment (Witmer, 1932).

With the passage of time, however, the nature of outdoor medical relief changed considerably. The Boards of Guardians became more accommodating to those who sought outdoor medical relief, in part as a means of reducing the number of poor who, as their health deteriorated, were placed in Poor Law institutions. Moreover, the harshness of the former Poor Law approach to outdoor medical care was softened as the result of the abolishment of the Board of Guardians and the establishment of Public Assistance Committees by the Local Government Act in 1929.

There was increasing public awareness that the demands made upon Poor Law outdoor relief were somewhat dependent on the number of people who were covered by National Health Insurance, old age pensions, and other welfare programs. Although there was virtually no official coordination across these programs, the recognition that they were somewhat interdependent did cause public officials to be less prejudiced against those who sought publicly supported outdoor medical relief. Meantime, profound changes took place after 1900 concerning attitudes toward poverty and the

poor. Increasingly, there was a widely shared view that the poor were not all lazy and improvident and that the state had an obligation to help the less fortunate. But the nation's governmental policies and institutions were constrained by the dead hand of the past, and the process of adjusting changing attitudes and institutions proved to be a slow and tortuous one.

Perhaps the public outpatient medical care programs which best reflected these changes in attitude were those involving school-children, and the school program of greatest importance was that which evolved from the Education Act of 1907, establishing medical inspection of children in state schools. This legislation resulted from: (1) the revelation of the widespread physical disability among working-class men who had presented themselves for military service during the Boer War, and (2) a government study which demonstrated that large numbers of school-aged children were undernourished, and for that reason could not adequately carry out their studies. These concerns were mounted at a time when many people were troubled about the effect that the inadequacy or "inefficiency" of Britain's human resources would have on the country's ability to maintain itself as a great power. To have more efficient resources, Britain must have, so Sidney Webb and others agreed, a national minimum standard of life below which individuals should not fall. Indeed, it is often during a war that a society will learn of the inadequacies of its human and physical capital, and following a war, there is often an effort to improve the well-being of the population. And this is what occurred in Great Britain following the Boer War.

But how the society should proceed to improve the physical well-being of its citizens was, of course, a difficult problem for the British to solve. Options at the turn of the century were somewhat constrained by the fact

that over five million working class people already had some form of medical insurance through friendly societies--an insurance system, however, that did not provide care for dependents. Since the existing private mechanisms appeared unlikely to respond to the physical problems of children, British society turned to the state. The Education Act of 1907, by providing outpatient medical services for children, eventually proved to be an important reason that the National Health Insurance system did not include children in its coverage. In other words, existing institutions placed constraints on British society's options for the formulation of new policies, which when implemented eventually would limit and constrain future policy choices.

Even though the Education Act mandated school medical inspection of children, for several years there was a serious problem of what to do with the large number of children identified as having some form of medical defect. If there were a serious medical problem with a low income child, the family could seek care in a voluntary hospital as a charity case, or as a last resort, the parents could approach the Poor Law medical officer, and thus technically become paupers. But voluntary hospitals were not always willing or able to provide children the care which they needed (Political and Economic Planning, 1937, p. 119), and most families simply rejected the stigma of pauperism which followed the receipt of Poor Law relief. As these choices were frequently not viable alternatives, widespread unhealthiness among children was the result, and of course, medical inspection was of little consequence without treatment (Gilbert, 1966, p. 126).

As the result of the need for medical treatment by schoolchildren, the local authorities eventually responded by providing medical services

to children. By March 1914, more than three-fourths of the Local Education Authorities (L.E.A.) were providing medical treatment for schoolchildren. Fifty-three L.E.A.s provided funds to approximately 100 voluntary hospitals to pay for services for schoolchildren, and 84 had established 150 dental clinics (Gilbert, 1966, p. 156). Later, these services were greatly expanded and improved, with all of the education authorities providing some form of medical and dental treatment. By 1936, there were 1,458 school medical officers in England and Wales, or one medical officer for every 6,725 children in average daily attendance, and 907 dentists (Political and Economic Planning, 1937, p. 121).

The administration of these services was coordinated by the Minister of Health and the L.E.A.s. Technically, the central government via the Minister of Health was responsible for the inspection and treatment of schoolchildren, but in fact, the responsibility was delegated to the local authorities. Because the administration of services was very decentralized, the personnel and quality of care varied somewhat from area to area, but overall the school services were of high quality. All children in elementary schools were inspected three times during their elementary school career. Local authorities were also required to provide inspection for the secondary students for which they were responsible, and they had the authority to provide it for those children who were in voluntary secondary schools (Political and Economic Planning, 1937, p. 120).

Other legislative steps which enlarged medical services involved maternity benefits. Once the state was providing medical services for the breadwinner via the National Health Insurance plan, and for schoolchildren,

a natural corollary was the provision of medical care for mothers. The National Health Insurance Act had provided the wife of an insured man the sum of £2 when she gave birth to a child, but no maternity services. Under the Maternity and Child Welfare Act (1918), the central government encouraged the local authorities to provide ante- and postnatal clinics, a system of home visiting, infant welfare centers, and funds for midwives. Until 1930, the central government provided Exchequer grants to local authorities to facilitate the development of these services, though after 1930, the local governments had to finance these services from local funds and rates. As was often the case, women were expected to pay according to their means to cover the costs of these services. Because the local authorities had considerable latitude in determining the type of services which they provided, these services also varied enormously from area to area (Political and Economic Planning, 1937, pp. 90-91).

In 1935, approximately 73 percent of expectant mothers in London attended antenatal clinics, 63 percent in the county boroughs of England, but in English counties the percentage was only 17. In many rural areas, however, the local authorities paid private doctors for providing expectant mothers with antenatal care. Throughout England, approximately 50 percent of expectant mothers received some antenatal care by 1937 (Herbert, 1939, p. 134). Most of the clinics not only provided periodic examinations during the pregnancy but they provided education and various social services related to pregnancy. In 1936, the Midwives Act authorized local governments to provide a complete maternity service under the control of local authorities. In response, former voluntary and

public arrangements for midwifery services were combined, and a publicly supported, full-time salaried midwifery service was developed; there was an immediate increase in the number of expectant mothers who attended maternity clinics (*ibid.*, p. 137).

Many local authorities followed up a childbirth by home health visiting, whereby a nurse provided some supervision in the home for nursing mothers and newly born infants. In 1936, almost one-third of all expectant mothers in England and Wales received some home health visiting, and more than 95 percent of all children born in England and Wales received at least one "health visit" during the first year of life by the local authorities (*Political and Economic Planning*, 1937, p. 106). By the end of 1933, there were approximately 2,600 health visitors employed by the local authorities. Not only did they visit infants and new mothers, but during the 1930s they were making more than four million visits annually to children between ages 1 and 5 (McCleaer , 1932, p. 36). Moreover, many local authorities provided milk and food during both pregnancy and lactation; for example, approximately 400 maternity and child welfare authorities provided more than seven million gallons of milk annually to expectant and nursing mothers either free or at a price below cost, and approximately 13 percent of all maternity and child welfare expenditures were for food (*Political and Economic Planning*, 1937, p. 98). Some authorities even provided domestic aids to take care of the home while the mothers were incapacitated (Birmingham and Glasgow provided the best care of this type). In all areas, the family paid for this service on a graduated scale according to income.

The state, also at the local level, provided infant welfare centers, with more than 2,500 by the 1930s. They were generally staffed by a doctor and a nurse, provided care for minor illness, and concentrated on the education of the mother in regard to the feeding and general care of infants. The centers were especially important for diagnosing infant defects, but infants had to go elsewhere for specialized care. Providing medical care to more than 60 percent of the nation's young children in the 1930s, the infant welfare centers were an important part of Britain's health services. However, there was a major gap in Britain's public medical services for the group between ages 3 and 6 who attended no school. Although some local authorities maintained "Toddlers Clinics," public services for this age group were meager.

4. HOSPITAL CARE

Voluntary Hospitals

The First World War did a great deal to advance medical knowledge, especially in neurosurgery, orthopedic, plastic, and thoracic surgery, and diagnostic radiology. Moreover, there were substantial advances in such nonclinical areas as biochemistry, bacteriology, and endocrinology, which nevertheless had important clinical side effects. The clinical effects of these advances tended to center in the hospital, leading more and more of the populations of western nations to turn to the hospital for complex medical care. Advances in medical specialties usually meant expanding hospital staffs and more costly equipment. The financing of changes in

the complexity of medical technology was probably the most important problem which the hospitals--especially those in the private sector--faced during the interwar period.

The general voluntary hospitals had historically been financed largely from charitable contributions. Aside from contributions from wealthy patrons, the most important source of contributions for voluntary hospitals was the King Edward Hospital Fund which had been established by King Edward VII when he was Prince of Wales. Its purpose was to support London voluntary hospitals and to assist in the coordination of their efforts by sponsoring conferences with their representatives on a wide variety of subjects. The other major charitable organizations were the Metropolitan Hospital Sunday Fund and the Hospital Saturday Fund. The King Edward Fund provided approximately 10 percent of the income for London's voluntary hospitals, the Hospital Sunday and Saturday Funds approximately 7 percent of the income for voluntary hospitals throughout England and Wales (Burdett's yearbooks).

Because these organizations were clearly not sufficient to meet the expanding needs of hospitals, most voluntary hospitals were engaged in deficit financing following the First World War. In response, Parliament provided a half million pound grant to assist the hospitals in getting their accounts in order. Obviously, this one grant, administered by the Voluntary Hospitals Commission, was not adequate to solve the financial problems of the voluntary hospitals. Alternative means of financing hospitals meant resorting to insurance schemes and other forms of patient payments. In other words, the voluntary hospitals became somewhat more

dependent on patients to pay what they could afford. Meantime, the various approved societies provided approximately £200,000 annually for special cases of National Health Insurance patients, and the local governments made modest contributions to voluntary hospitals as payments for patients who were transferred from local government hospitals. Hospitals also resorted to energetic fund-raising appeals, relying on lotteries, dances, bazaars, dinners, and boxing matches (Abel-Smith, 1964, pp. 323-324).

But the major change in financing occurred as a result of direct and indirect payments by patients. Going to the substantial increase in the number of patients treated in voluntary hospitals--in 1921, approximately 25 percent of all patients were treated in voluntary hospitals, and by 1938 36 percent were (ibid., p. 385)--and by 1938 there were over 400 different insurance plans listed in the Hospitals Year Book (ibid., p. 390), almost all of which had been established after 1918 (Political and Economic Planning, 1937, p. 234). Large numbers of individuals purchased various types of health insurance, with the result that a patchwork of uncoordinated and often high-priced policies were outstanding; some of which covered only a fragment of a patient's potential medical need. Some insurance programs provided medical insurance for individual needs over and above those covered by the National Health Insurance plan, whereas other insurance plans were designed for individuals who were excluded from NHI. By 1935, there were approximately 10 million people who were covered by a wide assortment of plans which provided payment for treatment in either public or private hospitals (Royal Commission on Workman's Compensation, 1945, pp. 1080-1081).

The voluntary insurance plans represented an important means whereby working class families provided hospital insurance for themselves. Although employers made negligible contributions to the plans, they often deducted a modest amount from their employees' wages and turned the money over to local hospitals or insurance companies (Levy, 1944, p. 162).

As the number of people receiving care in the hospitals increased, the British Medical Association argued that there should be an upper income limit placed on the eligibility for membership in an insurance contributory scheme and that general practitioners should be permitted to treat their patients in the hospitals. Hospitals were generally reluctant to grant the latter demand, though a number of contributory schemes did limit their membership to those in the lower income groups (Political and Economic Planning, 1937, p. 235).

Historically, people above a certain level of status and income had not expected to be admitted to voluntary hospitals. But as medical procedures became more complex and effective, upper income groups increasingly turned to the hospitals for care. Even so, the hospitals were slow to develop common responses to their new clients. Many questions had to be resolved. Should the upper income groups who did not participate in or who were not eligible for contributory insurance schemes be charged the full cost for their stay? Should hospital consultants, who normally did not charge patients who were treated inside the hospital, make an exception when treating upper income patients by billing them for the full cost of their treatment, for they surely would have been charged a fee had they been treated in the home? Should hospitals charge the

wealthy more than the full cost of their treatment and maintenance in order to cover the expenses for less fortunate patients? Should hospitals permit patients to be treated by their own doctors who otherwise were not members of the hospital staff?

The responses to these questions varied somewhat from hospital to hospital. A few hospitals did permit doctors who were not staff members to treat their patients in the hospital, but most did not. Most large hospitals charged upper income patients the full cost of their treatment with the exception of the consultant's fees. By the late 1920s, the large voluntary hospitals had added a number of private paying beds to accommodate the upper income groups. Indeed, by 1929 London had more than 1,000 private paying beds (Abel-Smith, 1964, p. 339). But most consultants continued to do their inpatient work without fees.

By 1938, the sources of voluntary hospital income had become quite varied, making a sharp change from the almost exclusive dependence on the charitable contributions of the late nineteenth century. Voluntary hospitals received between 40 and 50 percent of their income from patients paying on their own behalf or from payments by local authorities on behalf of patients.

The administrative structure of hospitals became more elaborate and complex as the source of funding became more varied and hospital operating costs increased. As hospitals had to estimate patient fees for approved societies, local governments, insurance organizations, and paying patients, there were increased pressures for each hospital to standardize its accounting procedures.

Because there was some effort to charge patients on the basis of their ability to pay, hospitals appointed a full-time administrative staff, known as almoners, whose task it was to determine each patient's financial circumstances. The main function of the almoner was to prevent those who should make some payment for their treatment from receiving free treatment, and to make certain that each patient was charged according to his ability to pay (Newsholme, 1932, p. 100; Herbert, 1939, p. 119). An unintended side effect of the almoner's role was that doctors were now able, via the almoner, to learn a great deal about the patient's home life and work situation, and to make better judgments about the appropriate time for sending a patient home. Not surprisingly, the role of almoner moved over time increasingly in the direction of a psychiatric social worker.

Slowly, a group of professional administrators emerged to assist in managing the increasing complexity of voluntary hospitals. No longer could a group of volunteer lay people carry out all of the administrative work of the voluntary hospital. As medical specialization increased and as hospitals became more internally differentiated, hospitals required administrators with tact and a high level of knowledge of the inner workings of a hospital. However, there was no formal professional training provided for hospital administration, and most professional hospital administrators entered their profession as apprentices (Abel-Smith, 1964, pp. 403-404). As a result, few voluntary hospitals had administrators with university degrees, and their status within the hospital remained low vis-à-vis the doctors. Thus, the hospital-based doctors were able to make not only the key decisions about the treatment of patients but also

to shape the critical decisions about how many paying beds were to be within the hospitals, how many consultants and specialists would be on the hospital staff, and whether general practitioners would be permitted to treat their patients inside the hospital. Accordingly, the hospitals tended to remain understaffed, and the expansion of any facilities which adversely affected the senior members of the hospital staff were simply not undertaken (*ibid.*, p. 407).

Even so, there were modest external influences on the government and management of hospitals in the interwar period. Historically, the trustees of a voluntary hospital were the individuals who had contributed large sums of money to it. Following the First World War, as the source of hospital funding became more diversified, the trustees became a more heterogeneous group of individuals. The local governing authorities, the British Red Cross Society, and the various insurance contributory organizations--in recognition of their financial payments to the hospitals, became representatives on the hospital governing boards (Herbert, 1939, p. 112; Political and Economic Planning, 1937, p. 231). Moreover, workingmen's organizations which had developed their own contributory schemes demanded and in some instances received a share in the governance of hospitals.

The most serious problem confronting the voluntary hospital sector was the lack of coordination from hospital to hospital. In an age when medical technology was relatively simple and hospitals were small and few in number, the lack of systematic planning and poor coordination had not created serious problems. But by the interwar years, the situation had changed. Some parts of the country had an oversupply of hospitals, whereas

others had critical shortages. At the outbreak of World War II, almost half of the nation's 700 voluntary hospitals had fewer than 30 beds, and poor hospital medicine was widespread in Britain in the small general practitioner-dominated cottage hospital. Most cottage hospitals had inadequate equipment, and their staff often attempted to carry out surgery which was beyond their competence (Abel-Smith, 1964, p. 406).

As specialists and consultants received most of their income from private paying patients outside the hospitals, they tended to be concentrated in those areas of the country where there were large numbers of wealthy residents. As a result, there was an extremely heavy concentration not only of specialists and consultants but also of large voluntary hospitals in London. And because beds within hospitals were allocated to "honoraries" on the basis of their status and power within the hospital and not on the basis of the needs of patients, some specialists had empty beds while others had long waiting lists. As Brian Abel-Smith (p. 407) observes, the occupancy of voluntary hospitals was not high, but in the late 1930s there were approximately 100,000 people waiting to be admitted to them. It was this maldistribution and malutilization of resources which led to a great deal of discussion during the thirties about the need for planning and coordination of Britain's hospital resources.

Historically, there had been weak mechanisms for coordination among private hospitals, though several types of organizations did attempt to rationalize and coordinate the voluntary hospital sector. In London, the King Edward Hospital Fund was a central collecting agency for many types of gifts. In 1936, it distributed more than £300,000 to approximately

150 hospitals in the London metropolitan area. Because it stipulated certain conditions for providing grants and because its grants were equivalent to ten percent of some hospitals, the King's Fund was able to achieve a modest amount of coordination between the voluntary hospitals of London (Herbert, 1939, pp. 120-122).

Outside of London, however, there was very poor coordination of hospital facilities. The British Hospitals Association (B.H.A.), which would later become more powerful, was a relatively weak organization in the interwar period. Founded in 1884, the Association held annual conferences and published a wide variety of statistics and information about hospitals. But during the interwar years it had very little influence over individual hospitals, for most were relatively uninvolved in its affairs. As the Sankey Report on hospitals observed in 1937, the B.H.A. was "a school master without the authority of a cane trying to keep in order one thousand mischievous boys and failing"; it was without the ability "to speak promptly and confidently regarding the views of its members and with the assurance that all would abide by a majority vote" (quoted in Abel-Smith, 1964, p. 411). Most hospitals were simply too attached to local constituencies to be concerned about the broader needs of the voluntary hospital sector, and many hospitals refused to have any affiliation with the B.H.A. For example, the prestigious London teaching hospitals usually had a board of governors who were at the apex of the nation's social and political system, with the result that they could go directly to the Cabinet in order to obtain anything desired from the government. With that kind of political influence, most teaching hospitals

believed that they had nothing to gain from the B.H.A., which frequently attempted to curtail their activities.

Even though all hospitals were not affiliated with the B.H.A., it did purport to represent all hospitals. To coordinate their activities, the B.H.A. was divided into 23 regions, 18 of which were very active, 5 of which were almost nonfunctioning. And though these regional committees were not of great importance in promoting the convergence of hospital practice across regions, they helped hospitals, especially the smaller and underequipped ones, to understand their inadequacies better. Moreover, the B.H.A. helped to establish the idea of planning hospital needs along regional lines, an approach to hospital coordination and planning which was to become very important under the National Health Service.

Convalescent and Nursing Homes

Perhaps convalescent and nursing homes should logically be discussed as voluntary hospitals, but historically they have been viewed as separate types of institutions. The convalescent homes movement began in the nineteenth century as a means of providing a place where people could recuperate from illness. Before 1900, when hospitals were viewed primarily as institutions for treating the deserving poor, convalescent homes were an alternative institution for treating middle class patients. Later, as hospitals began to be the center for complex medical technology where people of all social backgrounds sought care, convalescent homes became places for people from varied backgrounds to recuperate from illness.

The major factor distinguishing the convalescent home from the hospital was the limited facilities. Convalescent homes provided skilled nursing,

but in general lacked specialists and consultants on their staff. By 1935, there were approximately 500 convalescent homes: of these, approximately 350 were operated from philanthropic contributions, 50 were linked to mutual assistance groups, and 40 to local governing authorities (Political and Economic Planning, 1937; pp. 266-269). In total, there were approximately 24,000 beds in the convalescent homes of England and Wales. The philanthropically based homes expected the patient to pay on the basis of what he could afford; mutual assistance groups, such as trade unions and friendly societies, provided a type of insurance scheme for their members whereby they were eligible for convalescent care when needed.

Like the voluntary hospital sector, there was a maldistribution of convalescent homes, with a critical shortage in the poorer parts of the country. There was poor coordination between the homes and hospitals, despite the efforts of the B.H.A. to rectify the problem. During the 1930s, the B.H.A. did achieve some success in raising the standard of administration in convalescent homes and disseminating information about patient care among the homes.

Unlike convalescent homes, which were either in the public or the private nonprofit sector, most nursing homes operated for a profit. Largely for this reason, there was considerable public distrust about the quality of care which they provided. By 1921, there were approximately 26,000 nursing home beds in England and Wales, with enormous variation in their quality. When ill, the wealthy preferred to be treated in some of the best nursing homes rather than in hospitals, and partly for that reason

there were some very elegant nursing homes. But in most, the facilities left a great deal to be desired. Some were actually in deplorable condition, with overcrowded and unsanitary buildings and grossly neglected patients. Some were simply buildings which rented rooms to lodgers, with a few rooms which were set aside as nursing home rooms. As consumers were not organized to see that any regulation occurred in the nursing home industry, it was the nursing profession, through the College of Nursing, which used its power to have the state regulate and control the quality of nursing homes. Significantly, most doctors, as reflected by the B.M.A. publications, appeared to be unaware of the inadequacy of care in the nursing homes. The specialists and consultants treated patients in the hospital, and if they ever entered a nursing home, it was to treat a wealthy patient in one of the nice but unusual nursing homes. Unlike the doctors, however, the nursing profession had an economic incentive in having nursing homes regulated: They wanted to restrict the supply of unqualified nurses on the market. As a result of the lobbying on the part of the College of Nurses, in 1927 Parliament passed the Nursing Homes Registration Act, which was designed to improve the quality of nursing homes and to protect trained nurses from unqualified nurses. Among its provisions were that nursing homes had to be operated by a "fit" person on "fit" premises and that some qualified person had to be on the staff.

Like other types of voluntary hospital facilities, the nursing home sector was very uneven in quality, highly decentralized, maldistributed, and had poorly coordinated facilities for inpatient care. Governmental regulation did improve the quality somewhat, but as long as the facilities

were in the private sector, there was considerable regional imbalance in the supply and quality of nursing homes. Indeed, governmental regulation probably contributed somewhat to a greater maldistribution. Following the enactment of the regulation act of 1927, there was a sharp decline in the number of nursing home beds in some of the poorer parts of England and Wales where there were both fewer and lower quality homes (Abel-Smith, 1964, p. 395). On the other hand, the number of nursing home beds declined, in part, because many middle and upper income groups who formerly relied on nursing homes during illness became increasingly willing to enter the hospital. As a result, this type of private for-profit institution was rapidly declining by the beginning of the Second World War.

Public Hospitals

After the turn of the century, the number of beds in public hospitals began to increase substantially. As the private hospital sector did not grow rapidly enough to meet the increasing demands of society, the public sector filled the void. As long as the demands for medical care were class-based or made by a particular group, the private sector tended to have the capacity to respond to them. But as medical technology became increasingly complex and efficacious, there was a substantial amount of convergence across social classes in the demands for medical care. And the greater the homogeneity of demands for medical care across social classes (i.e., the less the demands were heterogeneously based), the more the public sector responded.

More specifically, however, the public sector grew in response to the inadequacies of the private sector to meet all of the society's demands. In 1911, there were approximately 154,000 beds in an assortment of different types of public institutions, whereas there were about 172,000 public beds by 1921 (Abel-Smith, 1964, p. 353). The number of beds in Poor Law institutions slightly decreased in this period, while the number of specialized beds in hospitals substantially increased. In 1911, there had been approximately 1,300 beds in public sanatoria for tuberculosis patients, with an additional 4,200 more in private and voluntary hospitals. By 1929, in part owing to the provision in the National Health Insurance Act which provided beds for tubercular patients, there were 15,000 beds provided by local authorities for tuberculosis patients, and an additional 7,500 more beds, excluding those in the voluntary general hospitals (*ibid.*). Moreover, by 1921 there were almost 160 hospitals, public and private, which received government grants in order to maintain more than 2,500 maternity beds.

After the First World War, as all types of institutionalized care became more expensive, the local guardians began to revise their earlier policy of preferring to place paupers in Poor Law institutions rather than providing outdoor relief. (See Hollingsworth, 1980, for a discussion of Poor Law institutions.) Even so, many Poor Law institutions remained overcrowded. Meantime, a number of Poor Law infirmaries had continued to provide a fairly high quality of medical care, and increasingly paying patients were treated there. Nevertheless, many paying patients were mistakenly treated as paupers, thus discouraging much of the public from

seeking care in the Poor Law infirmaries. And even if some Poor Law infirmaries provided care comparable to that in many voluntary hospitals, in the 1920s there were still thousands of sick inmates in Poor Law workhouses. Some of the buildings were dilapidated, having been built before 1834, and as late as 1927 in some workhouses there was still no fully trained nurse to care for patients (Abel-Smith, 1964, p. 357). Although the Poor Law authorities wished to improve their facilities, the resource base in some districts was too meager to provide the revenue to modernize the facilities.

Workhouses continued to be places where many old people were crowded and deprived of civilized amenities. Whereas public medical services for the working poor, schoolchildren, infants, and mothers improved, the needs of the infirm aged and the chronic sick were neglected between the two world wars. As Peter Townsend (1962) observed, "Far less information on these persons was available between 1910 and 1946 than was available between 1834 and 1909. No official inquiries were instituted and hardly any books or pamphlets were published which contained more than a few fleeting references to their circumstances or their needs" (pp. 27-28). Yet, the number of people aged 65 and over doubled between 1910 and 1945, and there were more elderly people living in workhouses operated as chronic sick hospitals in 1938 than at the turn of the century. By 1930, there were still almost 600 Poor Law institutions with almost 100,000 sick "inmates."

In recognition of the inadequacies of the Poor Law medical facilities, Parliament, in the Local Government Act of 1929, reorganized the Poor Law. Regarding medical services, the purpose of the act was to increase the

efficiency and quality of the public facilities. To achieve these ends, the Board of Guardians was abolished in order to create fewer and larger governing units, its functions were transferred to the County Councils and County Boroughs, and the Poor Law service was administered by Public Assistance Committees under the control of the various councils and boroughs. Each governing authority was then free to remove facilities for the sick from the public assistance programs and to transform them into public hospitals as part of the general public health services (Political and Economic Planning, 1937, p. 250). The hope was that this would greatly transform the type of hospitals which would be available to the public. However, the local authorities were provided a great deal of discretion in developing public hospitals, and thus change in the public hospital sector was very uneven across the country. By 1939, there were 70,000 beds in 140 hospitals under public control, though there remained approximately 60,000 beds in almost 400 Poor Law type institutions (Bruce, 1966, p. 227). Changes were modest in some areas, for some counties were too small and too poor financially to provide a full hospital service. The London County Council made the most impressive progress in the country, having inherited the high-quality facilities of the Metropolitan Asylums' Board, whose well-provided hospitals had been maintained by the London Board of Guardians. Elsewhere, counties made more progress than county boroughs, as only half of the county councils shifted the Poor Law facilities to regular hospitals. After 1930, in and around London, and in a few other areas, there was considerable progress in developing a comprehensive and coordinated general hospital system; elsewhere traditional arrangements and arbitrary administrative

boundaries hampered change (Political and Economic Planning, 1937, p. 17). As Peter Townsend (1962, p. 29) noted, the Local Government Act of 1929 was only a "half-hearted step" toward reform. Local councils tended to appropriate only the best Poor Law institutions to be converted into hospitals, and in some cases this exacerbated problems. Many of the chronically ill and the elderly simply had no hospital to care for them. Public Assistance Committees had to do their best with derelict buildings, many of which were substandard when they had been completed a century earlier. And by 1939, they still were responsible for approximately 60,000 "sick inmates."

The transition of public hospitals from the governing authority of the Boards of Guardians represented an important shift, however. Public hospitals, like any other municipal service, were now under local democratic control, with the result that they became more responsive to community needs. As there were multiple sources of revenue, however, there were numerous influences which shaped the policies of the public hospitals. The bulk of the revenue came from local rates, supplemented by block grants from the Exchequer which could be withdrawn if a minimum level of service were not maintained (Abel-Smith, 1964, p. 360; Political and Economic Planning, 1937, pp. 17, 251-252). At the same time, all public hospitals, except infectious disease institutions, were compelled by statute to recover from patients all or a portion of the cost of their maintenance. Because the statute was somewhat ambiguously worded, however, hospital authorities had considerable discretion in deciding what portion of a patient's maintenance was to be charged; but by 1930, the day had passed

when most patients in public hospitals were nonpaying (Political and Economic Planning, 1937, p. 252). Even so, as late as 1939 patients in public hospitals paid no more than ten percent of the cost of their treatment (Herbert, 1939, p. 124).

The medical staff of public hospitals exercised less authority, enjoyed less freedom, and had fewer opportunities for pecuniary gain than doctors in the voluntary hospitals. Whereas the "honorary" in the voluntary hospital had an allotment of beds and decided whether a patient would or would not be admitted to a hospital, the public hospitals were required to admit all patients coming to them. Meantime, the increase in the number of local authority hospitals required an increase in the number of hospital staff. Originally, the Poor Law infirmaries had been staffed by full-time medical officers, who were for the most part general practitioners. As medical specialties expanded, however, the local authorities found it necessary to recruit a different type of staff. Unlike the voluntary hospitals, which relied heavily on a visiting honorary staff, the public hospitals attempted to recruit a full-time salaried medical staff. Because the senior staff of the voluntary hospitals usually enjoyed a lucrative private practice, the public hospitals were unable to recruit the senior staff of the voluntary hospitals. As a result, the public hospitals appointed young doctors who were paid quite adequate salaries for their age, but who nevertheless had few chances of promotion; thus, there was not as intense competition for hospital staff positions in the public as in the voluntary hospitals. To attract consultants and specialists, the public hospitals engaged visiting consultants from the prestigious voluntary

hospitals, whose role was generally to provide "second opinions" and to conduct specialized surgery (Political and Economic Planning, 1937, p. 253; Abel-Smith, 1964, pp. 375-378; Herbert, 1939, pp. 122-125).

Even though the differences between the public and voluntary hospitals were narrowing over time, another area where there was considerable persistence in the differences between the two systems was in the type of patients. The public hospitals still had a virtual monopoly on the treatment of infectious diseases, and they also performed most of the maternity work (Political and Economic Planning, 1937, p. 253). In addition, most patients with chronic illnesses were treated in public hospitals, and it continued to be common practice for voluntary hospitals to transfer incurable post-operative and various chronic cases to public hospitals. If all the public hospital beds were occupied, extra ones were erected if necessary down the center of a ward or even in the hallway (Newsholme, 1931, p. 99). In London and other large cities, however, the public hospitals were relatively well equipped and did treat many acute cases. But in much of England and Wales, and in Scotland, the public hospitals had continued during the 1920s to focus mostly on chronic and infectious diseases, as well as maternity cases. Following the Local Government Act of 1929, the stigma of public hospitals as pauper institutions began to disappear, with the result that public hospitals acquired more legitimacy and use, and slowly began to do more acute case work.

By 1938, large general hospitals in the public and private sectors still behaved very differently. Access to public hospitals was much more egalitarian, but the quality of care was somewhat lower than that in

voluntary hospitals, partly due to the fact that voluntary hospitals had more professional staff and more revenues. Because voluntary hospitals had access to more money per bed, medical innovations diffused among voluntary hospitals more rapidly than among public hospitals of the same size. Moreover, large voluntary hospitals were more adaptive to medical innovations because they were more research oriented and had larger teaching facilities than public hospitals of comparable size.

Even though public hospitals were somewhat more egalitarian than voluntary hospitals, the voluntary hospitals were, however, somewhat more crowded than public hospitals since patients continued to shun Poor Law hospitals. Observers have long commented on the long waiting time for entry to hospitals under the National Health Service--yet there were long waiting lists prior to the Second World War as well. The prestigious London hospitals had a waiting period of at least one month at the same time that London Poor Law hospitals had many vacant beds (Levy, 1944, p. 171).

By 1939, most students of British medical care were convinced that there was a serious shortage of hospital beds throughout the country, and yet neither the public nor private sectors seemed able to remedy the situation. After 1930, there was increasing cooperation between the public and private hospital sectors, with some modest effort to engage in regional planning. But as long as the public sector was decentralized, the potential to remove regional inequities and to coordinate hospital services within and across regions was very limited. In Wales and in the north of England, the small cottage-type hospital was still the dominant model, meaning that

if patients in that part of the country wanted access to the same type of facilities available to patients in and around London, it would be necessary to travel considerable distances.

Concluding Observations

Relative to the United States, Great Britain has a higher proportion of general practitioners, as distinct from specialists, and a more egalitarian medical delivery system. Much of the explanation for these differences is in the variation of the historical evolution of the two systems. British consumers historically were much better organized in their labor unions and friendly societies than their American counterparts, and thus played a significant role in shaping the nature of medical services. In addition, because national health insurance occurred before the existence of a complex historical technology, the state had established an administrative and financial structure which encouraged large numbers of practitioners to engage in general practice. In those countries that developed national health insurance late (e.g., Sweden and Canada) or not at all (e.g., the United States), the governments did not have the financial and administrative structure to provide the incentive for a large proportion of its profession to engage in non-hospital based, general practice. It is this historical process which helps to explain why such a large portion of the British medical profession practices exclusively outside the hospital.

Although differences between the public and voluntary health sectors continued to exist prior to World War II, the history of the British medical delivery system suggests that technology alters structure, for

once there was a technology which was believed to be efficacious,
private and public medical practices--particularly in the hospitals--
began to converge.

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