PAY BEDS COMMITTEE.

REPORT

OF A

SPECIAL COMMITTEE

OF

KING EDWARD'S HOSPITAL FUND FOR LONDON.

Part I. REPORT OF COMMITTEE

WITH APPENDICES.

JULY, 1928.

LONDON:
, AND PUBLISHED FOR KING EDWARD'S HOSPITAL FUND FOR LONDON
J. BARBER & SON LIMITED, FURNIVAL STREET, HOLBORN, E.C.4, AND
CURSITOR STREET, CHANCERY LANE.

Price, 1s. *Post free, 1s. 5d.*

PAY BEDS COMMITTEE.

REPORT

OF A

SPECIAL COMMITTEE

OF

KING EDWARD'S HOSPITAL FUND FOR LONDON.

Part I. REPORT OF COMMITTEE

WITH APPENDICES.

JULY, 1928.

LONDON:
PRINTED AND PUBLISHED FOR KING EDWARD'S HOSPITAL FUND FOR LONDON
BY GEO. BARBER & SON LIMITED, FURNIVAL STREET, HOLBORN, E.C.4, AND
CURSITOR STREET, CHANCERY LANE.

ORDER OF APPOINTMENT.

I hereby constitute a Special Committee of Inquiry to be called the PAY BEDS COMMITTEE and appoint the following persons to be members thereof:—

VISCOUNT HAMBLEDEN, *Chairman.*

SIR JOHN ROSE BRADFORD,

SIR BERNARD MALLET,

MR. V. WARREN LOW,

PROFESSOR WINIFRED CULLIS,

of whom three shall be a quorum.

EDWARD P.,
President.

13*th May*, 1927.

DELEGATION OF POWERS.

Resolution of General Council, 13th May, 1927:—

That, until the Council shall otherwise direct, the Pay Beds Committee shall have the powers of the General Council with respect to the following matters, that is to say:

To inquire and report upon the question of hospital accommodation in London for persons prepared to pay more than ordinary Voluntary Hospital patients; and to report the conclusions at which they may arrive;

and such powers are hereby delegated to them.

CONTENTS.

Unless otherwise indicated, the marginal references in this Report are to the questions in the Minutes of Evidence published in Part II. The list of witnesses referred to above will serve as an index to these references.

KING EDWARD'S HOSPITAL FUND FOR LONDON.

PAY BEDS COMMITTEE REPORT.

1.—We were appointed in April, 1927, by H.R.H. the Prince of Wales, President of King Edward's Hospital Fund for London, to be a Special Committee, the following being the reference :—

"To inquire and report upon the question of Hospital accommodation in London for persons "prepared to pay more than ordinary Voluntary Hospital patients ; and to report the conclusions "at which they may arrive."

SCOPE OF INQUIRY.

2.—We have taken London to mean the area of operations of the King's Fund, which extends to a radius of 11 miles from St. Paul's.

3.—We have held 22 meetings and have examined 40 witnesses. We have received evidence in this way from representatives of Hospitals, including some which have pay beds, some which have schemes for providing them, and some which have neither ; from medical men, both from Hospitals and from the great medical societies, the Colleges of Surgeons and Physicians and the British Medical Association ; from the Charity Commission ; from witnesses who have personal knowledge of the existing provision in the United States, including Dr. Goldwater, who came over specially for the purpose ; from witnesses who are connected with schemes to assist members of the middle and professional classes to make provision for the expenses of illness in advance ; and from others who have direct knowledge or interest in the problem from the side of the Hospitals or from that of the prospective patients.

4.—We addressed a questionnaire, a copy of which will be found in Appendix I, to the Hospitals. The primary object was to obtain information about the existing accommodation and procedure at Hospitals which had made provision of the kind under discussion, and also similar information about schemes for making such provision in the future. At interviews with witnesses from Hospitals the replies served as a written précis of evidence. A considerable part of the information is tabulated in Appendices II and III.

5.—The information thus obtained from the Hospitals introduces almost all the principal questions that have arisen in the course of the Inquiry. It introduces them in the way in which they have arisen in actual practice, and illustrates the various solutions that have been adopted. We propose, therefore, to summarise under each heading the experience of the Hospitals themselves, before going on to discuss the personal opinions of witnesses or to express our own views. This method of approach is in accord with the spirit of the voluntary system and of the King's Fund. Under that system, statements of principle are not formulated by any central authority which imposes a policy on the separate Hospitals. Each Hospital is free to act on its own judgment. When the time comes for the King's Fund to take up a subject as a central body for the Hospitals, it begins by studying the actual practice at the various institutions, and not by laying down any *a priori* doctrines.

6.—Amongst the questions that emerge in the actual practice of the Hospitals are the following :—

(A) Definition of "persons prepared to pay more than ordinary Hospital patients."

(B) Present provision of Hospital accommodation for such persons ; the nature of the present accommodation, and its relation to the ordinary work and finance of the Hospitals.

(C) Hospital charges for maintenance and for special services, and the relation of maintenance charges to cost.

(D) Medical fees.

(E) Arrangements for medical attendance.

(F) Classes of patient treated.

(G) Demand for further provision.

We shall also have to consider :—

(H) Methods of supplying this demand, including the schemes of Hospitals for adding to the present provision.

(K) Methods of providing for cost of maintenance and cost of building, including insurance schemes for enabling prospective patients to make provision in advance ;

and various other points arising out of the Inquiry.

DEFINITION OF PERSONS PREPARED TO PAY MORE THAN ORDINARY VOLUNTARY HOSPITAL PATIENTS.

7.—During recent years there has been a considerable extension, both of the classes included amongst Voluntary Hospital patients and of the payments made by ordinary patients. There was a time when the Hospitals were only called upon to provide comparatively simple treatments for the necessitous poor, which meant those who were unable to pay for medical attendance. With the development of expensive methods of treatment and diagnosis, large numbers of the middle and professional classes are now unable to pay the full cost of these services, some of which, according to our evidence, are often difficult to obtain outside the Hospitals. At the same time, experience has shown that large numbers of the ordinary Hospital patients are both able and willing to contribute towards their cost. At present, therefore, there is a demand for Hospital treatment from several different classes which may be grouped into three : first, those who cannot afford to pay anything, and who receive when in the ordinary wards free maintenance and treatment ; second, those who can and do contribute according to their means towards their cost of maintenance in the ordinary wards, though still receiving free medical attendance from the visiting staff of Physicians and Surgeons ; third, those whose standard of living causes them to desire better accommodation, or at all events more privacy, than is provided in the ordinary wards, and who are prepared to pay for it according to their means, and also to pay something for medical attendance. Beyond these there is a fourth class, those who can afford to obtain their treatment in private nursing homes and to pay full medical fees.

cf. 1624–8 1675

par. 108

cf. 1148

Definition of ordinary patients.

8.—Under our terms of reference, the subject-matter of our Inquiry begins with the dividing line between the second class and the third, and the position of this dividing line is to be sought in the amounts which ordinary Voluntary Hospital patients are now normally prepared to pay. According to the replies to the questionnaire, the highest payment normally received from patients in the ordinary ward, taking the Hospitals generally, appears to amount to somewhere near £2 2s. a week, the average payment being of course much lower, more like 15s. even when the free cases are omitted. Some Hospitals give the highest normal figure as high as £3 3s., some as low as £1 1s. If these payments are compared with the charges for pay beds quoted below, it would appear that patients able to pay £3 3s. would be near the borderline ; 3 guineas being a high amount to be received in an ordinary ward, but a low charge for a private ward. This does not mean that all patients paying 3 guineas or more ought necessarily to have special accommodation, irrespective of the relation which 3 guineas bears to the cost at the Hospital. It only means that they are, as a matter of fact, paying more than patients ordinarily pay, though not necessarily more than, or even as much as, the cost of their maintenance, which differs at different Hospitals.

App. I, Q. 19

par. 39 and App. II col. 6

1156

9.—Another general indication of the upper boundary of the "ordinary Voluntary Hospital patient" may be found in the income limits of the Hospital Saving Association. This is a body which, by agreement with a large number of co-operating Hospitals, organises workshop collections all over London on the basis of 3d. per head per week. Its members thus make provision beforehand, by a kind of insurance, to cover the amount they would be asked to contribute. When they or their dependants attend a co-operating Hospital, they are excused from Almoner's inquiries into means, which are designed to protect the Hospital and its medical staff against abuse. They are also exempted from requests for patients' contributions, and the Association makes a payment to the Hospital in respect of their maintenance. The income limits for membership of the Association are thus recognised as a sufficient test of suitability as an ordinary Hospital patient. These income limits are £4 a week for a single man or woman,

£5 for married couple without children under 16 ; £6 for married couple with children under 16. On this standard, therefore, persons prepared to pay more than ordinary Hospital patients may be regarded as including persons earning more than £6 a week, or £300 a year, with a rather lower limit for single men or women without dependants. This may be compared with the salary limit of the National Insurance Acts, which for non-manual workers is £250 a year.

Definitions of pay bed patients.

10.—A further guide may be found in the income limits or other definitions or descriptions given by witnesses from Hospitals that provide, or have definite schemes for providing, special beds for pay bed patients.* Taken together, these descriptions cover a fairly wide range, because, as will be seen later on, there are considerable differences in the style of accommodation, the arrangements as to medical fees, and the rates of charge. Differences in family liabilities are also taken into account. Thus, amongst the Hospital limits that have been mentioned, for those above £250 or £300 a year, are the following :—

413

410-2, 457-8, 534 (A) from £400 to £800 or £1,000 a year, but mostly between £400 and £500 ;

(B) up to £1,500 a year ;

392 (C) from £400 to £1,000 a year ;

App. II, No. 15 (D) up to £350 for a single man or woman, or £500 if married, plus £50 for each dependant ;

App. II, No. 58 (E) up to £700 a year ;

468 (F) those who can afford, for example, up to £50 in all (*i.e.*, Hospital charges and whatever is paid in medical fees) ;

1480, 1488, 1513 (G) those who can pay 5 or 7 guineas a week and a reduced medical fee not exceeding 50 guineas but no extras, these being the proposed charges for a scheme to be confined to the class immediately above the Hospital class.

Income scales which have been mentioned by other witnesses have included :—

1129 (H) those who had between £250 to £800 or £900 ;

1311 (K) those able to pay a total Hospital charge of 21 or 28 guineas for the whole period of stay, besides extras and a doctor's fee ; and

App. VII (L) a scale of reduced medical fees, published in the *Lancet* on July 17th, 1920, under which at one end persons with £350 a year would pay 10 per cent. of normal operation fees and 25 per cent. of consultation or nursing home fees, while at the other end persons with just under £1,500 a year would pay 60 per cent. and 100 per cent., respectively.†

392, 455–7, 516-8, 779-81, 897, 1129 Descriptions by witnesses have included the following: Artisans earning more than £5 a week, small shopkeepers, smaller salaried clerks, clergy, retired officers, retired civil servants, professional men, the "new poor" whose income has shrunk since the War.

Some special classes.

11.—Generally speaking, it is for the class thus defined and described that the question of Hospital provision in special pay beds has arisen. There is, however, a certain amount of overlapping between this provision and the ordinary wards on the one hand, and the private Nursing Home on the other.

12.—In the first place, a certain number of patients of this class are treated in the ordinary wards of the Hospitals which have no special pay beds. Some Hospitals, in reply to the question what is the highest payment normally received from ordinary patients, quote figures considerably above the £2 2s. or even the £3 3s. already mentioned—for example, £3 15s., £4 4s., or £4 5s. These are reported as exceptional, and evidently refer to patients

1150 1228 who pay more than the ordinary occupants of the general wards, and in fact pay what is regarded as being their full cost of maintenance in the ordinary wards. In the scale which serves at

1237-8 the London Hospital as a rough guide to the assessment of ordinary patients, a figure has

* The term "pay bed patients" is suggested by the title of the Committee. The alternative "paying patients" is ambiguous now that so many ordinary patients contribute according to their means, while "private patients" is often used for patients in single rooms, or for the patients in the private practice of members of the medical staff.

† The lower parts of this scale have been adopted at the Freemasons Hospital, which provides beds at £3 3s. a week for members of the craft who would otherwise be ordinary hospital patients but prefer to pay these charges and fees for the special accommodation ; as well as a few beds at rather higher rates. The income figures are adjusted by deductions for dependants.

999

1660-4

recently been added for persons earning up to £400 a year, and 1·3 per cent. of all the patients pay between 3 guineas and £4 10s. These include cases for which Physicians or Surgeons of the Hospital particularly requested a bed, or casualties or other emergencies brought in. This often occurs at Hospitals, and clearly these patients come within our definition. We have it also in evidence from various Hospital witnesses that the provision of pay wards has the effect of releasing beds in the ordinary wards that would otherwise be occupied by patients of the class we are considering.

30, 160, 356, 475, 514, 612, 1245, 1262, 1559, 1756

13.—In the second place, below the income limits mentioned above there are a number of persons who, from upbringing and normal mode of living, desire special accommodation, but who nevertheless are not, in time of sickness, able to pay more than ordinary Hospital patients can now pay, if as much. For these a certain amount of special provision has been made. At some Hospitals they are admitted to special wards free or at very low rates. We shall regard this provision as coming within the scope of our Inquiry.

14.—In the third place, our terms of reference place no upper income limit to the classes of persons to be included in the Inquiry. The question whether the Voluntary Hospitals should provide special beds at full rates, for patients who can afford to pay for the most expensive kind of private Nursing Home accommodation, comes, therefore, within our sphere. We have evidence, oral and written, on the provision that is made for patients of all classes at Hospitals in the United States and in other countries. One or two Hospitals in London have a small number of beds for which high prices are charged. The question whether this provision should be extended will be discussed.

798–895
1352–1477
App. IX

par. 149

Relative numbers.

15.—We have not ourselves been able to obtain any estimate of the relative numbers of the different classes we have mentioned. An estimate submitted in evidence by the British Provident Association gave the following figures for London, based largely on the census and on National Insurance figures: Ordinary Hospital patients, free and contributing, $5\frac{3}{4}$ million; middle and professional classes, $2\frac{1}{2}$ million (or 600,000 families); well-to-do, 250,000; out of a total population of 8,500,000 for Greater London.

922, 931, 936

Origin of demand for Hospital accommodation.

16.—The demand for special Hospital accommodation on the part of the persons who come within our definition arises partly from inability to pay the charges of Nursing Homes, and partly from the fact that it is often difficult to find, outside a Hospital, the facilities for diagnosis and treatment, and for immediate medical attendance in the event of an emergency occurring during treatment, which the ordinary Hospital patient receives at a Voluntary Hospital. Members of the middle and professional classes, who have subscribed or do subscribe to Hospitals, now often feel that in time of sickness they themselves cannot obtain the modern facilities for treatment which they are helping to provide for the ordinary Hospital patients. What actually gave rise to our present Inquiry was a report by the Propaganda Committee of the King's Fund that they had been met with this argument when advocating the claims of the voluntary system. We have not been informed by any of the Hospitals without pay beds that their appeals for funds have come up against this objection. But there has been general agreement amongst Hospitals which have such beds that their popularity has been increased thereby.

1742 but cf. 1761

32, 128, 255, 434, 530, 686, 985, 1759, but cf. 1667, 1687

17.—There is no doubt whatever that the demand is a very real one. We have had practically unanimous evidence to this effect from members of the medical profession, from the Hospitals, and from numerous professional associations to which we addressed inquiries on the subject. As will be seen from the various income limits quoted above, the demand comes from several different sections of society, ranging from those just above the income limits of ordinary Hospital patients up to and even including the quite well-to-do. There is, therefore, a demand for different kinds of accommodation at different rates of payment. The Hospitals have already provided a considerable number of beds at different rates. To be in a position to discuss the demand that still remains unsatisfied, it is necessary first to study the experience of the Hospitals that have already made this provision, or have definite schemes for doing so. We shall, therefore, proceed to consider the existing supply, and shall return later on to the question of the nature and amount of the unsatisfied demand.

par. 88

PRESENT HOSPITAL PROVISION FOR SUCH PATIENTS.

Statistics of existing pay beds.

18.—The number of Hospitals which replied to the questionnaire was 150, and the total number of available beds in those Hospitals at March 31st, 1928, was about 15,600. Of these, the number of Hospitals that provided special beds for persons other than ordinary
App. II Hospital patients was 80, and the number of such special beds was 1,055.*

19.—This figure includes those specially provided, free or at a low charge, for middle class patients in straitened circumstances; but does not, of course, include beds in the ordinary wards that happen to be occupied by patients who could afford a private ward if one was available at the Hospital in which they are being treated.

20.—Of these 1,055 beds, 164 are provided by 6 of the 12 General Hospitals with Medical Schools; 358 by 22 out of 32 other General Hospitals with Resident Medical Officers; and 126 by 20 out of 22 Hospitals without Resident Medical Officers. The rest are provided by Special Hospitals of one kind or another: 127 by the 8 Hospitals for Women; 28 by 3 out of 13 Children's Hospitals; and the other 252 by other Special Hospitals.†

21.—If the beds are grouped according to geographical situation, it will be found that 477 are within 3 miles of St. Paul's; 429 between 3 and 7 miles; and 149 between 7 and 11 miles.
App. IV The innermost zone contains most of the beds in Special Hospitals; the outermost contains mainly beds at small Hospitals without Resident Medical Officers, but also a few Hospitals with Consultant Staffs.

22.—Of the total number of beds, 200 are reported as being for men; 322 for women; and 36 for children; while 497 are not differentiated. The following are earmarked for specialities: maternity, 18; gynæcological, 33; obstetric or gynæcological, 3; ear, nose and throat, 17; fever, 24; genito-urinary, 2; heart, 1; ophthalmic, 5; rectal, 26; consumption, 43; skin, 6; venereal, 2; nervous diseases, 40; orthopædic, 7; stone, 6; tropical diseases, 50.

Different kinds of accommodation.

23.—The beds may also be classified according to the differences in the kind of
App. II, col. 5 accommodation, particularly in the amount of privacy. There are single-bedded private rooms
8 where the patient is completely secluded. There is one-bed accommodation which consists
170 of a separate room in every respect except that the front is filled in with a sliding curtain instead of a wooden door. There are single-bedded cubicles where a ward is divided by partitions which do not reach the ceiling, the front of each cubicle being closed by a curtain. There are
957–64 small wards of from 2 to 8 beds, sometimes divided, or divisible, by curtains or screens; and
305–6 sometimes larger wards of 12, 15 or even 24 beds, with permanent or temporary curtains, so
512 as to provide a certain degree of privacy either at the wish of the patient, or while he is receiving special attention or has visitors.

24.—If the total number of beds is sub-divided on these lines, there are 546 beds in single rooms or cubicles, with permanent partitions on at least three sides; 106 in 2-bed wards; 207 in wards of from 3 to 8 beds, and 196 in wards of more than 8.

25.—Taking each class of Hospital separately, the General and Cottage Hospitals have 413 single-bed wards or cubicles; 64 beds in 2-bed wards; 76 in wards of 3 to 8; and 95 in larger wards. The corresponding numbers for the special Hospitals, including those for women and for children, are 133, 42, 131 and 101 respectively.

26.—The pay bed accommodation usually has other privileges over the ordinary wards.
83–4, 172 There is sometimes a larger nursing staff, or a larger proportion of qualified nurses to probationers,
219, 72 or a staff consisting entirely of qualified nurses; sometimes a special staff. Diet is often fuller, or presents more choice: this frequently takes the form of an evening meal instead of the
672 light supper in the ordinary wards. Occasionally there is a separate kitchen, or at least different utensils and separate cooking. Eleven Hospitals, including 7 in the suburbs, report no difference in diet. Superior crockery, equipment and furniture are sometimes mentioned.

* These do not include King Edward VII.'s Hospital for Officers, or the Freemasons Hospital. There are also pay beds at institutions which are administered by religious bodies, and have not the ordinary constitution of a Voluntary Hospital; and there may be pay beds at Hospitals which are not on the books of the King's Fund, and about which no information is available.

† For an explanation of the grouping of the Hospitals, *see* note to Appendix II (note * on page 42).

Visitors are usually permitted more often—once or even twice a day instead of once or twice a week. Some Hospitals provide day rooms for convalescents, or part of a cubicle ward is fitted up for this purpose. Two Hospitals report separate operating theatres.

59, 61
170

27.—We received some interesting evidence about the relative popularity of different kinds of accommodation, often from Hospitals that have experience of more than one kind. Some patients prefer the privacy of single rooms, and will pay extra for it. Some prefer the semi-privacy of a cubicle, without the feeling of being entirely shut away. They like to make visits from one cubicle to another, while at the same time the solid side wall, instead of a curtain, secures privacy when desired. Hospitals where this is not carried to the ceiling say there is more ventilation and a lower cost of maintenance. Some patients prefer the large general ward for the sake of company, at all events after they have tried it, or have tried both. It is a relief to see visitors coming and going, and anything else that occurs. Where a ward has curtains or screens, they are often drawn back most of the time. Small wards of 3 or 4 beds are often liked, but the 2-bed ward is sometimes said to be unpopular, except where cheapness is a consideration. According to some witnesses the Doctors also have preferences. Some think the open wards are better, if there are also single rooms to which patients can be removed for quiet. Some like the patient to have a single ward just after an operation, but to be transferred to a cubicle or open ward later on, because convalescents encourage each other. Others, on the contrary, find that convalescents are too much given to discussing their complaints.

242, 513, 722
1076–7
963
62
63
187
513, 1691, 64
733
339
242, 946
735
1021
63, 59

28.—The experience of New York, as reported to us by Dr. Goldwater, is that a few years ago there was a great demand for private rooms as distinct from larger wards, but that in practice these proved too expensive to be run without a charge on the general funds of the Hospital. The result has been that, while the wealthier patients demand single rooms, which grow more and more elaborate, small wards of 2, 3 or 4 beds are provided for those who do not pay their full cost.

1385–6
1416–7
cf. par. 41

Statistics of patients treated.

29.—Complete statistics for the year 1926 are obtainable for 847 pay beds at 61 Hospitals The number of patients admitted to these was 10,607, or about 13 patients per available bed. On this basis the 1,055 beds would treat about 13,000 patients a year. The average daily number of occupied beds was 71 per cent. of those available. If sub-divided according to the class of Hospital the daily occupation was as follows: At teaching Hospitals 82 per cent.; at other General Hospitals with Resident Medical Officers 68 per cent.; at the Hospitals without Resident Medical Officers 60 per cent.; at Hospitals for Women 68 per cent.; and at other Special Hospitals 74 per cent. We refer later on to the bearing of these percentages on the question of supply and demand.

App. II, cols. 12–14
par. 92

Origin and history of existing pay beds.

30.—Of these 1,055 beds here described, 494, or nearly one half, date from before the War. The earliest year mentioned in the replies is 1850, when the Florence Nightingale Hospital was founded. Since 1920, 465 have been added. During the same period the ordinary beds have increased by about 1,600. In 1920 there were about 12,900 ordinary beds and 590 pay beds; there are now about 14,500 ordinary and 1,055 pay. In 1920 the pay beds were 4 per cent. of the total beds; they are now 7 per cent.

Relation to ordinary hospital work.

31.—In most cases the pay beds are not in a separate self-contained block. Sometimes they were originally intended to be part of the general wards, but were temporarily devoted to the special purpose because the Hospital had not sufficient funds to open them, or to keep them open, for ordinary patients. Sometimes special wards or rooms have been added. Sometimes rooms vacated as the result of extensions have been converted into pay wards. This may result in the pay wards being scattered about in different parts of the Hospital. Sometimes they have been specially built as a separate wing or a separate floor. Sometimes each general ward has one or two private wards amongst the annexes opening out of the corridor which connects it to the main building or to the main corridor. It has become increasingly common for extension schemes to include the provision of pay beds in one or other of these ways.

584
635
385
420, 1243
671

32.—The pay wards, especially when attached to general wards in the manner last

mentioned, are not always kept quite distinct from the general work of the Hospital. At
678–9 some Hospitals they are also used as separation wards for ordinary patients, and sometimes
976 they are regarded as available for ordinary patients in times of pressure, or when not in use by pay bed patients, or even as preferentially available for that purpose.

33.—There are also differences from the financial point of view in the original relations between the pay bed department and the rest of the Hospital. Where the pay beds are part of the original Hospital, their capital cost was of course provided from the same source as the rest of the building, and the Hospital Authorities have satisfied themselves that the accommodation can properly be used for this purpose. The same applies to cases where the beds have been built out of the general funds of the Hospitals. Such arrangements may in certain
1622, 1636 circumstances require the sanction of the Charity Commissioners, who may grant permission temporarily and renew it from time to time, if satisfied that the primary purpose of treating the sick poor is being carried on at least up to the extent intended by the trust deeds. The recent additions to the existing provision have more and more frequently been built out of the proceeds of appeals for extension schemes which have specifically included the provision of pay beds as part of their objects, or occasionally out of funds given specially for the purpose.

PRESENT HOSPITAL CHARGES.

34.—The total payments which have to be made by the patient in one of these pay beds may be considered under two heads, which are usually kept quite separate: Hospital charges and medical fees. Hospital charges include the regular weekly charge, often described for convenience as the charge for maintenance. There may also be extra charges for certain services supplied by the Hospital. Medical fees consist primarily of the payments to the Physician or Surgeon for his treatment of the case. In addition to this, certain of the extras are frequently included, not in the Hospital charges but in the medical fees.

Weekly charges for maintenance.

35.—The weekly charges at the different Hospitals vary over a wide range. This is partly due to differences in the character, size and situation of the different Hospitals. It is partly due to the differences in the kind of accommodation provided, in the circumstances of the patients catered for, or in the cost of maintenance of the particular kind or kinds of accommodation provided.

36.—There may be different charges at the same Hospital, either because it provides
App. II, col. 6, and App. V more than one kind of accommodation, or because it adapts its charges, within limits, to the circumstances of the patients. Some Hospitals quote maximum and minimum rates between which the charge may vary for one or other of these reasons. Other Hospitals quote a single figure for a particular kind of accommodation, or for each particular kind if they provide more than one. Some of these, however, are prepared at times to admit patients who cannot pay the full amount; and at some a higher rate may be quoted to those able to afford more.

37.—Out of 851 beds with fixed charges,* 451, or rather over 50 per cent., are at rates
App. V Table A of from 4 to 5 guineas; namely, 276 at 5 guineas, and 175 at 4 guineas. Below these there are 160 at 3 guineas, and 30 at 2 guineas. Above them there are 158 at 6 guineas, 37 at 7 or 8 guineas, and 15 where the charges are 9 or 10 guineas.

38.—The 194 beds which have more than one price are naturally less easy to classify.
App. V Table B At 92 of them the charge may be as low as 2 guineas or even less, though it may be as high as 3, 5 or even 7 or 8 guineas. At 40 of them the charge may be as high as 10 guineas or more and is never less than 7 guineas. If we again take the rates of 4 and 5 guineas, we find that at these Hospitals these prices occur in connection with 106 beds, or about 54 per cent., one or other of these charges being the maximum for 44 beds, and the minimum for 13.

App. V Tables C, D 39.—If the fixed charges and the ranges of charge are added together, the latter being taken at the mean rate, we get the following aggregates. Out of all the 1,045 beds for which charges are made, there are 557 at from 4 to 5 guineas, and 158 at 6 guineas; there are 230 cheaper beds, at 3 guineas or less; and 100 more expensive beds, at 7 guineas up to 10 guineas or more.*

* For the purpose of the summary in paragraphs 37 to 42, rates at odd half-guineas (as shown in Appendix II, col. 6) are included with the next higher guinea; and the 10 free beds for priests and nuns at the Hospital of St. John and St. Elizabeth are omitted.

Charges at different kinds of Hospital.

App. V Table C

40.—If these charges are classified according to the size, character and situation of the Hospital, the following results emerge.* The teaching Hospitals have no beds below 5 guineas, 78 at that price, 62 at 6 guineas, and 24 at 8, 9 or 10 guineas. The other General Hospitals with Resident Medical Officers have 108 beds at 5 guineas, 53 at 6 guineas, and 28 at from 7 to 10 guineas; while there are also 64 at 4 guineas and 95, almost all suburban, as low as 3 guineas. With the Hospitals without Resident Medical Officers, which also are mostly suburban, the range of charges is lower. There are 50 beds at 4 guineas, 43 at from 5 to 7 guineas, and 33 at 3 guineas or less. The other Hospitals, those for women, or children and for special diseases, show a still wider range, having 72 beds at rates averaging as low as 2 guineas (of which 26 are for women), 44 beds at 3 guineas, 121 and 110 at 4 and 5 guineas, respectively, and 13 at 7 guineas, besides 24 at the London Fever Hospital at higher rates.

Charges for different kinds of accommodation.

App. II, col. 6, and App. V Tables E, F

41.—The rates of charge vary also with the kind of accommodation provided. Amongst the teaching Hospitals it is possible to obtain single-bed accommodation in the form of a cubicle, with side walls or partitions and curtains in front, for 5 guineas. If St. Thomas's with curtains instead of doors are regarded as rooms, private rooms cost 6 to 10 guineas. At the other larger General Hospitals private rooms or cubicles are available at 5 or 6 guineas, though they may cost as much as 8, 10 or even 15 guineas, and very occasionally 4 guineas, though there are several at 3 guineas. At the smaller Hospitals they range from 7 guineas down to 3. At the special Hospitals the range (apart from the expensive private rooms at the London Fever and the 2-guinea rooms at the London Lock) is from 7 guineas to 3, the largest number, especially at the Women's Hospitals (at some of which medical treatment is free) being at 4 or 5 guineas. Taking all the Hospitals together, out of 536 single beds, 139 are at 6 guineas, 166 at 5, and 78 at 4; 53 are at less than 4 guineas and 100 at more than 6 guineas.

App. V Tables G to K

42.—Of the 106 beds in 2-bed wards most are at from 3 to 5 guineas, though one of the teaching Hospitals has a small number at 6 guineas. The wards with from 3 to 8 beds are more popular. They contain 207 beds in all, of which 140 are at 4 or 5 guineas and the others at 2, 3 and 6 guineas. Larger wards, when not divided by curtains, are usually at 3 guineas, while if with curtains, as at King's College Hospital, they may be 5 guineas.

Relation of present weekly charges to cost.

43.—In fixing these weekly charges, each Hospital appears to have been influenced by one or other or both of two considerations: the cost to the Hospital and the means of the prospective patients. At some Hospitals the charge, for some or all of the pay beds, is deliberately fixed below cost, with the object of providing for a class who, it is held, can properly receive partial assistance from the Hospital funds. In some cases the charge is fixed at the amount which it is estimated will just cover expenses, with the result that the classes actually catered for do not include those who cannot pay at least that amount. In a few cases the charges, for some or all of the pay beds, are designed to be above cost; the Hospital is then catering for a class from whom it can and does make a profit, and the profit is used either to meet the deficit on the pay beds whose patients do not cover their cost, or to help the Hospital to meet the expenditure on its ordinary wards. We shall discuss at a later stage the classes of patient who are actually admitted, after we have finished our account of the existing provision; and we shall confine ourselves at this point to the question of cost.

44.—The difficulty most Hospitals have in stating the cost of their pay beds arises from the fact that they do not keep separate accounts for this department of their work. A complete system of departmental costing would automatically disclose to the Hospital management the cost of the pay beds. Such a system has often been advocated by the King's Fund and others as the ideal method for comparing economy of management at different Hospitals and for securing internal control of expenditure. In the case of pay beds, as with any other department which, either wholly or as part of its function, undertakes work for which the Hospital expects to be paid, it would have the additional advantage of enabling the appropriate charges to be accurately determined. But departmental costing, even for these branches of work, is still very incomplete, though its outlines have been described by the King's Fund in the recent edition of the Revised Uniform System of Hospital Accounts.

* *See* note on page 7.

45.—Where a Hospital has more than one grade of pay beds with more than one rate of charge, there is the additional difficulty of sub-dividing the cost of the whole department so as to show which of the beds are making a profit and which are being run at a loss; and consequently which of the different classes of paying patients are self-supporting and which are being helped by their fellows or by the general funds of the Hospital.

46.—In the absence of separate accounts, the general idea on which the Hospitals appear to have worked is that the cost of the pay beds will be the average cost of the ordinary beds, with the addition of a sum, which would not be very large, to cover the extra services or amenities provided for the paying patients, and the extra work that may be involved in single rooms or small wards as compared with large general wards.

522–4

Estimates of maintenance cost.

47.—The estimates given in evidence showed considerable variation, due partly to the above-mentioned uncertainties and partly to the different circumstances of different Hospitals. Thus in relation to Teaching Hospitals it has been suggested that 5 guineas is the lowest possible charge; that this sum just covers expenses without allowing anything for rent or administration; that 6 guineas just meets the actual cost; that with 10-guinea and 6-guinea beds the former cover the rent on the latter; that 5 guineas just covers the cost in a curtained general ward, as also does 8 guineas in a private room, while 6 guineas in a 2-bed ward makes a small profit; that private rooms at 7 guineas would not pay if interest on capital was included, but that 5 guineas in cubicles might be possible; and that a flat rate of 7 guineas a week in private rooms or 5 guineas in 4-bed wards, to include all extras, is expected to cover expenses without allowing anything for capital charges. Witnesses from Hospitals without schools quote rather lower figures. At one Hospital with beds at 4½, 5 and 6 guineas, it is estimated that the 4½-guinea beds do not pay, but that the 5 and 6-guinea make up the loss; at another, where the charges are 4 and 5 guineas, it is believed that the 4-guinea just cover expenses, and the 5-guinea give a balance sufficient to cover rent. Another witness, with experience of beds at £2 10s. and 8 guineas, considered that private beds at 4 guineas could not pay. As regards a cheaper class of bed, one of the smaller suburban Hospitals told us that the charges had been fixed at £3 3s. to £5 5s., and that the average cost in the ordinary and private wards combined was £3 2s. 3d.

26
106
6, 351
510
1295, cf. 1348
1483–4, 1554
199, 239
399–405
607
663

48.—In order to supplement these estimates, we asked the Hospital Economy Department of the King's Fund to go into the whole question of cost. A summary of their report is printed as an Appendix. While emphasising the great differences in the figures, and the difficulty of arriving at any uniform basis, it suggests that at the Teaching Hospitals the average maintenance cost is in the neighbourhood of £6 a week, and in the other Hospitals from 4½ guineas down to 3 guineas. These figures cover current maintenance and some of the services which are frequently charged as extras. If they are compared both with the range of the estimates quoted above and with the range of weekly charges at the different groups of Hospitals, it would appear that in a great many cases the charges do approximately cover the cost of maintenance; or, in other words, that a large number of the patients pay their way as regards current expenditure, and are only in receipt of financial assistance from the Hospital in the fact that the accommodation is provided for them free of rent or interest on capital expenditure.

App. VI part 1

Estimates of capital cost.

49.—The amount of the capital expenditure involved is also discussed in the Report of the Hospital Economy Department. Here again the difficulties of arriving at any general conclusion are great, and the estimates differ enormously with the circumstances. The figures that have been mentioned range from something less than £400 a bed to more than £2,000. It would seem, however, as a general conclusion, that it may be roughly estimated that a complete pay bed Hospital could be built and equipped for something less than £1,000 per bed exclusive of site. Where pay beds are added to an existing Hospital, the cost would be only a proportion of the cost of a complete unit, ranging from 25 per cent. for wards alone (without any annexes) up to any higher percentage, according to the amount of other accommodation that had also to be provided. If, however, in comparing Hospital charges and cost it is desired to take into account capital expenditure or the interest thereon, it does not follow that in such cases the only item to be considered is the outlay on the additional building, irrespective of the share obtained by the pay bed patients in the facilities provided by the existing buildings.

App. VI, part 2

cf. pars. 129, 147

Extra charges for specific services.

50.—In addition to the weekly charges which we have been discussing, the Hospital usually makes extra charges for certain specific services. The number of services which are not covered by the weekly charge differs at different Hospitals. Sometimes extra payment is only required when the service is special. The services for which the patient most often pays are: anæsthetist (65 Hospitals out of 80); X-rays (61); extra nurses (56); pathological examinations (52); massage (48); electrical treatments (39); operating theatre (35); radium (33); special drugs and dressings (32); and light treatment (27). In the case of anæsthetists the charge is included in the medical fee at 59 Hospitals out of the 65. At 34 Hospitals the charge for pathological examinations is part of the medical fee. In three or four of these cases the Hospital collects the fee and passes it on. Very occasionally the services of a Resident Medical Officer are charged for as an extra, when he deputises for the Surgeon. The number of extras charged for at individual Hospitals, whether paid through the Hospital or as part of the medical fee, are indicated in the Appendix. They vary from none up to as many as 10, the average being between 5 and 6. Where these extras are included in the Hospital bill the payments are not always retained by the Hospital; they are often passed on to the operator or to some outside agency.*

Total cost to patient.

3110
1557
cf. 1323
1514
1243
467, cf. 567

51.—The question of the total charges to the patient is of some interest: this is often what the patient wants to know. It is for this reason that the Middlesex, for instance, propose to have flat rates of weekly charge which shall be sufficient to cover, on the average, all specific services whether required by the individual patient or not; and a maximum medical fee irrespective of the length of stay. At the West London about 75 per cent. of the patients are assessed by the special Committee at a total inclusive amount including medical fee.† A similar basis may be adopted elsewhere by individual medical men in fixing their fees. The average amount of the Hospital bill presented to a patient (as distinct from medical fees) has been put by individual witnesses at 17 or 18 guineas in beds at 4½ to 6 guineas; 20 guineas in 6-guinea beds for surgical cases or 18 guineas for medical, £12 15s. 6d. in 5-guinea beds, £16 4s. 2d. in 6-guinea, and £26 16s. in 8-guinea. But these are averages, not maxima.

221
319
509

pars. 121–31

52.—The question of the proper relation of Hospital charges to cost will be discussed in a later section. We have here merely summarised the facts.

MEDICAL FEES.

53.—But the Hospital charges are frequently only part of the cost to the patient, for in a typical voluntary Hospital one of the chief differences between the pay wards and the general wards is that in the pay wards the Physicians and Surgeons often receive fees from the patients, while in the general wards they do not. Now that so many of the ordinary Hospital patients contribute towards their maintenance according to their means, and may even pay their full maintenance cost if able to do so, the differences between the general wards and the pay wards in the matter of accommodation provided and the amounts paid to the Hospital may become little more than differences in degree. But the difference between wards where the actual medical treatment is provided by the honorary medical staff of the Hospital free of charge, and wards where the Doctors receive private fees, is one of principle.

App. II, col. 7

54.—At most of the Hospitals with pay beds in connection with which medical fees may be paid, the question of the amount of such fees is regarded as being one for the patient and the particular Physician or Surgeon, and not for the Hospital. The fee is paid separately, and does not appear on the Hospital bill.

55.—As, however, pay beds are generally intended for people of moderate means, it is usually contemplated that the medical fees, like the Hospital charges, will be on a modified

* The figures are (for 10 services, other than R.M.O., at 80 hospitals or 800 possibilities):—

1. Extra charge made for service, when required,		
(*a*) whether ordinary or special	405	
(*b*) only if special	43	
		448
2.—No charge made		211
3.—No information or no such service		141
		800

† A percentage of the assessed medical fee is then deducted for radiologist and pathologist.

scale. There are several varieties of practice, according to the extent to which the Hospital aims at this result and formulates procedure for securing it.

581 91-3, 1485 1512 223-9 675 731-2 951-5 App. II, col. 7 1486 407-15 450-2 1243 1516 467-8 974

56.—Where the pay beds are definitely on nursing home lines at full charges, the physicians and surgeons can likewise charge full fees. Where the Hospital charges are lower there is generally an understanding that the average fees will be lower than those charged to patients in nursing homes. The amount of the fee is usually arranged between patient and consultant, often through the general practitioner, taking into account family circumstances. But the Hospital takes no responsibility and has no official cognisance, even where the patient's circumstances are inquired into by the Hospital before admission. Sometimes the medical staff agree between themselves on a scale of fees or on a maximum which will not be exceeded. Sometimes the Hospital draws up a scale or fixes a maximum. Occasionally the rules of the Hospital provide that the Hospital shall itself assess or approve the fee, either through its secretary or almoner or by a special committee, on which the medical staff may be represented. The Hospital may even assess the patient at an inclusive charge, and allocate part of this to the Hospital and part to the doctor. In some cases the medical staff prefer to be relieved in this way of the task of determining the amount of a reduced fee; and even where private arrangements are the general rule, in individual cases the fee may be arranged through the resident medical officer or secretary. Finally, there are 7 Hospitals where there is a definite rule that no fees at all are to be charged for work done in the Hospital, though this is sometimes limited to the cheaper grade of pay bed, and does not prevent a charge for consultation outside before or after the stay in Hospital. Some Hospitals have reported that even where payment is the normal practice, individual patients are sometimes treated free. Occasionally, in the cheapest grade of bed, it is stated that, although payment is permitted, treatment is usually free.

App. II, col. 7

57.—The following are examples of the scales that are in force. At the West London, where the Hospital charge is 4 or 5 guineas, surgical fees range from 5 guineas up to about 40 or 50 guineas; medical fees from 3 guineas the first week and subsequently 2 guineas, up to 7 guineas weekly for three weeks. At the Chelsea Hospital for Women, which charges 5 guineas, the maximum surgical fee is 36 guineas, though there may be a physician's fee as well if considered necessary by the surgeon. At the Hospital for Women, Soho Square, where the Hospital charge is also 5 guineas a week, the maximum surgeon's fee is 20 guineas. At the Belgrave Hospital for Children, which charges 3 guineas a week, the medical staff have fixed a maximum of 15 guineas for minor operations and 30 for major. The Royal National Orthopædic has a maximum operation fee of 30 guineas paid through the Hospital, and this is usually charged only when the weekly payment to the hospital, which ranges from 4 to 6 guineas a week, is itself at the maximum. In the new scheme at the Middlesex it is proposed to have a maximum of 50 guineas; the fees will be assessed by the almoner, who will also collect them and distribute them to the members of the medical staff concerned, in accordance with a schedule to be laid down.*

par. 50 1286

58.—We have already referred to the fact that at some Hospitals medical fees cover certain services which at others are included in the weekly Hospital charge or are paid for as extras. These may include fees to anæsthetists, pathologists or other medical specialists, and to the Resident Medical Officer in the rare circumstances already mentioned. This has to be borne in mind in arriving at the total amount which a patient will have to pay, or in comparing the cost at a nursing home and at a Hospital.

ARRANGEMENTS FOR MEDICAL ATTENDANCE.

59.—The subject of the arrangements for medical attendance follows naturally on that of medical fees. It is one on which considerable difference of opinion has been expressed. The principal questions that arise are whether the treatment of patients in the pay beds should be confined to the medical staff of the Hospital concerned, and whether it should be confined to consultants or be open to general practitioners. We propose to begin as usual by describing the differences in actual practice.

par. 10 note

* For a scale published in the "Lancet," and adopted at the Freemasons Hospital, *see* Appendix VII. This is based on percentage reductions in normal fees pro rata with the patient's income.

60.—On the first question the existing practice may in most cases be described under one of three heads :—

(A) the treatment of patients in the pay beds may be confined, like that of patients in the ordinary wards, to the medical staff of the Hospital ;

(B) treatment may be open, not only to the medical staff, but also to any recognised consultant according to the definition of that term adopted at the Hospital ;

(C) treatment may be open to any registered practitioner, so that the patient has free choice of Doctor.

At some Hospitals, however, the arrangements combine more than one of these principles, and sometimes there are special circumstances which have produced special rules.

61.—The second question, in some cases, leads to a classification which cuts across the first. For while at the large General Hospitals, and at most of the special Hospitals, limitation to the medical staff means, in London, limitation to consultants, at the smaller General and Cottage Hospitals in the suburbs the staff often consists wholly or primarily of general practitioners.

62.—The question of treatment by general practitioners itself falls into two parts: treatment of the early or acute stages, including the performance of operations, and treatment of the later stages.

Limitation to medical staff.

App. II, col. 8
1492

63.—Limitation to the medical staff is in force at 4 of the 6 teaching Hospitals which have pay beds. These are King's College, Royal Free, University College (Royal Ear Department) and Westminster. At the Middlesex the same rule is proposed. It also applies to 8 other General Hospitals with over 100 beds, viz :- the Connaught, German, London Temperance, Queen Mary's, St. John's (Lewisham), Seamen's Dreadnought, West London and Woolwich ; to the Italian Hospital, to the surgical beds at the London Homœopathic ; and to the less expensive beds (but not the private rooms) at the Hospital of St. John and St. Elizabeth, the Hostel of St. Luke (for Clergy), and St. Andrew's Dollis Hill. Limitation to the medical staff also applies at the Weir Hospital and at 7 of the smaller Suburban Hospitals with general practitioners on the staff. The same limitation applies also to 7 of the 8 Hospitals for Women which have pay beds, and to 21 out of the 24 other Special Hospitals.

64.—The beds at these Hospitals total to about 640. It may be noted that they include the following where no medical fees are permitted : Italian, Elizabeth Garrett Anderson, St. Saviour's (Ladies), National (Queen's Square), Gordon (Fistula), and, as regards some of its beds, the South London for Women.

Wider choice of consultants.

App. II, col. 8

65.—The choice of Physician or Surgeon is open at St. Thomas's to consultants who are not on the medical staff of the Hospital, provided they are on the staff of one of the large General Hospitals in London. In practice, the outside consultants are usually on one of the other teaching Hospitals. Even so, only about 9 per cent. of the patients are treated by them. At Guy's, the rules admit of the same procedure, subject to the approval of the Medical Superintendent, but in actual practice the number of cases so treated is much smaller, even if those are included who are simultaneously under a Doctor of the Guy's staff and under the care of another consultant for some other disease.

38
143–5
90
89, 141

66.—Amongst the Hospitals without schools, wider choice of Consultant applies at the Royal Northern, where 25 per cent. of the 38 pay beds are available for Physicians and Surgeons attached to other Hospitals ; at the Bolingbroke ; at the Mildmay Memorial ; to operation cases at the Hampstead General ; and to patients in the private wards at St. Andrew's Dollis Hill.

229
744–6, 759–61

67.—At three of the smaller General and Cottage Hospitals with general practitioners on the staff there is free choice of consultant, though sometimes within specified limits, while subsequent treatment is confined to the medical staff. There is similar free choice of consultant at the Florence Nightingale Hospital for Gentlewomen, at the Victoria Hospital for Children, and in the more expensive beds at the Hostel of St. Luke for the Clergy.

68.—The beds to which this rule applies come to about 200.

Free choice of practitioner.

App. II, col 8

69.—Treatment is open to any registered medical man, whether consultant or general practitioner, at the pay beds of King Edward Memorial Hospital, Ealing, and Willesden General Hospital; the Hampstead General Hospital in non-operation cases; in the private wards of the Hospital of St. John and St. Elizabeth; at 12 out of the smaller General and Cottage Hospitals; and at 2 special Hospitals. This rule applies to about 160 beds. In some cases, however, the freedom of choice is subject to reservations, *e.g.*, local doctors; women doctors; consultant (if desired) to be chosen from Hospital list; approval by Medical Superintendent or by medical officer for the week.

Arguments relating to these alternatives.

70.—The differences in practice which have been described result partly from differences in circumstances and partly from differences in policy. The arguments for or against the general principle of free choice of Doctor, whether Consultant or General Practitioner, have been stated by various witnesses, including the representatives of the British Medical Association.

1162, 1696 cf. 268 1268 1124–8, 1189 but cf. 490 1328–9, 1329, cf. New York 1227, 1411–3 325, 1268 1190

71.—It is held by some that the limitation of treatment to the medical staff gives an unfair advantage, as compared with the rest of the profession, to the particular groups of medical men who are connected with Hospitals that happen to have pay beds; even allowing for the fact that the medical staff may have been regarded as having a preferential claim because they are also treating the sick poor in the ordinary wards. This objection would be increased if the Hospitals took well-to-do patients at high rates; and it has been suggested that in any event limitation to medical staff should always be accompanied by limitation of medical fees. Increase in the number of Hospitals with pay beds might render the objection less widespread, but would in other respects intensify it. Medical witnesses from some Hospitals are prepared to contemplate extension to outside Consultants if and when the number of pay beds at their Hospital is increased. When discussing the possibility of a big contributory scheme covering a wide area and associated with a large number of Hospitals, British Medical Association witnesses suggested that, in that event, presumably the patient would be given an opportunity of choosing where he would go, and that this would mean in actual fact that he chose his Consultant.

1162, cf. 76 1236

72.—Quite apart, however, from any question of finance, it has been held that limitation to the medical staff causes the outside Consultant, and still more the General Practitioner, to lose touch with his patient, and that the development of the pay bed system should afford increased opportunities for the ordinary Medical Practitioner to come into contact with the latest developments of work under Hospital conditions, and should provide him with increased institutional facilities.

1528 325 1268 51–2 328, 361 423, 445 1071, 1334 cf. 623 1166 1252 623, 634 1166–71, 1225–6

73.—On the other hand, the question has been raised whether the admission of Doctors who are not on the staff of the Hospital is administratively practicable. Even as regards the admission of other Consultants some Hospital witnesses have expressed doubts; though the experience of the Hospitals where the beds are already open is evidence that it can be done, at all events where there is a fairly large number of beds, and a relatively small number of cases treated by outside men. There is, however, general agreement amongst witnesses from the larger Hospitals with Consultant staffs that it would not be practicable for the General Practitioner to come in and take part in the treatment, as this would mean that a number of different Doctors, not themselves Hospital Consultants, would be giving directions to the Hospital resident staff and nurses. The British Medical Association recognise this difficulty in wards that are an integral part of the Hospital, but they do not think it should be an obstacle in a separate paying block, which for various reasons they prefer, and which they suggest could be run on the same lines as an ordinary Nursing Home. At the Hospital of St. John and St. Elizabeth this, indeed, is done without difficulty, even without a separate block. They admitted, however, that the limits attaching to choice of Doctor might be different at different Hospitals; that there might, for example, be one rule at St. Thomas's, where there is a separate block open to any Consultant, but that at a suburban Hospital pay beds should be open to General Practitioners as well; that there should thus be, in short, the "greatest possible freedom," but "within reasonable limits."

74.—Another question that is involved is whether the admission of medical men who are not on the staff is compatible with the exercise by the Hospital of its responsibility for the

1169
419, 1526
1104–6,
1128
1110

patients treated in its wards, or in a separate pay block, whether that responsibility be a legal one or only a moral one. This has been given as a definite reason for limiting treatment to the medical staff, so that in surgery, at all events, the work should be in the hands of those officially appointed to do the surgical work of the Hospital—the Consultants as well as the Resident Medical Officers.

40
744
1268
1332
143, 263–4
146, 267
746, 754
1275
1222
1223

75.—The Hospitals that nevertheless do not confine their pay beds to their medical staff usually protect themselves by adopting, in practice if not in words, some definition of the type of medical man whom they are prepared to admit. The choice of Consultant may be limited to a member of the staff of a recognised London Hospital, perhaps more closely defined as a large General Hospital or as a Hospital with over 100 beds, not a Cottage Hospital. If questions arise about the status of individual doctors, which does not often happen, they are settled by the medical authorities of the Hospital, or by the Governing Body in consultation with them.* Where treatment is open to general practitioners, or where it is suggested that it should be open to them, a wider definition is naturally required. The following criteria have been suggested by witnesses from the British Medical Association, so far, at least, as surgery is concerned: special experience in the class of work he is undertaking, or a special course of studies in that class of work, or recognition by practitioners in the neighbourhood as being specially skilled in that class of work. Here again it is suggested that the definition for a suburban Hospital might not be the same as for a Hospital like St. Thomas's, and that it would be a matter of domestic concern to be settled by each Hospital.

Relations with Patients' own General Practitioners.

1162
1230–1
1191–2,
1207–8
1531

76.—Where actual treatment is limited to Consultants, the relations with the patient's own doctor have nevertheless to be determined. The British Medical Association, in order to maintain the principle of continuity of treatment, suggest that a patient should not be admitted independently of his General Practitioner. When the patient has been admitted, they wish the arrangements to be such as to encourage the General Practitioner to take an interest in the treatment, to have access at all reasonable times, to be notified of the time of operation, to be communicated with when anything is going to be done, to receive reports from the Hospital, to be informed of the exact condition of the patient on discharge, and to get advice as to future treatment.

App. I
App. II, col. 10
cf. New York
856–8
326–7, cf. 1121
359–60
478–81, 487
229–36
276–289
273–4, 287
419
443, cf. 1121–3
618–624
cf. 1216–7

77.—We ourselves had this question in mind when we asked the Hospitals whether the arrangements provided for, or admitted of, the patient's own General Practitioner keeping in touch with the patient or with the treatment. From nearly every Hospital where the actual treatment is confined to the medical staff, or to the medical staff with the alternative of an outside Consultant, we have received an affirmative answer. In many cases the replies show that he is welcomed as a visitor or to attend operations. Some Hospitals go further. The Westminster encourages him to consult with the member of the medical staff: he can visit afterwards and make suggestions to the House Surgeon, which the latter carries out and reports to the Consultant. At King's College he may visit and consult. At the Royal Northern, if an outside Consultant is treating the case, the General Practitioner may, by arrangement with the Consultant and at the patient's expense, share in the treatment and give directions to the Resident Medical Officer. In practice this seldom happens; the General Practitioner regards it as an unnecessary expense to the patient, and leaves it to the Resident Medical Officer, who is himself a F.R.C.S. At the West London he may come in and help in the treatment by arrangement with the Hospital Consultant, though the responsibility rests with the latter. In the more expensive rooms at the Hospital of St. John and St. Elizabeth the full Nursing Home arrangements are in force: the General Practitioner may be responsible for the patient after the operation, whether performed by himself or by a Consultant; the Resident Medical Officer is only called upon in emergency.

cf. 694–711

78.—At most of the smaller outlying General or Cottage Hospitals, General Practitioners have, of course, the same power of access for treatment as at a Nursing Home, though in some cases this is confined to the particular medical men who form the staff, and in others to the

1030–6 par. 10 (note)

* The rules of the Freemasons Hospital contain the following definition:—"any Surgeon being a F.R.C.S. in purely surgical practice or Physician in purely consultative practice."

local profession. Sometimes the actual operation is done by a Consultant, who may be chosen
677 by the General Practitioner, or may be on the Hospital Staff, or on a Hospital list; sometimes by the patient's own Doctor; and sometimes there is a Resident Medical Officer who is available in case of emergency or if asked to act as deputy.

79.—It should be noted that, at all Hospitals with limitations to the medical staff, this applies only to treatment after admission. It is usually open to any medical man to
464 recommend patients for admission. If they come before the member of the medical staff in
par. 83 the course of his private practice, he admits them himself, subject to any rules there may be requiring applications to pass through a medical or lay officer of the Hospital. This is doubtless the most frequent channel. But, in the absence of any rule to the contrary, any medical man
465 can recommend a patient direct to the Hospital, and the proper officer at the Hospital will then refer the case to one of the medical staff. There is little evidence that the rules as to treatment affect the relations between the Hospital and the outside Doctors in the matter
273–4, 287 of admissions. At the Royal Northern the local Doctors appreciate the facilities for treatment
436–7 that are offered; at the West London they now often ask the Hospital Consultants to take
485–7 their cases. But we have the same evidence from King's College Hospital, where the whole of the treatment is confined to the Hospital Consultants. The maintenance of relations with the General Practitioner would obviously be most important to the success of any large extension of the pay bed system, if full use is to be made of the beds.

Conclusion on this subject.

80.—It will be seen that there are great differences in the procedure at different Hospitals; that these differences are largely due to different circumstances; and that none of the witnesses has suggested that any one procedure would be suitable for all Hospitals. We regard the question as one that the governing body of each Hospital should decide for itself.

CLASSES OF PATIENTS ADMITTED.

81—Our description of the existing pay bed accommodation is now completed. If the accommodation is considered as a whole, it would appear that, roughly speaking, a limited amount of provision has been made for each of three sections of the middle and professional classes: those in straitened circumstances, those of moderate means, and those who are comparatively well-to-do. For the first and last sections there are a small number of beds, the greater number being at intermediate rates appropriate for those of moderate means.

82.—Theoretically, the selection of patients for admission might be considered under two heads: medical suitability and financial circumstances. In practice, the selection rests so largely with the Medical Staffs that the procedure often cannot be distinguished.

App. II, col. 11 83.—If the method of admission is considered apart from the question of any inquiry into means, it is found that at 39 Hospitals admission is through a member of the Medical Staff; at 5 Hospitals there is the alternative of the patient's own Doctor or Consultant; at 18 the application also passes through an official of the Hospital (Secretary, Steward, Almoner, Resident Medical Officer or Matron); while at 9 it is made direct to the official. In 3 cases it comes before a Committee of the Hospital.

84.—As regards financial suitability, at 58 of the Hospitals there is either a rule or an
App. II, col. 11 understanding that the beds are intended for patients of moderate means. The limitation is usually defined as inability to pay ordinary Nursing Home charges and ordinary Surgeon's fees, or, where treatment is free, inability to pay any Surgeon's fee at all. At 10 of these Hospitals the decision in individual cases is left to the member of the Medical Staff; at 13 to the Medical man in conjunction with a Hospital official; at 5 the Hospital official decides; while at 8 the authority is a Committee of the Hospital. Occasionally there
450–3 is an income scale with a maximum, e.g., at the West London (with beds at 4 guineas and
410, 457 5 guineas: £800 to £1,000—most being between £400 and £500); at King Edward Memorial Hospital, Ealing (4½ guineas: single £350, married £500, with £50 for each dependant);
1056 Belgrave Hospital for Children (3 guineas: £700); Florence Nightingale Hospital
438 for Gentlewomen (2 guineas and 4 guineas: £400). Sometimes there is a prescribed form
1244 of application, or an income statement is required. In the new scheme at the Middlesex it

1480, 1486 is proposed to confine the beds to the class immediately above the ordinary patients, and the Medical Staff will refer cases to the Almoner for a decision as to their financial suitability and for assessment of their medical fees up to a maximum of 50 guineas, besides the flat rates of 7 guineas and 5 guineas to the Hospital, inclusive of extras.

93, 379, 655–8 85.—Where there is no definite income limit the Hospitals rely on the Medical men to admit or to recommend, as the case may be, only the class of patient for whom the kind of accommodation and the rate of charge is appropriate. If there was any tendency on the part of the Medical Staffs to extend the facilities to the wrong kind of people, there would be two factors tending to prevent this. One is the understanding that the fees would be on a reduced scale. At Hospitals with two kinds of beds at two rates of charge, this is relied on to prevent patients who can afford the higher rate, and correspondingly high fees, from being admitted to the cheaper beds at lower fees. The other check is the fact that it is usually more convenient to the Medical man to attend his well-to-do patients in Nursing Homes in the neighbourhood of his private practice. Sometimes there is an understanding with the Medical Staff that the patient's income should not exceed a certain figure (which may be as high as £1,500 a year), or that doubtful cases should be referred to the decision of the Hospital. Reduced fees are, however, not universal, and patients able to pay Nursing Home charges are not always excluded from beds at 5 guineas or less.

cf. 56

377, 379; cf. 203, 473

cf. 209

534

465–6, 712–4

653–4

571, 581, 764 86.—At the Hospital of St. John and St. Elizabeth, and at St. Andrew's Dollis Hill, there is an income limit for the cheaper beds, where treatment is provided by the Medical Staff usually free, but not for the more expensive ones, which are run on Nursing Home lines.

App. II, col. 11 87.—At 16 Hospitals there is no financial limitation or understanding at all. Two of these are special Hospitals providing treatment that cannot be obtained at any Nursing Home. Most of the others are suburban Hospitals. Sometimes the comparatively well-to-do patient is charged at a higher weekly rate; sometimes he makes a donation; sometimes he only comes when he needs special Hospital facilities; sometimes the accommodation is not such as to attract him; sometimes the charges approximate to those of the local Nursing Homes.

THE DEMAND FOR ADDITIONAL PAY BEDS.

88.—Having now finished our account of the existing provision and of the classes of patients who make use of it, we are in a position to discuss the evidence as to the extent and nature of the demand for more provision of the same kind. Numerous witnesses have testified to the existence of such a demand on a large scale. The evidence comes from Hospitals that already have pay beds, from Hospitals that have none at present but have schemes for providing them, from Hospitals that have neither pay beds nor schemes, from medical and other witnesses not speaking on behalf of Hospitals, and from various professional and other associations and societies to whom we have addressed inquiries on this part of our subject.

Evidence from Hospitals.

par. 119 89.—Of the 150 Hospitals which replied to our questionnaire, 92 report an unsatisfied demand. Of these, 44 have schemes for increasing the supply, including 20 which already have pay beds. At 33 there is no evidence of such a demand; of these, 9 are local Hospitals, often in poor neighbourhoods, and 20 are special Hospitals. The replies from the other 25 are doubtful.

110 90.—The most emphatic expressions of this demand come from the larger General Hospitals. Guy's, with 31 pay beds, could easily fill three times as many; St. Thomas's, with 40, reports a large demand; at Westminster, which has only 14, the demand is great and constant; and 5 other teaching Hospitals have schemes for adding beds. The Royal Northern finds a growing demand; at the West London it is steady; Willesden reports that its new accommodation is exceedingly popular. Amongst the smaller General and Cottage Hospitals the demand varies with local conditions. Of the 8 Women's Hospitals with pay beds, 4 report that there is a demand, that it is great, increasing, a real need. At a fifth the recent provision of 12 beds has been justified. At the other three, including the two Hospitals for Gentlewomen, the beds are not fully occupied; but this, it is thought, does not necessarily mean that there is no demand; it is attributed to special circumstances. Amongst the special Hospitals the demand is more variable, but 37 out of 71 report that it exists, and 18 of these have schemes.

Chelsea, E.G.A., S. Lond., Sam. Free H. Women Grosvenor St. Saviour's F. Nightingale

91.—The Hospitals with pay beds adduce as evidence of the urgency of the demand the difficulty of getting a patient admitted without a period of waiting. At St. Thomas's this may be from a week to a month. At Guy's, with 31 beds, it is three weeks ; there are sometimes 45 people waiting ; acute or surgical cases cannot be put on the list at all ; three times as many beds could easily be filled. At the West London, patients often have to wait some time, though the list is not unreasonably long. At King's College the pressure on the beds fluctuates, partly with the time of year : sometimes it is greatest on the men's side, at others on the women's. At the Hospital of St. John and St. Elizabeth the private rooms are always full. The South London Hospital for Women has a waiting list, and those who cannot wait have sometimes to be sent elsewhere. This is a common effect of a waiting list, with the result that the list itself represents only a fraction of the unsatisfied demand. This evidence, taken together, covers beds of all prices from 4 guineas upwards.

16
18
110
432
1244
496
502–8
610
994

92.—It should be noted that there are reasons why this pressure does not always produce a high average of daily occupation. In come cases the average is very high, as, for example, at the Westminster (13·7 out of 14), West London (23 out of 26), St. Andrew's Dollis Hill (53 on a nominal 52), and others where the beds are practically always full. But these are exceptional. Some witnesses have explained that paying patients are not quite like ordinary patients. Their rooms have to be booked some time ahead : at holiday times they do not come in such large numbers, or the Surgeons are away. Often the patient cannot come immediately the vacancy occurs. The sub-division between the sexes, already mentioned, may produce alternately vacant beds on one side while there is pressure on the other. This could be avoided if there were more wards. At one suburban Hospital we were told that the figure of average occupation referred only to patients who paid the pay bed charges, and that the wards were not empty at other times, but were used for ordinary patients, who in times of pressure were given precedence.

App. II, col. 12
749
16
507
18
109
503, 504–8
678–685

93.—Many of the Hospitals without pay beds also report a real and growing need. The fact that 24 have schemes for providing them is in itself evidence of this. But the absence of a scheme is not necessarily evidence to the contrary. The Hospital may not be in a favourable geographical position ; its trust deeds may stand in the way ; there may be no room on its site, or the demands from ordinary patients may be too great. Out of 45 replies from Hospitals with neither pay beds nor schemes, 19 contain evidence of demand, while 16 (including one local Hospital and 13 special Hospitals) report no known demand. An interesting confirmation of the reality of the pressure on the Hospitals comes from the Charity Commissioners, to whom applications for permission to provide pay beds are made with such frequency that they often advise the founders of new Hospitals to take the necessary powers from the outset, as they will be sure to want them sooner or later. It is the experience of the King's Fund also that of recent years a large proportion of the extension schemes submitted for the sanction of the Fund include pay bed accommodation in some form or other.

App. III
1312, 177
1628
1643–5

Evidence from other witnesses.

94.—The witnesses who did not attend as representatives of individual Hospitals have also given evidence of the demand. Dr. Wilson (Royal College of Physicians) spoke of a large class who required treatment, but whose homes were unsuitable and who could not afford Nursing Home fees. Dr. Thursfield confirmed this. Mr. McAdam Eccles, speaking for the British Medical Association, reported that the present accommodation was inadequate both in number of beds and in proper provision.

1755–64
1310
1203

95.—The replies received from professional associations and from societies for the assistance of distressed members of the middle and professional classes give a general confirmation. Out of 27 which were able to give information, 22 reported a demand, while 1 was uncertain. Of the other 4, one had already secured pay bed accommodation for its members by means of a provident arrangement with the South London Hospital for Women, and the other two stated that their beneficiaries could not afford pay beds, except sometimes at the Florence Nightingale Hospital, where charges are low and there are often no medical fees.

App. VIII

Estimates of amount of demand.

96.—We find it impossible to calculate any reliable figures of the total amount of this unsatisfied demand. We have already mentioned the estimate made by the British Provident

par. 15

Association, which puts the middle and professional classes in the London area at 2½ million out of a total population of 8½ million, and the well-to-do at 250,000. From their experience they consider that the incidence of illness and operation requiring institutional treatment is about 30 per 1,000 per annum. If each occupied bed served 15 patients a year, the average stay being three or four weeks, and if the beds were worked at the same pressure as the present pay beds at teaching Hospitals, viz., 82 per cent. occupied, the total number of beds required for 2½ million people would be about 6,000. If the 250,000 well-to-do persons were included, the total beds needed would, on these estimates, approach 7,000, including, of course, all the beds at present in existence.

919–22
cf. pars. 29, 92
937

97.—This incidence of illness is based by the witnesses on the experience of the Hospital Saving Association, with a membership of 350,000; on the King's Fund Statistical Report figures showing 200,000 in-patients in a year, which is calculated by the British Provident Association to represent about 32·9 per 1,000; and on the 6 years' experience of the British Provident Association itself, with a membership which has reached 2,400. It is not certain that the general incidence of institutional treatment would be as high as 30 per 1,000. The British Provident Association itself suggests that the incidence might be lower with the middle and professional classes than with the ordinary hospital patients, because the standard of health is higher and because a larger proportion can be treated at home. The actual membership of the Association is as yet small, and the persons who are first attracted in the initial stages are likely to be an unfavourable sample as regards age and liability to require benefits. The other figures tendered by witnesses on a basis of actual experience relate to even smaller numbers, but, such as they are, they give a rather lower incidence. One refers to the staff of a large commercial concern: a male staff of 3,851, with wives 2,267 and dependants 1,770, described as a small group of more or less healthy lives, though doubtless not all middle class. The incidence of sickness and operations requiring in-patient treatment came out at about 20 per 1,000, which included operations for tonsils and adenoids amounting to nearly 37 per 1,000 for the children. The other is the experience of the professional association just mentioned, which has a provident arrangement with the South London Hospital for Women—the Association of University Women Teachers. The number of members subscribing to the scheme is 335, and the payment to the Hospital covers 9 or 10 weeks in the year, which is found to meet requirements. This gives an incidence of about 1 per cent., or 10 per 1,000; they are probably a favourable actuarial sample of professional lives.*

902
cf. 937
1131–2
cf. par. 134

98.—The above estimate of 6,000 or 7,000 beds required includes, of course, all the beds at Nursing Homes as well as those in Hospitals. The Voluntary Hospitals at present provide about 1,000. The existing provision elsewhere, and the alternative methods of increase, will be discussed in a later section dealing with the methods of providing additional accommodation.

par. 105

99.—So far we have been discussing total demand. There is also a certain amount of evidence on the question of differences in demand for accommodation of different kinds and at different rates of charge.

Demand for different kinds of accommodation.

100.—As regards the kind of accommodation, some witnesses report that single-bed wards are what the public wants, in preference to large wards, even when cubicled, or to 2-bed wards, which last are sometimes thought to be the least popular form. The desire for privacy is one of the factors which make people prepared to pay more than ordinary Voluntary Hospital patients; though, as we have seen, it is sometimes found that the patients who have tried both prefer the general ward, while others like the semi-privacy of the cubicle with movable curtains. Even within the 1-bed limit there is a demand for different grades of accommodation at different prices.

242
292, 946
par. 27
1262
cf. 179

Demand from different classes of patient.

101.—As regards capacity to pay different charges, several witnesses consider that the greatest demand is for beds at low rates. St. Thomas's, where beds cost 6 guineas, considers there is a large demand from the class just above the ordinary Hospital patients, whose normal maximum payment is, as we saw at the outset, 2 guineas or at most 3 guineas. Norwood, which

par. 7

* *See also* note on page 76.

charges 4 or 6 guineas for a private room, finds a demand for better accommodation and more privacy than in the general ward, if these could be had for 2½ or 3 guineas. St. Andrew's Dollis Hill, which has wards at 2½ guineas, usually without medical fees, and single rooms at 6 to 8 guineas, with fees, finds a demand for beds at rates in between. The Hospital of
766 St. John and St. Elizabeth, which has pay beds at £2 10s. with medical treatment usually free,
606 and at 8 guineas or more with full medical fees, frequently comes across (sometimes in the ordinary wards) patients who can afford 4 guineas, but not more, besides a modified fee; or, as Dr. Greenwood put it, "a large number of people who are able to pay about half what the "ordinary private nursing home charges, and about a quarter of what the surgeons charge."
607–8 These patients would doubtless like a private room, but could, at that price, only be provided
cf. New York par. 28 with cubicles. The Royal Northern, which reports a growing demand, finds that patients
1310 would rather pay 5 or 6 guineas for a private room than 4½ guineas for a cubicle. Dr.
1258, 1262 1272 Thursfield considers the largest demand ranges from 3 to 7 guineas. Witnesses from St. Bartholomew's suggest demands varying from 2 to 8 guineas, or 10 guineas including extras, the greatest demand being at 5 or 6 guineas. Of the 22 societies that report
App. VIII a demand, one specially refers to private rooms at less than 5 guineas; another would find 6 guineas too high (in connection with a provident scheme for officers' families which provides a maximum of 4½ guineas a week towards expenses of illness); a third mentions less than
part II, p. 106 7 guineas. The almoners of St. Thomas's Hospital estimate, from a study of a three-weeks' sample, that of the patients treated in the general wards, 10 pay beds a week could be filled with patients who would apply for admission to a paying ward at charges of from £3 10s. to £5; and that there would be a further demand at the same prices from persons who at present have just sufficient savings for a Nursing Home and Surgeon's fee. The almoners also find that, for beds for removal of tonsils and adenoids, there is a small steady demand from persons able to pay about £20 or £25 inclusive. They also report an urgent need for accommodation for chronic, incurable or long-period cases, and also for moderately priced maternity beds. This last is confirmed by the replies from maternity Hospitals situated near middle-class neighbourhoods, where the demand is no doubt connected with changes in housing conditions.

102.—Some witnesses estimate the class from which the demand comes by income rather than by weekly charge. Mr. McAdam Eccles, who is connected both with the Hospital
1129 Saving Association for ordinary Hospital patients and with the British Provident Association for the middle classes, suggests a range from £250 a year, which is the income limit between the two, up to £800 or £900 a year. This range would cover the less well-to-do sections of the middle class—e.g., "patients of moderate means, especially clerks, male and female, "small shopkeepers, artisans earning more than £5 a week." It would begin with those who, to judge from the payments received in the ordinary wards, could hardly afford as much as
cf. par. 8 3 guineas a week. It would end with those receiving the income which is normally the upper limit for the beds at 4 to 5 guineas at the West London, one of the Hospitals where applications
606 are sifted by a special committee. Dr. Greenwood's "quarter of what the surgeons charge" would, on the scale of fees published in the "Lancet," correspond with an "adjusted" income
App. VII of £600 a year. Mr. Thorpe, of the Freemasons Hospital, considers that there is a very
See par. 10 (note) 1016 big demand from persons with less than £500 a year, which is the income limit for a married couple at the King Edward Memorial Hospital, Ealing, with beds at 4½ guineas.

103.—The question whether there is a demand from the well-to-do gives rise to more
65 difference of opinion. St. Thomas's finds that, while its 6-guinea beds have a waiting list,
353 its 9-guinea beds are not always occupied. Westminster, on the other hand, could fill more than
1272 1255 it has at 10 guineas. An estimate from St. Bartholomew's put the upper limit at 8 guineas.
pars. 149–155 But we shall deal with this question separately in a later section.

104.—Taking the replies as a whole, there seems to be a good deal of evidence to show that the largest demand comes from two sections: those who have a rather higher income than the ordinary Hospital patient, but who yet cannot afford the full cost of a pay bed as well as a reduced medical fee, and those somewhat better off, who can afford 4, 5 or 6 guineas a week and a moderate fee. There is also a demand for beds at higher rates from those who cannot readily obtain elsewhere the full facilities which a Hospital provides. These sections shade off into one another, but it is nevertheless necessary, in considering the demand and the method in which it can be supplied, to recognise that there is a difference in principle

between those who can afford to pay the cost of the minimum facilities for which they ask, and those for whom part of the cost would have to be provided from other sources.

METHODS OF INCREASING THE ACCOMMODATION.

Alternatives for consideration.

105.—In order to form an opinion on the best method of supplying the demand which has just been described, it is necessary to consider not only the provision now made or proposed to be made in Voluntary Hospitals, but also the provision that is already made or suggested elsewhere, including Nursing Homes, separate Hospitals for paying patients, and
1149, 1178 Hospitals under the control of public authorities.

Hospitals under public authorities.

106.—In the London area the only Hospitals under the control of public authorities, apart from those for infectious diseases and a few other special classes of case, are the Guardians' Institutions, till recently known as Poor Law Infirmaries. Under present conditions the extent to which special accommodation in these institutions is available for middle-class patients is for various reasons negligible, and the question of their future, in relation to the Voluntary Hospitals and to the other health services of the community, would lead us too far beyond the scope of our inquiry.

Nursing Homes.

107.—Of the accommodation outside the Voluntary Hospitals by far the greatest number of beds are in Nursing Homes. Until the passing of the Nursing Homes (Registration) Act, 1927, following upon the inquiry by the Select Committee which reported in 1926, there was no register of Nursing Homes other than Maternity Homes; and no complete statistics appear to be available. The Report of the Select Committee mentions homes for five kinds of cases—medical and/or surgical, maternity, those requiring special observation and treatment, senile and other chronic cases, and convalescents. We are concerned mainly with the first two, whose functions are described by the Select Committee as being "similar to those exercised by "a Hospital, the demand for Nursing Homes in these cases arising from those patients who "can afford to pay for their treatment and desire both greater privacy and more home-like "conditions than can be obtained in a public ward of a Hospital, or whose means render them "ineligible for certain General Hospitals."

Select Committee's Report, par. 4

108.—Several medical witnesses have laid great stress on the advantages which patients
1765-6 can obtain at a Hospital as compared with the great majority of Nursing Homes. Many of the homes have no lifts; many are without operating theatres; very few have X-ray apparatus, and we have not heard of any in London that has a Resident Medical Officer. British Medical Association witnesses, while deprecating competition between Hospitals and Nursing Homes, expressed the view that in these respects none of them was comparable with even the poorest Hospital. X-ray or pathological examinations or other ancillary services can be obtained, but only at great cost to the patient, and (except in one or two instances) not under the same roof, which in the case of X-ray may involve risk to the patient during transport. Several medical witnesses emphasised the importance, in the event of emergency, of a Resident Medical Officer, who is present at all Hospitals except some of the smaller special or suburban ones. In view of the recent Report of the Select Committee we have not thought it necessary to inquire into the general nature of Nursing Home accommodation, or to express any opinion of our own. That Report refers to evidence as to the unsuitability of many of the buildings; the frequent absence of operating theatres, lifts and other provision and equipment for surgical cases; inadequate accommodation for nurses, sometimes even in the better-class homes; and the difficulty which is often found in securing a sufficient supply of adequately trained nurses. On the question of the general accommodation the Select Committee expressed the following opinion:—

1152, 1202-3
1239
cf. 1244, 1257
1336
1704, 1286
1323, 1518-0
66-8, 164
217, 1091
1114-20, 891
166, 113
1204, 1285
App. II, col. 9, cf. 1136-8
Select Committee's Report, pars. 9, 10
do. 10 (i)
do. 10 (ii)
do. 24
do. 11 (i)

"That the dwelling-house converted into a nursing home with its many structural "deficiencies which cannot be overcome is, at any rate in acute surgical cases, a very "poor and expensive substitute for the specially built, adequately equipped and staffed "Hospital. It is, of course, true that at the present time there is a considerable demand

"for nursing home accommodation and that in fulfilling this demand nursing homes "serve a useful purpose. In stating this opinion your Committee do not intend to "criticise the work carried out by well-run nursing homes, for it is clear that in many "cases the owners or managers of these homes are making the very best of structurally "unsuitable buildings. Your Committee desire to emphasise their opinion that the "future trend of development in regard to the provision of accommodation for the "paying patient should run more along the lines of the provision of specially built and "equipped private Hospitals and homes and of the extension of the paying-ward system "in the existing big Hospitals."

Taking this as our starting-point, we have to consider these two alternatives.

Separate Hospitals or pay beds at Voluntary Hospitals.

1652, 1654, 1666, 1747, cf. 1091

109.—In favour of the separate Hospitals or homes as against pay beds at existing Hospitals it has been argued that the whole of the resources of the Voluntary Hospitals, in the way of funds, sites, buildings, equipment and personnel, are required for their primary work of treating the sick poor, both in-patients and out-patients, or for extensions of that work or the development of new branches and departments, in response to increasing demands; that the ancillary services such as X-ray and pathological examinations are adequately supplied only at the teaching Hospitals, whereas paying patients are not available for teaching; that

cf. 1271, 1327 1725–8

many of the patients do not need these services; that the Resident Medical Officer is a luxury which even the rich usually do without; that it is doubtful whether pay-bed receipts really cover expenses, if the costs of administration are fully charged; that the use of the resources

1692–6

of the Voluntary Hospital for paying patients is unfair to the Nursing Homes, and also, if treatment is confined to the medical staff, to other medical men; and that either to divert

1666–7

resources from the sick poor or to undertake a profit-making business would alienate sympathy from the Hospitals. It is suggested that patients who are unable to pay the cost of treatment and of the ancillary services should go into the ordinary wards, that those who can pay should go to Nursing Homes, and that, if Hospital accommodation is required for any intermediate class, it should be supplied by means of funds specially provided and should not be confined to the medical staff of the Hospital, and might therefore just as well be at a separate institution unconnected with the Hospital.

110.—The answers to most of these arguments can, we think, be found in the account we have already given of the experience of the Hospitals which have provided pay beds. These Hospitals seem to be supplying a real need. They do not appear to have suffered in popularity from having extended the scope of their work in this direction, but rather the reverse. If it is feared that any particular detail of procedure will lead to undesirable consequences, the varieties of practice are so numerous that they are almost certain to contain examples of alternative methods, designed to secure the advantages and avoid the possible disadvantages.* It does not necessarily follow, for instance, that attendance on paying patients at a Voluntary Hospital is confined to the medical staff. The general balance of advantages and disadvantages will often depend on the circumstances of the particular Hospital. At some Hospitals in poor

See pars. 63–69

1312 1317–8

neighbourhoods there may be no local demand, and the geographical situation may not be attractive to patients from a distance. At some Hospitals, on the other hand, the value of the site may be so great that the rent chargeable to a pay bed section would be too high. At some Hospitals it may be the case that the specialised staff and equipment—X-ray, pathologist or even operating theatres—are already fully occupied. But this would result from the relation at the moment between the size of the departments and the total number of beds. It would be a permanent obstacle only if both had reached the maximum size for efficient or economical working. In that case, it would be a permanent obstacle to any form of extension, and would not affect the question what form of extension would be legitimate and desirable. So far as personnel is concerned, skilled radiologists and other operators would be required wherever

* As regards teaching Hospitals, we notice that at one of these it is a condition of special pay bed facilities offered to subscribers (*see* par. 134 below) that unless the patient raises objection the member of the Honorary Staff attending him will be accompanied by his students. It is, of course, necessary to give this option to patients who are paying extra for special privacy and other amenities. But the patient who objects is placing himself in the position of being willing to benefit by all the knowledge gained in the past from the cases of other patients, but of refusing to permit any future patients to benefit by anything that might be learned from his own case.

the patients were treated; and it is a question for each Hospital whether the staff as it exists can undertake more work, and, if not, whether it can be advantageously increased. Similar considerations apply also to nursing staff, where it may be easier to maintain the necessary standard if the staff of the pay beds is not a separate unit in itself, but is part of the organisation of qualified Nurses and Probationers at a Hospital, whose members are constantly gaining wider experience from interchange with ordinary Hospital work. Each of these arguments may have a different weight with different Hospitals, or with different classes of Hospital, or different classes of case. It is nowhere suggested that all Voluntary Hospitals should have pay beds, or that all should have them on the same scale, or should adopt the same methods, or that all pay beds should be at Voluntary Hospitals.

The present extended function of the Voluntary Hospital.

111.—If it is granted that the addition of pay beds to a Voluntary Hospital is, where the circumstances are suitable, a form of extension legitimate in itself and advantageous both to the patients and to the Hospital, the question remains whether it ought to be deferred pending a considerable further addition of beds for ordinary Hospital patients. The answer depends on the view taken of the function of the Voluntary Hospitals and of the way in which that function may properly be developed in present-day conditions, i.e., how far the definition of the Hospital function—originally described as the treatment of the sick poor—can properly be regarded as covering classes of patient who could formerly have paid for such medical attendance as was available, but who now, owing to general changes in the financial circumstances of different classes, and to the development of new and expensive methods of treatment, are no longer able to do so. Just as the Poor Law definition of destitution, as applied to medical relief, is no longer confined to the absence of the bare necessaries of life, but includes "inability to provide whatever medical treatment is necessary," so also the definition of the function of the Voluntary Hospital can be extended to cover what are often called the "new poor." As we have seen, the classes of patient which come within the scope of our inquiry may be roughly divided into three—those in straitened circumstances, those with moderate means, and those who are well-to-do. Those in straitened circumstances would come within any present-day definition of the ordinary Hospital function. The inclusion of the well-to-do would admittedly be a new development, which can only be justified if it indirectly helps the Hospital to fulfil its ordinary function. The extended definition of the ordinary function may fairly include those of moderate means, who cannot in present conditions afford the charges of an efficient Nursing Home.

Report of Poor Law Comn. 1905–8, part V, ch. 1, par. 13

1651

cf. pars. 149–155

112.—There is another way in which the definition of the Voluntary Hospital function has been extended in such a way as to render the distinction less rigid. Many of the patients are no longer regarded, either by the Hospital or by themselves, as destitute persons who can only be the passive recipients of charity. They are invited to co-operate towards their own assistance and the assistance of their fellows by contributing according to their means when in Hospital, and by subscribing towards the maintenance and even the extension of the Hospital, or Hospital system, whose services they may some day need. We have already referred to the development of contributory schemes such as the Hospital Saving Association, whereby large numbers of persons within the ordinary Hospital income limits provide in advance, by a kind of mutual insurance, the funds with which to cover their maintenance if and when they need Hospital treatment. The Voluntary Hospital system has thus become largely a co-operative effort in which all classes of the community, including the Hospital patients themselves, combine, as their means permit, to provide Hospital services which produce benefits for all classes: directly for the less wealthy because without the Hospital the necessary medical treatments cannot be brought within their means, and indirectly for the more wealthy because without the Hospitals the necessary medical treatments would not exist. During a development of this kind the line between the patients who may benefit directly and those who should only benefit indirectly need not be drawn at the same place as it was before the development began.

par. 9

113.—There is, moreover, no reason to suppose that the addition of pay beds will prevent or delay the addition of beds for ordinary patients. As we have seen, since 1920 the Hospitals of London have added about 1,600 ordinary beds, as against 465 pay beds, and the

par. 30

latter are still only 7 per cent. of the former. Many of the schemes for additional pay beds are associated with extensions of the ordinary wards up to the full extent which the necessity of securing a corresponding increase in maintenance income will at the moment permit.*

114.—If, therefore, it is within the sphere of the Voluntary Hospitals to supply the demand for pay beds as well as the demand for ordinary beds, if there are practicable schemes for adding more pay beds, and if by so doing the Hospitals are satisfied that they will increase their popularity and their resources, with resulting benefit to the whole of their work, there seems to be no good reason why they should not do so.

The alternative of the separate Hospital.

115.—The separate Hospital may be itself a Voluntary Hospital established primarily for the treatment of one or more of these classes of patient, at less than cost price, and dependent on voluntary contributions to make up the difference between the weekly charges and the cost. Such are, for example, the Florence Nightingale Hospital for Gentlewomen, St. Saviour's Hospital for Ladies of Limited Means, the Hostel of St. Luke for the Clergy, and St. Andrew's Hospital Dollis Hill, described as mainly for the middle and professional classes. The fact that this provision is in separate institutions and not associated with any ordinary wards does not involve any fundamental difference in principle.† There is the practical difference that the whole cost of administration, operating theatre, X-ray apparatus, Resident Medical Officer, and the like, has to be borne by a smaller number of beds. The three first mentioned are, indeed, not large enough to have residents, or to provide their own ancillary services.

116.—Alternatively, the separate Hospital may be a development of the Nursing Home, possessing, in its building and in its procedure, some of the institutional features associated with the word "Hospital," but financed wholly by the charges made to patients. There is nothing administratively impossible in the provision of all the usual Hospital facilities in such a separate institution. Financially, the question whether it would pay and at the same time would meet the needs we have been describing would depend largely on the cost per bed of the overhead charges and the specialised services, and this would depend largely on the number of beds. There are instances where provision has been made both for wealthy patients and for patients of moderate means, the total profit being restricted to a certain percentage, and the additional profit on the more expensive beds being used to meet the deficit on the cheaper beds. It has been suggested that the same principle might be applied on mutual lines in connection with some kind of insurance scheme.

117.—In either case the establishment of an efficient and economical separate Hospital means the provision of the full equipment and permanent staff of a Hospital, and beds on a sufficiently large scale to keep that equipment and staff fully occupied. It is a question whether the same number of beds could not be provided more efficiently and economically by adding a comparatively small number to each of several existing Voluntary Hospitals, with or without a small increase in existing staff or equipment; and whether, from the point of view of the patients, it would not be more convenient to have the beds thus distributed in different parts of London and not concentrated in a small number of large institutions.

Summary of the arguments.

118.—It does not seem to us to be necessary to regard the different methods of providing pay beds as being mutually exclusive. There may well be room for all. Apart from some arrangement whereby the more expensive beds help to pay for the less expensive, the private Nursing Home can hardly provide all that is required except at charges suited only to the well-to-do. There will continue to be the demand mentioned by the Select Committee from those who can afford to pay for their treatment and desire the greater privacy and home-like conditions; and there will continue to be experienced nurses who find scope for their professional ability in managing homes to supply this demand. There may also well be room for the development of a larger kind of Nursing Home on Hospital lines, if it can be made to pay. But we are satisfied that in many ways it is desirable that there should be a considerable

See par. 108

* As shown in paragraph 119 below, the extension schemes which have reached the stage of actual building or the collection of funds will provide about 275 additional pay beds. The number of ordinary beds that will be provided by schemes that have reached the same stage is about 900.

† St. Andrew's, in fact, is not wholly confined to middle-class patients: it treats some ordinary patients, some of whom are free and some paid for by the Hospital Saturday Fund.

increase in the number of pay beds attached to Voluntary Hospitals. The patients will gain by having access to the resources of the rest of the institution. It is to the advantage of the medical profession that more of them should, in connection with their private practice, be brought into touch with the Hospitals. It will benefit the individual Hospitals, and the Voluntary Hospital system as a whole, for the Hospitals to be looked upon as the centres of the most advanced forms of medical and surgical treatment, not only for the sick poor in the old sense of the word, but for all for whom the problems of illness, whether the financial problems or the medical problems, require for their solution the assistance of some form of common or co-operative effort.

Additional beds proposed at Voluntary Hospitals.

119.—As we have seen, the London Voluntary Hospitals already provide 1,055 pay beds; and 44 of them have extension schemes which would include pay beds. Amongst these are 21 of the Hospitals which now have such beds, and 23 which have none. The schemes may be sub-divided into four classes, according to the stage reached in their preparation. Those where building is already in progress will soon provide about 100 pay beds. Those for which funds are now being collected will provide about 180 more beds. In addition to these, there are schemes definitely proposed for the future which would provide between 400 and 500 beds; and there are schemes under discussion or suggested which are expected to provide another 110 beds, besides those for which no number can as yet be given. When all the schemes have been completed for which either building or the collection of funds has begun, the number of pay beds will be increased from 1,055 to more than 1,300. If all the schemes in contemplation were also carried out the total number would be more than 1,900.*

App. III

cf. pars. 30, 113

120.—The addition in this way of another 900 beds would be a substantial step in advance, though obviously it would not be a final total, and the additional beds need not necessarily be confined to these particular Hospitals.

METHODS OF PROVIDING FOR COST OF MAINTENANCE AND BUILDING.

Whether maintenance cost should be wholly covered by charges.

121.—We have seen in our survey of the existing provision that the cost of the current maintenance of pay beds is sometimes met wholly out of the charges to the patients and sometimes partly out of the charges and partly from other sources; and that it is only in rare instances that the charges are designed to cover interest on the capital cost as well. A consideration of the proper relation of charges to cost involves questions of principle connected with the two features which differentiate pay beds from ordinary beds, namely, the question in what circumstances special accommodation should be provided, and the question in what circumstances the payment of medical fees should be permitted.

(i) *As a condition of the provision of special accommodation.*

122.—For example, it has been suggested that Voluntary Hospitals should not provide special pay bed accommodation unless the rate of charge is such that no part of the cost of the current maintenance of the pay beds falls on the general funds of the hospital subscribed for the relief of the sick poor. There are, however, various ways in which this suggested principle can be interpreted.

123.—It may be held, for instance, that on this principle special pay bed accommodation should not be provided for a patient unless the current maintenance cost of that individual patient to the Hospital is covered by the charges paid by that patient to the Hospital; and that, if he cannot pay his cost, he should go into an ordinary ward where he would contribute according to his means.

124.—Or it may be held that the individual pay bed patient need not necessarily pay the whole of his current maintenance cost, provided the deficit is met from some source other than funds subscribed for the relief of patients in the ordinary wards. This may be effected in three ways:—

(A) The deficit may be met out of profits derived from other pay bed patients who

* *See* note * on page 5.

pay more than their cost, so that the current maintenance cost of all the pay bed patients taken together is (at least) covered by the receipts from all the patients taken together.

(B) The Hospital may have received endowments or current contributions from donors who have specifically indicated that they desire their gifts to be used for assisting in the maintenance of pay beds, or for that purpose amongst other purposes of the Hospital.

(C) A considerable proportion of the contributors to the Hospital, and of the general public, may have come to hold the view, to which reference has been made more than once in this Report, that the function of the Voluntary Hospital has been so widened in recent years as to include not only the treatment of ordinary Voluntary Hospital patients in the general wards but also the treatment of persons of moderate means, the patients of each class contributing what they can afford. In so far as this view has come to be held, the term "general funds subscribed for the relief of the sick poor" is regarded as being wide enough to cover the assistance of pay bed patients who are unable individually to meet the whole of their cost. Under this alternative the justification for the provision of special accommodation would be that in the ordinary wards the Hospital provides, for many ordinary patients, accommodation and facilities which cost more than their payments; and that it does this because it considers that the amenities for which they could afford to pay would not be adequate. The argument we are discussing would mean that the Hospital could properly make two grades of provision on this basis for two classes of patient, one in the ordinary wards and one in the pay wards, the amenities being determined, in each case, in a somewhat similar relation to the patient's ordinary standard of living.

cf. pars. 111–114

125.—As we have seen, there is at present great variety of practice in the manner in which the maintenance cost of pay beds is met. Each Hospital has been dealing in its own way with the question of pay bed accommodation as it has arisen in practice. This is the method by which the voluntary system deals with new needs; the development of general principles tends to follow, rather than to precede and circumscribe, free experiment in practice. We do not consider it necessary or desirable that the King's Fund should attempt to formulate rigid rules which would either condemn or stereotype any particular variety of present practice. It is better to indicate the general principles which, as the result of our survey of the present methods, and of the questions involved, we consider should be kept in view in any general extension of the pay bed system. On this particular point, we should recommend the following as the principle to be aimed at: first, that pay bed accommodation should as a general rule be provided at rates of charge which at least cover the current maintenance cost of all the pay beds taken as a whole; second, that the provision of special accommodation on a limited scale for patients of small means at rates which involve a charge on the general fund can legitimately be regarded as coming within the present extended function of the Voluntary Hospital system, provided that it is looked upon as a secondary part of that function, and that the treatment of ordinary patients is maintained as the primary part; and, third, that if at any given Hospital it is uncertain whether this second principle is compatible with the stated objects of the institution, such low-priced accommodation should not be provided unless a sufficient amount to cover the resulting deficit is received in contributions from donors who have specifically indicated that they have no objection to this deficit being met out of their contributions. If the cost of a pay bed cannot be covered by one or other of these three methods, the patient should not be provided with special accommodation, but should go into the ordinary ward and contribute, like other ordinary patients, according to his means.

(ii) *As a condition of the payment of medical fees.*

126.—Again, it has been suggested that the question whether medical or surgical fees should be permitted should depend on whether the charges paid to the Hospital cover the cost to the Hospital.

127.—On this point the arguments that may be used in favour of the provision of special pay bed accommodation for patients who cannot afford the full cost can be used against the

payment of medical fees by such patients. For these arguments mean, as we have seen, that the function of the Voluntary Hospital is extended to cover such cases ; and that the provision for these patients, at a cost exceeding the charges, of special accommodation which bears a certain relation to their usual standard of living, is parallel to the provision made for ordinary patients, at a cost exceeding their contributions, and bearing a somewhat similar relation to their different standard of living. But it is one of the features of a typical Voluntary Hospital that in the ordinary wards no medical fees are charged, maintenance being provided from voluntary funds, including the contributions of the patients themselves, and the medical treatment being provided gratuitously by the visiting medical staffs.

128.—It seems to us that if patients are provided with special pay bed accommodation at less than cost price, they are essentially in the same position in relation to the voluntary system as patients in ordinary wards. Here, again, we do not recommend that the King's Fund should make a hard and fast rule which would condemn particular arrangements, such as those which may, for instance, be in force in connection with special charities for the assistance of middle-class patients of limited means. But, as the general principle for any considerable development of the pay bed system, we hold that no patient in a pay bed should pay any fee to a Physician or Surgeon, whether a member of the medical staff or not, for treatment received in the Hospital, unless the charges which that individual patient pays to the Hospital cover the whole cost to the Hospital of his current maintenance and of any special services he receives from the Hospital.

Whether the capital cost should be covered by the charges.

cf. par. 49

129.—The question has also been raised whether the capital cost of providing the special accommodation should be covered by the charges to the patients, or whether it can be provided from other sources. The first alternative would usually mean that the weekly charge should be sufficient to cover not only current maintenance, but also interest on the original capital cost. The second alternative would usually mean that the capital cost would be provided either out of the original building fund of the Hospital, or out of accumulated general fund surpluses, or out of a building fund specially received or collected for the provision of pay beds or for a scheme which included pay beds as well as other items.

par. 33

130.—We have already discussed the origin of the existing pay bed accommodation and its relation to the ordinary wards of the Hospitals. Here, again, the argument of the extended function of the Voluntary Hospital system can be used, provided always that the primary duty of treating the sick poor is carried out at least to the extent contemplated by the original trusts and objects of the Hospital. We do not consider it necessary that the weekly charges should cover interest on capital as well as current maintenance, either for financing the provision of further pay beds, or for calculating the relation of charges to cost in connection with the questions of principle discussed in the earlier part of this section.

131.—As regards any large extensions in the future, however, we think the ideal to be aimed at is that the capital cost of providing pay beds should in all cases be met out of funds specially contributed for the purpose, or out of the proceeds of building appeals in which the proposal to provide pay beds has been specifically mentioned. Even where this is done, it should nevertheless be recognised that patients who are merely paying their current cost, and have not themselves contributed to the capital cost, are, in obtaining what they cannot afford to provide for themselves, deriving benefit from funds contributed to the Voluntary Hospital system.

INSURANCE SCHEMES FOR PAY BED PATIENTS.

132.—Whatever views are adopted on these questions, it is clearly desirable that as many of the patients as possible should be enabled to place themselves in such a position that they can pay the full cost of maintenance in a pay ward and a medical fee as well. With this object various schemes have been put forward for assisting prospective pay bed patients to make provision in advance by means of some form of mutual insurance, as has been done for ordinary Hospital patients by contributory schemes like the Hospital Saving Association.

133.—An insurance scheme may deal only with Hospital charges, or it may also deal with medical and surgical fees. It may cover the whole cost or only reimburse the insured

up to a specified sum. Its benefits may be applicable wherever the insured is treated, or it may be associated with a particular Hospital. The Hospital charges may, as we have seen, be limited to current maintenance, or may include interest on capital. Various schemes of these types have been brought to our notice.*

Schemes connected with Hospitals.

134.—At two or three of the London Hospitals with pay beds some slight element of insurance has been introduced. At one Hospital an annual subscriber of not less than one guinea may, subject to certain conditions, claim that a bed in the paying ward is available for him and his dependants, and that the accumulated amount of his subscription may be deducted from the maintenance charges, which are themselves based on the estimated cost of current maintenance. We do not think the details of this method are wholly to be recommended. The Hospital would appear to be for an indefinite period under a liability attached to past receipts which are not earmarked to meet that liability but are part of the general fund.

947, 989 pars. 95, 97

At another Hospital, four beds at 5 guineas are placed at the disposal of four teachers' associations in consideration of an annual donation of £50 each bed, the Hospital providing 10 weeks' maintenance in the year without further charge. The associations recoup themselves by annual premiums from their own members, but with this the Hospital is not concerned.

135.—An example of a complete insurance scheme organised by a Voluntary Hospital in connection with its own pay beds is to be found at the Norfolk and Norwich Hospital, which has a contributory scheme for ordinary patients, and has recently supplemented it by a separate scheme for its paying patients. There are 12 pay beds in single rooms. There is an income limit ranging from £350 if single to £550 if married and with children. Treatment is limited to the medical staff. Admission is by consultation between a member of the staff and the patient's doctor. Persons who do not join this insurance scheme will, when accommodation is available, be admitted for £4 per week, besides medical fees limited to 15 guineas. For persons who do join it, and pay an annual premium of 30s., the Hospital will provide free in-patient treatment for four weeks and certain special out-patient treatments for eight weeks, for the insured and his wife and children. The consultation fee is not covered.

136.—As an example of a Hospital which has announced its willingness to enter into special arrangements for the supply of accommodation and treatment, if an outside body will organise an insurance scheme on approved lines, our attention has been drawn to St. Chad's Hospital in Birmingham. This is a Hospital for paying patients, managed by a private company with dividends restricted to 6 per cent. Patients within certain income limits are assessed for an inclusive fee covering maintenance, medical fees and interest on capital. The minimum inclusive fee is 2 guineas plus a guinea a day, and 88 per cent. of the patients pay less than half the usual cost at a Nursing Home. The annual report for 1925–6 says :—

> "The Committee, after careful consideration, feel that the Hospital could be "made of real value to many who cannot at present avail themselves of its help, if some "simple system of insurance were provided. The Hospital itself cannot undertake "any insurance obligations, but is prepared to accept and treat any patients insured "by an outside body on approved lines at a fixed scale irrespective of the kind of "treatment required. This scale is as follows: All patients to pay six guineas and "one guinea for each day's stay, except those needing a major operation, when an "additional charge of ten guineas would be made. Knowing what the liabilities are, "it should not be a difficult insurance problem to cover the risk of illness requiring "special treatment in a nursing institution or Hospital for paying patients for a small "annual premium. The Committee think that a premium of 20s. to 25s. per individual "would be adequate."

Schemes not connected with particular Hospitals.

137.—As regards insurance organised by bodies not associated with particular Hospitals we have received detailed evidence relating to the scheme of the British Provident Association for Hospital and Additional Services, which was founded in 1921 and has its headquarters in London. This association is not directly concerned with the actual provision of Hospital

* *See also* note on page 76.

accommodation or treatment. It assists its members to provide beforehand the whole or part of the cost of accommodation and treatment which the members arrange for themselves.

138.—The British Provident Association deals primarily with the cost of maintenance in Hospital or Nursing Home. An additional premium deals with surgical fees for major operations. The ordinary premium is 21s. a year for a single person, 31s. 6d. if one dependant, and 42s. if more than one dependant. In return for this, the Association reimburses its members and dependants the cost they incur for Hospital in-patient services at a Voluntary Hospital up to £5 a week for three weeks, or for similar services at a Nursing Home if for a major operation; cost of home nursing up to a specified limit, consultation fees up to three guineas for a visit or one guinea for a call; radium treatment, ambulance service and, at the discretion of the Association, certain supplementary services. The additional premium, which requires a special form of proposal and a medical certificate, provides contributions towards the cost of Surgeons' fees for major operations. For this purpose operations are divided into four classes, according to the measure of surgical skill involved. There are three ordinary scales of contribution for each class of operation, according to the amount for which the member desires to insure. In the lowest scale the amounts range from £3 2s. 6d. up to £25, the amounts in the other two scales being twice this and four times respectively. The fee covered by the highest ordinary scale is thus £100. The annual premiums for this additional benefit range from 17s. 6d. to 35s. for a single man, and from 45s. to 90s. for a family of three, with a further 10s. to 20s. for each additional person. The scale of benefit can be increased by an increased premium.

139.—The main object of the British Provident Association, as the rate of maintenance benefit shows, is to enable the less well-to-do sections of the middle and professional classes to make provision. But there is no income limit, and some people of substantial means have
903 joined in order to insure against operation fees which, by the payment of additional premiums can be covered up to any amount. The experiment is still on a small scale, but it is claimed that its six years' experience is sufficient to show that it meets a real need, that its actuarial estimates (referred to in paragraphs 96 and 97 above) are sound, and that an extension of the same principle might enable large numbers of the middle and professional classes to pay their full cost of maintenance in Hospital, and enable the Hospitals to provide pay bed accommodation for them without any charge falling on general funds.

A suggested general insurance scheme.

140.—Witnesses from the British Provident Association suggested to us a scheme of development on these lines consisting of three parts—one to cover current maintenance, one to cover medical fees, and one to cover the capital cost of the necessary accommodation. As regards current maintenance, Sir Alan Anderson estimated that the existing ordinary premiums
907-10 of 21s., 31s. 6d. and 42s. would, on a large scale of membership, cover about £5 a week for three
901 weeks, besides the minor benefits already mentioned. Surgical fees would continue to be a matter for a separate additional policy. As regards capital cost, it was suggested that
898 subscribers to the scheme and others interested should be invited to put up a capital sum of £10, or such other figure as might be determined, and take a share in the concern. Those who did this would have first call on beds provided by means of these capital contributions. The scheme was only put before us in outline, and the details would still require to be worked out.

141.—In considering how an insurance scheme could be applied to the solution of the problem before us, the following points would have to be taken into account.

Special conditions of an insurance scheme in London.

142.—In the first place, the problem in London is much more complicated than in a city like Norwich. It is comparatively simple for the Norfolk and Norwich Hospital to organise contributory schemes in direct association with the Hospital, both for the ordinary Hospital patients and for the classes who use the pay beds. But in London there are more than 140 Hospitals, a large proportion of which have no definite geographical area of work, while the inhabitants of any given area have in many cases no one Hospital to which they look for treatment more than to any other. When, therefore, after Lord Cave's Report in 1921, a new

contributory scheme for ordinary patients was started for London, it took the form of the Hospital Saving Association, a central body drawing members from all parts of London on the one hand, and, on the other hand, dealing with all the different Hospitals. For the same reasons it seems clear that a large scale insurance scheme for the middle and professional classes in London corresponding to the Norwich scheme would have to take the form of a central organisation like the British Provident Association, acting in co-operation with a large number of different Hospitals. There would then be contributory schemes for all the classes of patient regarded as coming within the extended sphere of the Voluntary Hospital, the Hospital Saving Association with its income limits confining it to the ordinary Hospital patients, and the body on the lines of the British Provident Association for persons above those limits.

Relation to Voluntary Hospitals.

143.—In the second place, a centrally organised scheme of this kind could presumably be worked in conjunction either with pay beds at Voluntary Hospitals or with separate institutions for paying patients only, or with both simultaneously. Members of the scheme treated at ordinary Nursing Homes run for profit could be assisted by the ordinary membership premium up to the £5 a week for three weeks, or whatever amount was found to be actuarially possible and was guaranteed by the scheme; but this would not as a rule cover the charges. Whether it would cover the charges at a separate Hospital would depend, as we have seen, largely on the size of the Hospital, since all the overhead expenses, the cost of special equipment, resident medical staff and the like, would have to be borne by the pay beds alone, whereas in a pay bed department of a Voluntary Hospital they are shared between the pay beds and the ordinary beds to the mutual benefit of both. From the financial point of view it might be found that the choice would lie between the establishment of a few large separate institutions, and a development of the present system whereby a large number of comparatively small pay bed departments are attached to Voluntary Hospitals in all parts of London. The latter alternative might present administrative problems, since a central association, with its more or less uniform rules, rates of premium and of benefit, and so on, would be working with independent Hospitals having to some extent different methods and different maintenance costs. But these difficulties might well be outweighed by the advantages. The members of the scheme might prefer to have beds available near their homes, at local Hospitals which are already known as centres of efficient medical and surgical treatment in the neighbourhood, and at central Hospitals of world-wide reputation. It might be a question between a scheme to establish a few large paying Hospitals financed on mutual lines, whose work would be limited to the treatment of the members of the scheme, and a scheme to assist members of the middle and professional classes to have, in return for appropriate payments, a direct, as well as their present indirect, share in the benefits of the Voluntary Hospital service of London.

Relation to choice of Medical Attendant.

144.—In the third place, any large extension of pay bed accommodation resulting from the establishment of an insurance scheme of this kind might affect the balance of arguments for and against free choice of Medical Attendant. Both the members of the scheme and the medical profession would probably desire that there should be a wide choice. We have already described the present position and have indicated generally at which Hospitals, and which classes of Hospitals, pay bed treatment is confined to the medical staff, those at which it is open to other recognised Consultants, and those at which it is open to any registered Practitioner. We have quoted the arguments for and against the different alternatives. We have found Hospitals which are prepared to contemplate extension to outside Consultants if and when the number of pay beds at these Hospitals is increased; and we have also mentioned the suggestion by the British Medical Association witnesses that if the members of a contributory scheme had a wide choice of Hospitals this would mean in practice a wide choice of Doctor. If these views come to be generally held, and if they are combined with the principle, which we have also quoted from the British Medical Association witnesses, that there need not be uniformity amongst the different Hospitals, and also with our own view that the decision can be left to each Hospital, it should not be difficult for a central insurance association to make satisfactory arrangements on this point with a sufficient number of Hospitals.

pars. 63 to 69

pars. 70 to 75
par. 71

par. 71

pars. 73, 75
par. 80

Relation to medical fees and income limits.

145.—In the fourth place, the question of provision for medical fees would have to be considered, as it is by the British Provident Association, separately from that of maintenance in Hospital. If, as in the Norwich Hospital scheme, there is a strict income limit, so drawn as only to include persons whom the medical staff can fairly be asked to treat at a low maximum fee, then it is doubtless practicable to include the surgical fee as well as Hospital maintenance in the benefits offered in exchange for a fixed premium which is within the means of the whole of the class catered for by the scheme. But where there is no income limit, it would not be possible to fix any general maximum surgical fees lower than the maximum fees charged in private practice. Even if the most expensive cases were first reduced in number by a severe medical examination or declaration of health before admission to membership, the aggregate liability falling on all the membership taken as a whole would be very large. To include it in the scheme would be equivalent to averaging it amongst all the members; and it could only be covered if they all paid a correspondingly large premium. The British Provident Association scheme deals with the problem by having a small ordinary premium which aims at covering Hospital maintenance. Surgical fees then remain a matter for arrangement between Doctor and the individual member, just as they usually are at a Hospital pay bed. Subject to medical fitness at the time of joining, the member can, by taking advantage of a rising scale of supplementary premiums, secure a rising scale of contribution towards the fee so arranged with the Doctor, the balance of the fee being borne by the member himself. The scheme thus permits different sections of its clientele to pay premiums which increase gradually from the minimum required for Hospital maintenance (with a few minor benefits thrown in to increase its usefulness to the average member) upwards through a scale which provides a larger and larger sum towards the cost of surgical fees. So far as fees are concerned, therefore, no income limits are required, since the only effect of the scheme is to assist its wealthier members, by means of larger annual premiums, to pay fees proportionate to their larger annual incomes.

146.—So far also as Hospital maintenance is concerned, there need be no income limit to membership of the insurance scheme. The scheme would not necessarily involve the provision of pay beds at £5 a week for all its members: the British Provident Association at present re-pays the member up to that amount for three weeks, whatever he has to pay. If a Hospital limited its pay beds to persons of moderate means, or if it provided accommodation for the well-to-do at higher rates of charge, the arrangements between the Hospital and the central body of the scheme could be adjusted accordingly.

Relation to provision of capital cost.

147.—In the fifth place, the question of the relation of the insurance scheme to the provision of the capital cost of the beds has also to be considered separately. In the scheme as suggested, it is proposed that members of the middle classes should be invited to subscribe towards the capital cost themselves, and in return to receive a prior claim on the beds thus provided, at rates of charge based on the cost of current maintenance. Whether those who made this contribution were also subscribing members of the scheme and provided for the current cost by means of annual premiums, or whether the amount they contributed in advance was limited to the capital sum and they paid the current cost when the time came, the capital payment would, if its amount was correctly calculated in proportion to their share of the total capital cost of the beds they would occupy, render them entirely self-supporting as regards their Hospital maintenance. They would not be in any degree receiving direct benefit from the general funds of the Hospital, or even from special capital funds received by the Hospital in the past for providing pay beds. Their debt to the Hospital would consist only in the fact that they would indirectly be deriving benefit from the co-operative effort which had provided a Hospital service, and an insurance scheme, which enabled them to obtain full facilities for treatment at a cost within their means. This is a very desirable result, both from the Hospital point of view and on general social grounds. At the same time, we should see no objection to members who cannot afford the capital contribution being admitted to pay beds, the capital cost of which has been provided from other sources, while the maintenance cost is covered by their ordinary premiums.

c.f. par. 49

Conclusion on insurance schemes.

148.—We are of opinion that it is highly desirable that an effective mutual insurance scheme should be organised for assisting prospective pay bed patients to make provision in advance, as has been done for ordinary Hospital patients by contributory schemes like the Hospital Saving Association, and for middle class patients, on a small scale as yet, by schemes such as those of the British Provident Association and the Norfolk and Norwich Hospital.

THE QUESTION OF PROVISION FOR THE WELL-TO-DO.

149.—As already stated, our terms of reference do not exclude the question of Hospital provision for the well-to-do—i.e., those whose income is such that, after allowing for their liabilities, they can pay the full charges of an efficient Nursing Home and full medical or surgical fees. But as this is not the primary object of our Inquiry, we have thought is best to deal with it in a separate section.

150.—The only Hospital in London that definitely makes provision for this class is the Hospital of St. John and St. Elizabeth, where the charges for single rooms are from 8 to 10, or sometimes 15 guineas, besides extras. These are described as the ordinary Nursing Private Home fees; the Hospital takes and expects to receive in these rooms the kind of patient who goes into a West End Nursing Home; and the patients are expected to pay full consultants' fees, though the Hospital as such has no knowledge of what is paid. At other Hospitals which have, or suggest having, beds at £8 8s. to £10 10s., these beds are not intended for the wealthy, though often there is no actual income limit, and sometimes quite well-to-do patients come in, even at £8 8s. Generally speaking, it may be said that provision for the wealthy means weekly charges of over £10 10s., plus extras and full medical fees; while beds at £8 8s. to £10 10s. cater for an intermediate class.

578 cf. 66 581 393 563 cf. 1265 26, 66, 397 763–4, 1265 1179–1191 348–9

151.—Proposals for providing expensive rooms of this kind have been considered by some Hospitals, and we have discussed the question with several of the witnesses giving evidence on the general subject. It arises most often out of suggestions for the introduction of the system, typically developed in the United States, under which the Hospitals make provision for all classes of the community, and each class, other than the really necessitous, pays according to its means. We had evidence about this from Dr. McNee, who has had experience of American Hospitals, and from Dr. Goldwater, the Director of Mount Sinai Hospital, New York.

329, 397 cf. 1266 1639 798–895 1352–1477 App. IX

152.—The suggestion that this system should be introduced into London Hospitals has been supported by various arguments. In the first place, there is said to be a real demand, because even the wealthy cannot obtain elsewhere, at all events not under one roof or with equal efficiency, the accessory services provided by the equipment and resident staff of a Hospital. In the second place, it is held that the Hospitals, by supplying this demand at its full price (quoted as 15, 20, 25 or 30 guineas) can make profits which will assist them in making provision at low rates for those who cannot afford to pay their cost. Some witnesses consider that, from the financial point of view, the introduction of this system is essential to any considerable development of the provision of pay beds, especially if the total receipts, taking all classes of private patients together, are to cover not only maintenance expenses, but also capital charges. In the third place, it is suggested that, quite apart from the profit on the beds, the Hospitals would gain more voluntary support from the wealthy for their primary work of treating the sick poor.

66–8, 163 348–9, 396 441–2, 610 715, 891 1204, 1257 1315, 1336–8 1724 26, 66, 398 559, 1315, 1336, 1345 1525 26 117, 163 1262–4

153.—It is nowhere proposed that accommodation for the wealthy should be provided for its own sake, or as itself one of the primary objects of a Hospital: it always comes after provision for those unable to pay full rates, and as an indirect means of increasing that provision. It may here be noted that where the primary object of the Hospital is defined in its charter, or in trust deeds governing endowments, or in other legal documents, as being the treatment of the necessitous, the question has come before the Charity Commissioners in connection with pay bed schemes submitted for their sanction. Their decisions on such schemes have been based on the following principles: that (except where the trusts absolutely require gratuitous treatment) the term "necessitous" can often be so interpreted as to include what are called the "new poor," provided that accommodation is retained for the original beneficiaries

398 1266, 1273–4 1506 1621 1634 1628, 1651 1629, 1631

1622
1638–40
1630, 1647–51

at least equal in amount to that originally intended; that parts of the original building may in some circumstances be used temporarily for middle-class patients if the Hospital cannot maintain them for ordinary patients; but that land or buildings subject to such trusts could not be used to provide accommodation for the rich unless the Hospital charged a full rent, and did not require the property for other purposes. The interpretation of the law, where trusts are concerned, thus coincides with the policy which on general grounds has been suggested to us by witnesses.

329, 1090, 1148, 1204; cf. 1696, 275, 287; 489–0; 1227; 1407–15 1180–9, cf. 898; 926, 931 1310, 1700 1273, 1282, 1312–3, 1342 1505, 1702–5 1091–5 1703, 1747

154.—Opinions have also been expressed to us to the effect that developments on the lines suggested would meet with the general approval of the medical profession, provided that there was free choice of Doctor, and that the really well-to-do were not admitted to membership of insurance schemes which allowed of reduced medical fees. On the other hand, it has been suggested that the demand for such accommodation would not be great, especially at Hospitals whose geographical situation is unfavourable; that the really wealthy can already obtain all the services they need by paying for them; that the Hospital staffs and equipment are already fully occupied with other work; that the American system could not be grafted on to the English Voluntary Hospital system; and that the provision of expensive beds, as a "business" or "money-making enterprise" would not really be good propaganda, but would tend to alienate sympathy, and that it had better be done by means of separate paying Hospitals.

1684–7 1525

155.—Our own conclusion is that provision by Voluntary Hospitals for this class of patient, subject to the conditions mentioned in paragraph 153, might well be made. It is often an advantage to the wealthier patient, as well as to the poorer, to have access to the resources of a fully equipped Hospital. It is an advantage to the Voluntary Hospital service that all classes should come to recognise from personal experience the part which the Hospitals play in the development of the most advanced forms of diagnosis and treatment. Inasmuch, however, as the class of patient who now goes to Nursing Homes of the best type is always able to find accommodation, while the poorer patient, if he cannot find a pay bed in a Hospital, has to put up with accommodation and nursing of an inferior type, we consider that, if space or other facilities are limited, the provision for the latter should be regarded as the more urgent, and the provision for the well-to-do, where made, should be on such terms of payment as should, after including rent, interest on capital, and a full share of all overhead charges, yield a surplus which can be used to promote the primary objects of the Hospital.

GENERAL SUMMARY OF THE REPORT.

156.—The following is a general summary of the foregoing sections of this Report.

157.—Ordinary Voluntary Hospital patients may be regarded, generally speaking, as those who come within the income limits of the National Insurance Act or the Hospital Saving Association, i.e., below £250 to £300 a year. They are either treated in the ordinary wards free or contribute voluntarily towards their maintenance, according to their means. Their maximum contributions rarely exceed 2 guineas a week, the average for those who contribute being 15s. or less.

pars. 7–9

158.—Those for whom the question of special or "pay bed" accommodation has to be considered consist primarily, though not exclusively, of persons of moderate means who can pay up to 4, 5, 6 or sometimes 7 guineas a week and a limited amount in medical fees, their maximum income being variously placed at £500, £1,000 or even £1,500 a year or more, according to their circumstances.

pars. 10–17

159.—There are already pay beds at 80 of the Voluntary Hospitals of London, the total number of such beds being 1,055, of which 522 are at Special Hospitals. The accommodation includes single-bedded rooms or cubicles, small wards of from 2 to 8 beds, and large wards up to 24 beds, with or without curtains. Besides this greater degree of privacy, there is usually a fuller or more varied diet than in the ordinary wards, and often other special amenities or privileges as well.

pars. 18–33

160.—The weekly charges for maintenance in these beds range from 2 guineas a week up to 10 guineas or more. There are about 543 beds at 4 to 5 guineas; 161 beds at 6 guineas; 244 beds at 3 guineas or less; and 197 beds at 7 guineas or more. Charges vary partly with

pars. 33–42

the class of Hospital, partly with the kind of accommodation, partly with the class of patient
pars. 43–49 catered for, partly with other circumstances. Sometimes the charge is designed just to cover the maintenance cost. Sometimes the charges are less than the cost, and the difference is made up out of the general fund of the Hospital. Sometimes there is a profit, which is used to assist the general work of the Hospital. Sometimes there is a deficit on some of the pay beds, covered by a profit made on others.

161.—The Hospital often makes extra charges for specific services which are not included
pars. 50–52 in the weekly charge. These may include anæsthetist, use of operating theatre, X-ray, pathological examinations, special nurses, etc.

162.—Besides the Hospital charges for maintenance and extras, the pay bed patient
pars. 53–58 normally pays a fee to his physician or surgeon. The amount of the fee is usually arranged privately between doctor and patient. It may include some of the extras. It is often on a modified scale. Sometimes the fee is arranged by the Hospital; occasionally there is a fixed maximum; and at a few Hospitals no medical fee is permitted at all. At others, patients of limited means may be treated free.

163.—As regards choice of medical attendant, treatment in about 640 pay beds at 53
pars. 59–75 Hospitals is confined to the medical staff of the Hospital. In about 200 beds at 12 Hospitals it is open to other recognised Consultants. In about 160 beds at 19 Hospitals there is free choice of any Registered Practitioner; 12 of these are small suburban or Cottage Hospitals, 2 are Special
pars. 76–80 Hospitals, and there are exceptional circumstances at the others. At almost every Hospital the patient's own General Practitioner is encouraged to keep in touch.

164.—The patients using the accommodation thus described are mostly persons of
pars. 81–87 moderate means, able to pay charges approximately covering their maintenance cost and also a modified medical fee. A few Hospitals provide pay bed accommodation for patients in straitened circumstances, unable to pay more than ordinary patients, if as much. There is also a small number of beds specially provided for well-to-do patients able to pay high charges and ordinary fees, the Hospital making a profit. At some Hospitals with moderately priced pay beds there is a more or less definite income limit; at others it is an understanding with the medical staff that the beds are intended for persons of moderate means; at a few, mostly suburban, there is no such rule or understanding at all.

165.—It has been made abundantly clear that there is an unsatisfied demand for more
pars. 88–104 pay bed accommodation. The evidence comes from Hospitals that have pay beds, from Hospitals that have none, from medical witnesses speaking from their own experience, from associations representing various professions and sections of the middle classes, and from other witnesses. Patients who could afford the cost of pay bed accommodation are sometimes admitted into the ordinary wards of Hospitals without pay beds, because they need full Hospital facilities. As regards class of accommodation, there is most frequently a desire for single-bedded rooms, if these can be provided cheaply enough. As regards capacity to pay, the largest demands comes from two sections—those who have a rather higher income than the ordinary Hospital patient, but who yet cannot afford the full cost of a pay bed as well as a reduced medical fee; and those somewhat better off, who can afford 4, 5 or 6 guineas a week and a moderate fee. There is also a demand for beds at higher rates from those who can afford Nursing Home charges, but who cannot readily obtain elsewhere the full facilities which a Hospital provides.

pars. 105–107 166.—As regards the method of supplying the demand, it is necessary to consider what the existing alternatives are. These include the pay beds at Voluntary Hospitals, already described, at various rates of charges largely intended for persons of moderate means; a small amount of accommodation in separate Hospitals or Homes run on Nursing Home lines, but with restricted profit, so as to make some provision for persons of moderate means; and the existing accommodation at private Nursing Homes, at charges which provide a commercial profit.

par. 108 167.—Several witnesses have laid stress on the advantages which patients can obtain at a fully staffed and equipped Hospital, as compared with the great majority of Nursing Homes. These include lifts, operating theatres, and facilities for X-ray and other examinations and treatments under the same roof; and usually the presence of a Resident Medical Officer. The Select Committee of 1926, after discussing the disadvantages of the converted dwelling-house, expressed the opinion "that the future trend of development in regard to the provision

ERRATA

Paragraph 160: Existing Hospital Beds:—
For "543" at 4 to 5 guineas read "557"
" "161" " 6 guineas " "158"
" "244" " 3 guineas or less " "230"
" "197" " 7 guineas or more " "100"
to agree with paragraph 39.
Paragraph 163: Wider Choice of Consultant:—
For 200 beds at "12 Hospitals" read "13 Hospitals"
to agree with paragraphs 65–67.

" of accommodation for the paying patient should run more along the lines of the provision " of specially built and equipped Private Hospitals and Homes, and of the extension of the " paying-ward system in the existing big Hospitals."

pars. 109-118 168.—In considering these two alternatives, we have discussed the arguments against pay beds at Voluntary Hospitals as compared with separate Hospitals, and have shown that these arguments can be answered from the experience of the Hospitals that already have pay beds, and from a consideration of the present-day definition of the functions of the Voluntary Hospital system. This may be held to include provision not only for the sick poor in the original sense of the term, but also, on suitable terms of payment, for all those who, while not coming within the definition of the necessitous poor, are unable to obtain without some such assistance the medical treatment they need.

169.—The alternatives are not mutually exclusive. It may be possible for the private Nursing Home to provide what is required at prices suited to the well-to-do. There may be room for the development of separate institutions on Hospital lines, with full equipment and staff, though they would probably have to be on a large scale in order to keep the equipment and staff fully utilised and to spread the cost over enough patients to admit of moderate charges. There is certainly room for a considerable increase in the provision of pay beds at Voluntary Hospitals, where at each Hospital a comparatively small number of pay beds can share with the ordinary wards the advantages and the cost of full Hospital equipment and of the nursing and other technical staff, and where these advantages can thus be more easily brought within the reach of patients of moderate means.

pars. 119-20 170.—The Voluntary Hospitals already have schemes in hand or in active preparation which would increase the number of pay beds from 1,055 to more than 1,300, and there are further schemes more or less definitely under consideration which would make the total rather more than 1,900. The addition in this way of another 900 beds would be a substantial step in advance, though obviously it would not be a final total, and the additional beds need not necessarily be confined to these particular Hospitals.

171.—Our consideration of the method of providing for the cost of maintaining additional pay bed accommodation, and of meeting the capital cost of building and equipment, has raised

pars. 121-148 so many questions of principle affecting the whole of the pay bed problem, that the results can best be set down in the form of the general conclusions arising out of the Inquiry.

CONCLUSIONS.

172.—In stating these conclusions, we do not recommend that the King's Fund should

par. 125 lay down any rules that would either condemn or stereotype any of the methods which have hitherto been adopted more or less experimentally by the various Hospitals. We suggest, however, that the following should be the principles to be aimed at in any general extension of the system in connection with Voluntary Hospitals :—

pars. 122-125 (i) That pay bed accommodation should, as a general rule, be provided at rates of charge which at least cover the current maintenance cost of all the pay beds in the Hospital taken as a whole;

(ii) That the provision of special accommodation on a limited scale for patients of small means, at rates which involve a charge on the general fund, can legitimately be regarded as coming within the present extended function of the Voluntary Hospital system, provided that it is looked upon as a secondary part of that function, and that the treatment of ordinary patients is maintained as the primary part;

(iii) That, if at any given Hospital it is uncertain whether this second principle is compatible with the stated objects of the institution, such low-priced accommodation should not be provided unless a sufficient amount to cover the resulting deficit is received in contributions from donors who have specifically indicated that they have no objection to this deficit being met out of their contributions;

pars. 126-128 (iv) That no patient in a pay bed should pay any fee to a Physician or Surgeon, whether a member of the medical staff or not, for treatment received in the

Hospital, unless the charges which that individual patient pays to the Hospital cover the whole cost to the Hospital of his current maintenance and of any specific services he receives from the Hospital;

pars. 129–131 (v) That it is not necessary that the weekly charges should cover interest on capital as well as current maintenance, for the purpose of calculating the relation of charges to cost in connection with the principles just mentioned;

(vi) That, if the weekly charges do not cover interest on the capital cost of providing pay beds, this capital cost should be met out of funds specially contributed for the purpose, or out of the proceeds of building appeals in which the proposal to provide pay beds has been specifically mentioned;

(vii) That it should be recognised that pay bed patients who are merely paying their current cost, and who have not themselves contributed to the capital cost, are, in obtaining what they cannot afford to provide for themselves, deriving benefit from funds contributed to the Voluntary Hospital system.

par. 132 (viii) That it is desirable that as many prospective pay bed patients as possible should be enabled to place themselves in a position in which they can pay the full cost of maintenance in a pay ward and a medical fee as well.

pars. 132–148 (ix) That, to secure this, an effective mutual insurance scheme should be organised for assisting prospective pay bed patients to make provision in advance, as has been done for ordinary Hospital patients by contributory schemes like the Hospital Saving Association, and for middle class patients, on a small scale as yet, by schemes such as those of the British Provident Association and the Norfolk and Norwich Hospital;

(x) That it is desirable that, so far as London is concerned, an insurance scheme of this kind should, like the Hospital Saving Association, be organised by a central body working in co-operation with the individual Hospitals with pay beds;

(xi) That full consideration should be given to the suggestion that a scheme of subscription to the capital cost of providing pay bed accommodation might be associated with an insurance scheme covering maintenance charges;

(xii) That the provision of a large capital sum for the building and equipment of pay beds for the use of those who cannot afford more than the cost of maintenance would be a form of assistance to the Voluntary Hospitals which might be commended to possible donors.

173.—The following are other conclusions at which we have arrived:—

(xiii) On the question whether treatment of pay bed patients should be confined to the medical staff of the Hospital, or should be open to other Consultants, or to any Registered Practitioner, we have set out the arguments for and against the various alternatives. The balance of these arguments may be affected differently by the circumstances of different Hospitals: by the relation of the pay beds to the rest of the Hospital; by the number of pay beds at the Hospital; by increases in the number of Hospitals that have pay beds; and by any general development of insurance methods as a means of assisting prospective pay bed patients to meet Hospital charges and medical fees. We regard the question as one which the Committee of Management of each Hospital should decide for itself;

pars. 70–75

par. 144

pars. 149–155 (xiv) On the question of pay bed accommodation for the well-to-do, we consider that, in view of the difficulty of obtaining full Hospital facilities except at beds connected with Hospitals, this might well be provided on a limited scale by Voluntary Hospitals, provided that the accommodation is not required for ordinary patients or cannot be maintained for them, that priority is given to provision for those of moderate means, and that the charges to the well-to-do are sufficient to cover the whole cost of the beds provided for them, including rent and interest on capital, and to yield a profit available for other purposes of the Hospital;

(xv) We doubt whether the nature and extent of the existing pay bed accommodation at Voluntary Hospitals is generally known by the members of the middle and

professional classes. We suggest that the Management Committee of the King's Fund might consider whether the Fund should prepare and publish year by year for the information of the public a list of the pay beds at the London Voluntary Hospitals, with rates of charge and other particulars;

pars. 44–48

(xvi) We have referred to the difficulty of obtaining any reliable estimate of the cost of maintenance of pay beds. It seems to us very desirable that each Hospital should know definitely what the relation is between the payments received from pay bed patients and their cost. We suggest that the Hospital Economy Committee of the King's Fund should use its influence to secure wherever practicable the introduction of records which would have this effect.

Summary of conclusions.

174.—Finally, we may sum up our conclusions as follows:—

(xvii) We consider that the existing provision of 1,055 pay beds has proved to be a very valuable addition to the Voluntary Hospital service of London; that a material extension of this provision is urgently required to meet the existing demand; and that the organisation of a mutual insurance scheme to assist persons of moderate means to meet the cost of maintenance and medical fees is strongly to be recommended.

(xviii) We believe that an extension of the pay bed system at the Voluntary Hospitals, with due safeguards for the maintenance and extension of the ordinary beds, would be of advantage to the patients of all classes, to the individual Hospitals, and to the Voluntary Hospital system as a whole. The pay bed patients of moderate means would benefit because they would obtain accommodation and treatment at charges within their means, especially if aided by a scheme of insurance to make provision in advance. The well-to-do pay bed patients would benefit because they would obtain, in accommodation attached to a Hospital, facilities which can rarely be fully secured elsewhere—such as the constant presence of skilled medical and surgical attention in emergencies, and of a complete organisation of all the necessary ancillary services. They would in return pay charges which, when combined with the reduced cost effected by the large scale organisation of the whole institution, would assist the Hospitals to finance their ordinary work. The ordinary Hospital patients would have the use of beds in the general wards which are now occupied, as a matter of urgent necessity, by patients who absolutely need the special facilities of a Hospital, and who could and would pay extra for special accommodation if it was available. The Hospitals would greatly extend their usefulness and increase their prestige. It would be an advantage to them that all classes should come to recognise from personal experience the part which they play in the development of the most advanced forms of diagnosis and treatment. This experience would be a further stage in the movement by which the Voluntary Hospital system is already becoming largely a co-operative effort in which all classes of the community, including the Hospital patients themselves, combine, as their means permit, to provide Hospital services which produce benefits for all classes: directly for the less wealthy because without the Hospitals the necessary medical treatment cannot be brought within their means, and indirectly for the more wealthy because without the Hospitals the necessary medical treatment would not exist.

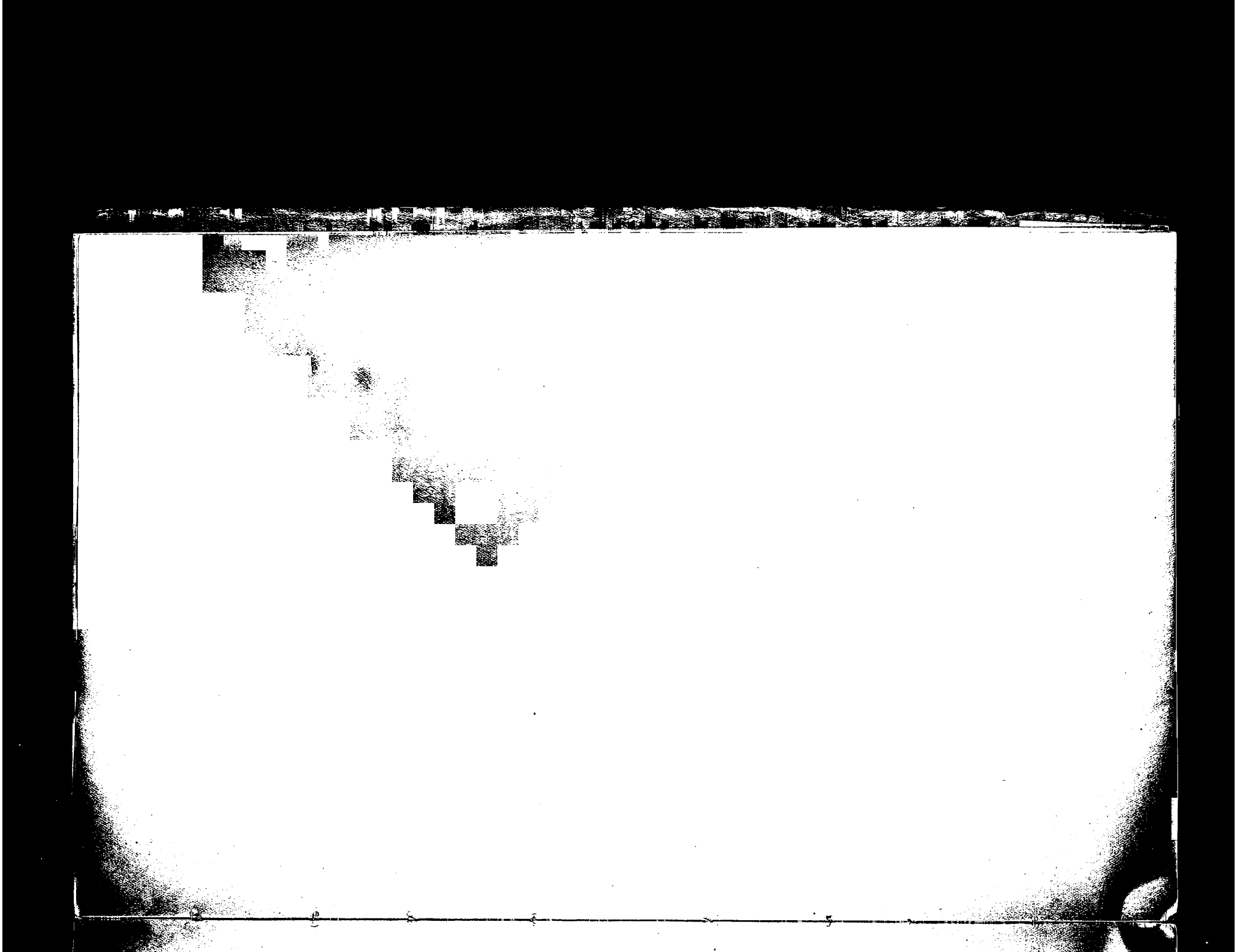
175.—The Committee are greatly indebted to the Honorary Secretaries of King Edward's Hospital Fund, Lord Somerleyton, Mr. Leonard Cohen and Colonel H. A. Wernher, for their regular attendance during the Inquiry and for many helpful suggestions.

176.—The Committee desire to record their appreciation of the great assistance rendered to them throughout the Inquiry, and especially in the preparation of the Report, by Mr. Maynard. They also wish to acknowledge the services of the other members of the Staff of the King's Fund for their help in the work of the Committee, which they have greatly facilitated.

177.—Lord Hambleden's signature is missing from this Report to the deep sorrow of all concerned in our Hospitals and their work. By none is this sense of loss more deeply felt than by his late colleagues on the Committee, with whom he was in complete accord during the time he was able to share in their deliberations. His great experience of Hospital work was of invaluable assistance to the Committee. He had presided over all the meetings for the receipt of evidence, including two at which the question of general conclusions was discussed. In spite of illness, he had prepared some notes as a basis for a Draft Report, and, notwithstanding its increasing gravity he had seen and made brief comments on the proofs of the Report, though unhappily he was debarred from seeing the Summary.

JOHN ROSE BRADFORD, *Acting Chairman.*
BERNARD MALLET.
V. WARREN LOW.
WINIFRED C. CULLIS.

H. R. MAYNARD,
Secretary.
7 WALBROOK, E.C.4.
July, 1928.



LIST OF APPENDICES.

APPENDIX I.

QUESTIONNAIRE ISSUED TO HOSPITALS.

1. (*a*) Has the Hospital any special beds for patients paying on a higher scale than an ordinary Voluntary Hospital patient ?.....
   (*b*) If there are no such beds, please answer questions 17, 18 and 19, and add Remarks (if any) under 20.
2. Please state the normal scale (or scales) of weekly charges for these beds.*
3. Please state the total number of these beds available
   (*a*) at December 31, 1926.....
   (*b*) at present (if not the same number).....
4. If the use of these beds (or any of them) is confined to (*a*) medical cases, (*b*) surgical cases, (*c*) specialties, (*d*) other medical categories, please give particulars, with respective numbers; subdividing (where applicable) into (i) men, (ii) women, (iii) children (with age limits for children).
5. What is the general method of admission to these beds (e.g., through the medical staff, through the Hospital Secretary, etc., etc.) ?
6. Is admission to these beds subject to any limitation in respect of financial position ?..... If so, please give particulars, and state by whom, and by what method, financial suitability is determined.
7. Is admission limited in any other way (e.g., by place of residence, nationality, religion, medical suitability, etc., etc.) ?
8. Please give a brief description of the accommodation (e.g., whether in general wards ; in separate wards ; in a separate block ; how many in single-bed wards, in 2-bed wards, etc., etc., and whether completely separated or divided by partitions, or by curtains, or otherwise).
9. Does the service differ from that of general wards in respect of diet ; kitchen arrangements ; nursing staff ; ward equipment ; or in other ways ?
10. Do the weekly charges quoted in 2 cover every Hospital service except the medical attendance referred to in 12 ?..... If not, please state the nature of the service(s) for which extra is charged by the Hospital and the amount of the extra charge (e.g., operating theatre fee, extra nursing, anæsthetist, X-ray, electrical, pathological, massage, etc., etc.).
11. Does the Hospital provide these patients with any facilities for subsequent special out-patient treatment (e.g., X-ray, etc.), and, if so, on what terms ?
12. (*a*) What are the rules as regards choice of medical attendant (e.g., can patients be attended by any General Practitioner or Consulting Physician or Surgeon they choose ; or must they be attended only by a member of the staff of the Hospital ? Are there any other limitations, and, if so, what) ?
    (*b*) What is the procedure as regards fees to the medical attendant referred to in 12 (*a*) (e.g., are the patients, or any of them, treated by the medical staff of the Hospital without fees ; do the patients make their own arrangements independently of the Hospital ; or does the Hospital, through any Committee or official or otherwise, take any cognisance of the arrangements, or exercise any control or supervision of the amount of the fees paid, and is there any scale of fee or any prescribed maximum; if so, please give particulars if possible) ?
    (*c*) Is there a Resident Medical Officer, and are his services available for these patients (i) without further charge ?..... (ii) with further charge ?.....
    (*d*) Do the arrangements provide for, or admit of, the patient's own General Practitioner (if he is not the medical attendant referred to in 12 (*a*)) keeping in touch with the patient, or with the treatment, while the patient is in the Hospital ?
13. (*a*) What was, for the year 1926, in respect of these special beds :
    (i) the average number of these beds occupied ?.....
    (ii) the total number of new patients admitted to them ?.....
    (iii) the average days of residence per patient in them ?.....
    (*b*) Does the difference between the total number of these beds and the average occupied represent the normal unavoidable loss of time between one patient and the next, or is it partly due to any other cause ?
14. (*a*) How do the receipts from these beds compare with the expenditure (e.g., do the receipts, generally speaking, exceed, or fall short of, the expenditure ; or are they equal ; and does expenditure in this comparison include any of the following items :—establishment renewals and repairs, administration, rent or interest on capital) ?
    (*b*) What were the total receipts from these beds in 1926 ? £.....

* NOTE (*a*)—If there are different rates of pay or contributory beds for these patients, please give (where necessary) separate answers to the various questions for each grade.

NOTE (*b*)—If it is desired that any particular answer should be regarded as private, this should be indicated against that answer.

(*c*) What was the total expenditure on these beds in 1926 in accordance with the details on the enclosed form P.B.8A ? £.....
If this figure cannot be given immediately, please leave blank and state here by what date you can supply the information on Form P.B. 8A.....
(*d*) Are the figures in (*b*) and (*c*) normal, or were they materially affected by any special circumstances in 1926 (if the latter, please add the figures for some recent normal year) ?

15. (*a*) Were these beds first provided before August 1914 ?.....
If later, please give the year.....
(*b*) Are they allotted to this purpose permanently, or only temporarily pending use as ordinary beds, or for some other purpose ?

16. (*a*) Is the capital cost of these beds known ?.....
(*b*) If so, please give the figure (stating what the figure includes, e.g., site, buildings, equipment, fees, sundries ; and approximate date of building).
(*c*) From what source was the capital cost provided (e.g., from the building fund of the original Hospital or other building fund without special reference to these beds ; from a building appeal for a scheme which included these beds ; from a building appeal confined to these beds ; from general fund surpluses, etc., etc.) ?

17. What is the view of the Hospital as to the existence of an unsatisfied demand for this kind of accommodation (e.g., (*a*) generally, (*b*) locally, (*c*) for special classes of patient ?

18. (*a*) Has the Hospital any scheme for providing beds of this kind, or for adding to the present number ?.....
(*b*) If so, how many ?.....
(*c*) What stage has the scheme reached, and when are the beds likely to be provided ?
(*d*) Is it yet possible to give answers to any of the questions 4 to 16 in respect of these future beds ? If so, please give the proposed particulars in the future tense under each question.

19. What is the highest patients' payment normally paid by ordinary in-patients of the Hospital ?

20. Remarks. (Information would be welcomed on the following points amongst others :—Difficulties or questions, if any, that arise in practice ; objections, if any, arising out of the objects, constitution, trusts, or policy of the Hospital, area of its site, or otherwise, to the provision of such beds ; effect (if any) of the presence or absence of such beds on public support for the Hospital ; effect (if any) of the presence or absence of such beds on the amount of accommodation available in the ordinary wards for ordinary Voluntary Hospital patients, etc., etc.).

APPEN

SUMMARY OF REPLIES TO QUESTION

General Hospitals

No.	Hospital.	Total beds normally available 31.3.28.	Pay Beds normally available 31.3.28.	Number of Pay Beds in each ward (and classification, if any).	Normal weekly charge: guineas. See note * below.	Procedure as regards medical fees.	By whom patient is attended.
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1	Guy's	643	30	30 cubicles (partitions and curtains) (12 m. 18 f.).	5 gns.	Arranged privately.	Any consultant with approval of Superintendent.
			1	1-bed.	6 gns.		
2	King's College ...	356	48	24-bed (curtains).	5 gns.	Arranged privately or through House Governor.	Medical staff.
			2	2-bed.	6 gns.		
			12	1-bed (31 m. 31 f.).	8 gns.		
3	Royal Free ...	268	6 }	1-bed (3 f. maternity).	6 gns.	Arranged privately.	Medical staff.
			3 }		7 gns.		
4	St. Thomas's ...	621 (A)	34	34 cubicles (walls and curtains).	6 gns.	Arranged privately or through Resident Medical Officer.	Any consultant (the usual supervision is in the hands of the Resident Medical Officer).
			6	1-bed (18 m. 22 f.).	9 gns.		
5	University College	466 (B)	8	1-bed (ear, nose and throat).	6 gns.	Arranged privately.	Medical staff.
6	Westminster ...	234	8	4-bed.	6 gns.	Arranged privately.	Medical staff.
			6	1-bed.	10 gns.		

* In nearly every case one or more of the following specific services, if required, are charged for as extras, Exceptionally expensive drugs and/or dressings; Electrical treatment; Light treatment; Massage; Extra nurses; sometimes as an addition to the hospital charge, sometimes as part of the medical fee, viz., Anæsthetist; Operating theatre; Pathological examinations; Radium; X-ray.

† The grouping of the Hospitals is based on the method adopted in the King's Fund Statistical Report on cost of working, &c., which is as follows, viz. :—I. General Hospitals with Medical Schools; II. General Hospitals without Medical Schools having 150 beds or over normally available; III. General Hospitals having 70 to 149 beds normally available; IV. General Hospitals having under 70 beds normally available, with a Resident Medical Officer; V. General and Cottage Hospitals having 30 beds or over without a Resident Medical Officer; VI. General and Cottage Hospitals having under 30 beds, without a Resident Medical Officer; VII. Hospitals for Women; VIII. to XIV. Various other Special Hospitals. In the Pay Beds Report the Hospitals are arranged in the following order:—General Hospitals with Schools (Group I); General and other Hospitals with Resident Medical Officers (II to IV); General, Cottage and other Hospitals without Resident Medical Officers (V and VI); Hospitals for Women (VII); Other Special Hospitals (VIII to XIV). Hospitals for members of the middle and professional classes are grouped with the Hospitals to whose pay bed departments they are most akin.

Notes: (A) St. Thomas's—Includes 40 beds at St. Thomas's Home; the Pay Beds are in this Home.

(B) University College—Includes 38 beds at Royal Ear Hospital; the Pay Beds are in this Branch.

DIX II.

NAIRE: HOSPITALS WITH PAY BEDS.

with Schools.†

Arrangements as to services of Resident Medical Officer.	Whether patient's practitioner can keep in touch.	(a) By whom patient is admitted. (b) Whether any financial limitation. (c) By whom financial suitability is determined.	Average occupied Pay Beds 1926 compared with Pay Beds available 31.12.26.	Pay Bed patients admitted 1926.	Average period of residence of Pay Bed patients in days 1926.	No.
(9)	(10)	(11)	(12)	(13)	(14)	(15)
Available free.	Yes—by arrangement with medical staff.	(a) Medical staff or Superintendent. (b) No limit, but patients are usually of moderate means.	23·9/31	662	12·9	1
Attends free daily.	Yes—by arrangement with medical staff.	(a) Medical staff. (b) No limit, but intended for patients of moderate means.	51·0/63	1,008	17·4	2
Attends free daily.	Yes—by arrangement with medical staff.	(a) Medical staff. (b) Intended for patients of moderate means.	6·8/9	160	15·5	3
Available free.	Yes—by arrangement with Resident Medical Officer.	(a) Secretary, R.M.O. or Steward. (b) Inability to meet Nursing Home and Surgeon's Fees. (c) R.M.O. and Steward.	33·3/40	773	15·0	4
Available free.	No.	(a) Medical staff. (b) Yes; limit.	(Not opened until 1927)			5
Available free.	Yes—by arrangement with medical staff.	(a) Medical staff or Secretary. (b) Not intended for wealthy patients.	13·7/14	225	22·7	6

General and other Hospitals with Resident Medical Officers.†

No.	Hospital.	Total beds normally available 31.3.28.	Pay Beds normally available 31.3.28.	Number of Pay Beds in each ward (and classification, if any).	Normal weekly charge: guineas. See note* on p. 42.	Procedure as regards medical fees.	By whom patient is attended.	Arrangements as to services of Resident Medical Officer.	Whether patient's practitioner can keep in touch.	(a) By whom patient is admitted. (b) Whether any financial limitation. (c) By whom financial suitability is determined.	Average occupied Pay Beds 1926 compared with Pay Beds available 31.12.26.	Pay Bed patients admitted 1926.	Average period of residence of Pay Bed patients in days 1926.	No.
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)
7	Acton	50	4 2	2-bed. 1-bed.	3½ gns. 4 gns. (A)	Arranged privately.	Medical staff and any consultant.	Available free.	Yes—by arrangement with medical staff.	(a) Medical staff. (b) No limit.	5·0/6	86	21·0	7
8	Bolingbroke ...	120	5 10	5-bed. 1-bed.	4 gns. 6 gns.	Arranged privately.	Honorary Medical staff and any consultant of a recognised Hospital.	Available free.	Yes—may visit and attend operations.	(a) Medical staff. (b) No limit.	8·0/12	140	19·8	8
9	Connaught (B) ...	100	10	1-bed (5 m. 5 f. or ch.).	5 gns. minimum.	Arranged privately.	Medical staff.	Available free.	Yes.	(a) Medical staff or Secretary. (b) No limit, but intended for patients of moderate means.	(Not opened until 1928)			9
10	German	160	4 6	2-bed (2 m. 2 f.). 1-bed.	4 gns. 5 gns.	Arranged privately (fees collected by Secretary, if so requested by medical staff).	Medical staff.	Attends free daily.	Yes—by arrangement with medical staff.	(a) Medical staff, or, in exceptional cases, Secretary. (b) No limit, but intended for patients of moderate means.	3·0/10	127	9·2	10
11	Hampstead ...	122	7 4 3	7-bed. (7 f.). 4-bed. 3-bed.	3½ gns.	Arranged privately.	Any practitioner, but operations may be performed only by Surgeons of London General and Special Hospitals.	Available free in an emergency.	*See* column (8).	(a) Secretary or Matron, on receipt of practitioner's certificate of responsibility. (b) No limit, but intended for patients of moderate means, especially beds at 3½ gns.	14·8/20	332	17·0	11
	Ditto ...		2 4	1-bed.	5 gns. 6 gns.									
12	Hospital of St. John and St. Elizabeth	134	2	1-bed (endowed).	50/–	Assessed by Special Committee (Medical Superintendent, Secretary of Medical Committee and Matron).	Medical staff.	Available in an emergency.	Yes—patient is responsible for any extra fees.	(a) Special Committee (Medical Superintendent, Secretary of Medical Committee and Matron). (b) Yes; limit. (c) Special Committee (as above)	22·6/28	318	25·2	12
	Ditto ...		16	1-bed.	8 gns. to 15 gns. (C)	Arranged privately.	Any practitioner.	Available in an emergency.	*See* column (8).	(a) Medical staff. (b) No limit.				
	Ditto ...		10			Arranged privately.	Medical staff.	Available in an emergency.	Yes—by arrangement with medical staff.	(a) Special Medical Officer. (b) No limit.				
13	Ilford	64	4 8 2	4-bed. 2-bed. 1-bed.	3½ gns. 5 gns.	Arranged privately.	Any practitioner.	Available free.	*See* column (8).	(a) Medical staff. (b) Limited means. (c) Medical staff and/or House Committee.	?	108	?	13

† *See* note † on page 42.

Notes: (A) Acton—Non-local residents are charged 4 gns. in the 2-bed wards and 5 gns. in the 1-bed wards.
(B) Connaught—Formerly the Walthamstow, Wanstead and Leyton Children's and General Hospital.
(C) Hospital of St. John and St. Elizabeth—10 beds for Priests and Nuns of the Diocese of Westminster, to whom no charge is made but on whose behalf donations are given.

General and other Hospitals with Resident Medical Officers †—*continued.*

No.	Hospital.	Total beds normally available 31.3.28.	Pay Beds normally available 31.3.28.	Number of Pay Beds in each ward (and classification, if any).	Normal weekly charge: guineas. See note* on p. 42	Procedure as regards medical fees.	By whom patient is attended.	Arrangements as to services of Resident Medical Officer.	Whether patient's practitioner can keep in touch.	(a) By whom patient is admitted. (b) Whether any financial limitation. (c) By whom financial suitability is determined.	Average occupied Pay Beds 1926 compared with Pay Beds available 31.12.26.	Pay Bed patients admitted 1926.	Average period of residence of Pay Bed patients in days 1926.	No.
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)
14	Italian	58	5	1-bed.	3 gns.	No fees are allowed.	Medical staff.	Available free.	Yes—information is given by Resident Medical Officer or medical staff.	(a) Medical staff or Secretary. (b) Inability to meet Surgeon's Fees.	The Inment was tically th	patient d closed f e whole	epart- or prac- of 1926.	14
15	King Edward Memorial	104	8	1-bed.	4½ gns.	Arranged privately.	Any practitioner.	Available: extra fee arranged privately.	*See* column (8)	(a) Executive Committee. (b) Single £350 p.a.; married £500 p.a.; and £50 for each dependent. (c) Executive Committee.	4·8/6	88	20	15
16	London Homœopathic	172	7 2	7-bed. (7 f.). 2-bed (2 m.)	4 gns.	Arranged privately.	Medical cases—any homœopathic physician. Surgical cases—surgical staff.	Available in an emergency.	Yes.	(a) Sister-in-charge. (b) Yes; limit.	4·6/9 (B)	89	20·0	16
	Ditto		1 5 1 2 1	1-bed.	5 gns. 6 gns. 8 gns. 9 gns. 10 gns. (A)	ditto	ditto	ditto	ditto	(a) Sister-in-charge. (b) No limit.	4·4/10 (B)	80		
17	London Temperance	136	5	1-bed.	6 gns.	Arranged privately.	Medical staff.	Available free.	Yes—may visit with consent of medical staff.	(a) Medical staff. (b) No limit, but intended for patients of moderate means.	0·5/3 (C)	4	45·0	17
18	Nelson	62	8 3 3	1-bed.	3 gns. 4 gns. 5 gns.	Arranged privately.	Any practitioner (usually medical staff).	Available free in an emergency.	*See* column (8)	(a) On recommendation of patient's practitioner. (b) Left to discretion of patient's practitioner.	6·4/14	132	17·8	18
19	Queen Mary's ...	160	4	1-bed.	5 gns.	Arranged privately.	Medical staff.	Available free.	Yes.	(a) Medical staff. (b) No limit.	3·7/4	62	20·0	19
20	Royal Northern...	305	20 6 12	20 cubicles. 2-bed. 1-bed. (23 f. including 2 maternity).	4½ gns. 5 gns. 6 gns.	Arranged privately.	Any consultant of a recognised London Hospital.	Available free.	Yes — patient is responsible for any extra fees incurred.	(a) Medical staff (application form is sent to Secretary). (b) Inability to meet Nursing Home and Surgeon's Fees. (c) Patient's practitioner and/or Board of Management.	12·7/38(D)	253	18·5	20

† *See* note † on page 42.

Notes: (A) London Homœopathic—Patients in the 1-bed wards pay an additional charge of 1 gn. for the first week.

(B) London Homœopathic—Open only nine months in 1926.

(C) London Temperance—Open only three months in 1926.

(D) Royal Northern—Twenty-one beds were added in December, 1926.

General and other Hospitals with Resident Medical Officers†

No.	Hospital.	Total beds normally available 31.3.28.	Pay Beds normally available 31.3.28.	Number of Pay Beds in each ward (and classification, if any).	Normal weekly charge: guineas. See note* on p. 42.	Procedure as regards medical fees.	By whom patient is attended.
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
21	St. Andrew's, Dollis Hill	52	44	22-bed (22 m. 22 f.).	2½ gns. (A)	Usually none.	Medical staff.
			8	1-bed.	6 gns. to 8 gns.	Arranged privately. (If Resident Medical Officer attends—1 gn. per week.)	Any consultant of a recognised London Hospital, and Resident Medical Officer.
22	St. John's, Lewisham	102	2 1	1-bed.	4 gns. 6 gns.	Arranged privately.	Medical staff.
23	Seamen's (Dreadnought)	250	8 12	4-bed. 3-bed (20 m.).	2 gns. to 8 gns.	Paid to Hospital. Total cost to a patient of fees and Hospital charges is approximately 3 weeks' salary.	Medical staff.
24	Weir	30	4	2-bed (2 m. 2 f.).	3 gns. to 5 gns.	Arranged privately.	Medical staff.
25	West London ...	226	8 18	2-bed. 1-bed.	4 gns. 5 gns.	Assessed or approved by Special Committee. Operation fees: 5 gns. to 50 gns. Treatment fees 2 gns. to 7 gns. per week.	Medical staff.
26	Willesden ...	109	4 11	2-bed. 1-bed.	3½ gns. 6 gns.	Arranged privately.	Any practitioner.
27	Wimbledon ...	56	3 2 5	3-bed (curtains). 2-bed (curtains). 1-bed.	4 gns. 6 gns.	Arranged privately.	Any practitioner.
28	Woolwich War Memorial	112	24 8	24 cubicles. 1-bed. (8 m., 16 f., 8 ch.)	3 gns. 5 gns. minimum.	Arranged privately or through Secretary.	Medical staff.

† *See* note †

Note: (A) St. Andrew's—Of 953 patients, 139 were admitted free because necessitous, and 21 on production of Hospital Saturday Fund Letters.

Resident Medical Officers†—*continued.*

Arrangements as to services of Resident Medical Officer.	Whether patient's practitioner can keep in touch.	(a) By whom patient is admitted. (b) Whether any financial limitation. (c) By whom financial suitability is determined.	Average occupied Pay Beds 1926 compared with Pay Beds available 31.12.26.	Pay Bed patients admitted 1926.	Average period of residence of Pay Bed patients in days 1926.	No.
(9)	(10)	(11)	(12)	(13)	(14)	(15)
Available free. Available free in an emergency.	Yes—may visit and attend operations.	(a) Secretary or Matron on recommendation of patient's practitioner. (b) Yes; limit. (c) Matron or Secretary.	53·0/52	953 (A)	20·3	21
Available free.	Yes—by arrangement with medical staff.	(a) Medical staff and Matron. (b) No limit.	1·8/3	40	16·0	22
Available free.	Yes.	(a) Medical staff and Secretary. (b) No limit, but as patients are mostly in Mercantile Marine or Colonial Service, they have limited means.	10·0/20	136	21·0	23
Available free.	Yes.	(a) Medical staff. (b) No limit, but intended for patients of moderate means.	3·0/4	35	29·7	24
Available free.	Yes—may visit.	(a) Special Committee. (b) Inability to meet Nursing Home and Surgeon's Fees. (c) Special Committee.	23·0/26	347	24·0	25
Available in an emergency.	*See* column (8)	(a) Matron. (b) Yes; limit. (c) Patient's practitioner and/or House Committee.	11·2/15	262	15·8	26
Available free.	*See* column (8)	(a) Medical staff. (b) No limit.	6·0/10	129	15·2	27
Available free.	Yes—may visit and attend operations.	(a) Secretary. (b) Yes; limit.	(Not opened until 1928)			28

on page 42.

General, Cottage and other Hospitals without Resident Medical Officers.†

No.	Hospital.	Total beds normally available 31.3.28.	Pay Beds normally available 31.3.28.	Number of Pay Beds in each ward (and classification, if any).	Normal weekly charge: guineas. See note* on p. 42.	Procedure as regards medical fees.	By whom patient is attended.	Arrangements as to services of Resident Medical Officer.	Whether patient's practitioner can keep in touch.	(a) By whom patient is admitted. (b) Whether any financial limitation. (c) By whom financial suitability is determined.	Average occupied Pay Beds 1926 compared with Pay Beds available. 31.12.26.	Pay Bed patients admitted 1926.	Average period of residence of Pay Bed patients in days 1926.	No.
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)
29	Beckenham ...	40	8	1-bed.	7 gns.	Arranged privately.	Any practitioner.	—	*See* column (8).	(a) Matron. (b) No limit.	4·2/8	110	14·0	29
30	Blackheath ...	30	2	1-bed.	4 gns.	Arranged privately.	Medical staff and consultants on active list of the Hospital.	—	No.	(a) Medical staff. (b) No limit.	1·6/2	23	24·6	30
—	*Brentford* (A) ...	*21*	*4*	*1-bed.*	*4 gns.* (B)	*Arranged privately.*	*Any practitioner.*	—	*See column* (8).	(a) *Matron.* (b) *Yes; limit.* (c) *Patients' practitioner.*	—	(A)	—	—
31	Bromley	42	4 (C)	1-bed (2 m. 2 f.)	6 gns.	Arranged privately.	Any practitioner.	—	*See* column (8).	(a) Medical staff, Hon. Treas. or Sec. and member of Cttee. (b) No limit, but intended for patients of moderate means.	1·1/4	27	15·0	31
32	Carshalton ...	31	2 6	2-bed (2 f. maternity). 1-bed.	2 gns. 3 gns. (D)	Arranged privately.	Medical staff.	—	No—except by courtesy in individual cases.	(a) Medical staff. (b) No limit, but intended for patients of moderate means.	6·0/8	110	18·8	32
33	Eltham	26	4	1-bed.	5 gns.	Arranged privately.	Any practitioner (usually medical staff).	—	*See* column (8).	(a) Medical staff. (b) No limit.	0·7/2	26	10	33
34	Enfield	53	2	1-bed	4½ gns.	Arranged privately.	Medical staff and consultants (or nominees) on active list of Hospital.	—	Yes.	(a) Medical staff. (b) No limit.	0·9/2	20	16·6	34
35	Finchley (E) ...	55	4 3 1 1	2-bed. 1-bed.	3 gns. 4 gns. 5 gns. 6 gns.	Arranged privately.	Medical staff and any consultant.	—	Yes—may visit.	(a) Medical staff. (b) No limit.	?	172	?	35
36	Forest	28	3 5	3-bed (3 f.) 1-bed.	3 gns. 6 gns.	Arranged privately.	Any practitioner (usually medical staff).	—	*See* column (8).	(a) Medical staff. (b) No limit.	4·3/8	99	16·0	36
37	Hanwell	16	1	1-bed.	3 gns. (minimum).	Arranged privately.	Any practitioner (usually medical staff).	—	*See* column (8).	(a) Medical staff. (b) No limit.	0·5/1	9	19·3	37
38	Hendon	51	3 2	1-bed.	5 gns. 6 gns.	Arranged privately.	Any practitioner.	—	*See* column (8).	(a) Medical staff. (b) No limit.	3·8/5	79	16·8	38
39	Hornsey (F) ...	48	8 4 4	8-bed (curtains). (8 f.) 4-bed (curtains). (4 m.) 1-bed.	3 gns. 6 gns.	Arranged privately.	Any local practitioner. Consultant must be on Hospital's list.	—	*See* column (8).	(a) Medical staff. (b) Yes: limit. (c) Patient's practitioner and/or Fees Committee.	10·6/16	271	14·3	39

† *See* note †

Notes: (A) Brentford—New Hospital opened in May, 1928, in place of old Hospital with 7 beds including 2 sometimes used as Pay Beds.
(B) Brentford—Usual charge to non-local residents is 5 guineas.
(C) Bromley—For local residents only.

on page 42.

(D) Carshalton—Usual charge to non-local residents is 4 gns.
(E) Finchley—For local residents only.
(F) Hornsey—For local residents only, except in emergencies.

General, Cottage and other Hospitals without Resident Medical Officers †—*continued.*

No.	Hospital.	Total beds normally available 31.3.28.	Pay Beds normally available 31.3.28.	Number of Pay Beds in each ward (and classification, if any).	Normal weekly charge: guineas. See note* on p. 42.	Procedure as regards medical fees.	By whom patient is attended.	Arrangements as to services of Resident Medical Officer.	Whether patient's practitioner can keep in touch.	(a) By whom patient is admitted. (b) Whether any financial limitation. (c) By whom financial suitability is determined.	Average occupied Pay Beds 1926 compared with Pay Beds available 31.12.26.	Pay Bed patients admitted 1926.	Average period of residence of Pay Bed patients in days 1926.	No.
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)
40	Hostel of St. Luke (A)	30	8 22	2-bed. 1-bed.	(a) Free (b) From 10s. 6d. (c) Up to 7 gns. (B)	No fees. Arranged privately.	Medical staff. Any consultant.	—	Yes—may visit and attend operations on invitation of medical staff.	(a) Committee. (b) Inability to meet Nursing Home Fees. (c) Committee.	11·4/16	194	20·9	40
41	Kingston (Victoria)	23	3	(In general wards.)	3 gns.	Arranged privately.	Medical staff (certain local practitioners).		Yes.	(a) Medical staff. (b) No limit.	2·0/3	65	11·8	41
42	Mildmay Memorial	30	2 2	2-bed (curtains). 1-bed.	4 gns.	Arranged privately.	Medical Superintendent and any consultant. Any Surgeon may operate.	—	Yes—by arrangement with Medical Superintendent.	(a) Medical Superintendent and Matron. (b) No limit, but intended for patients of moderate means.	3·0/4	48	25·0	42
43	Norwood and District	32	1 1	1-bed.	4 gns. 6 gns.	Arranged privately.	Any practitioner.	—	*See* column (8).	(a) Medical staff. (b) Intended for professional and middle classes.	1·5/2	20	27·3	43
44	Passmore Edwards Wood Green	55	2 5	2-bed. 1-bed.	4 gns. (minimum).	Arranged privately.	Medical staff and any consultant.	—	Yes.	(a) Medical staff or Matron. (b) No limit.	?	72	?	44
45	Phillips' Memorial	18	2	1-bed.	2 gns. to 7 gns.	Arranged privately.	Medical Officer.	—	Yes—may visit.	(a) Medical Officer. (b) No limit.	0·7/2	13	19·0	45
46	St. John's, Twickenham	20	1	1-bed.	3 gns. to 5 gns.	Arranged privately.	Medical staff or partner of a member of medical staff.	—	Yes—with approval of medical staff.	(a) Medical staff or Secretary. (b) Inability to pay more than 5 gns. a week. (c) Visitor and Medical Officer.	0·4/1	5	29·0	46
47	Victoria, Barnet	33	2 2	1-bed.	4 gns. 6 gns.	Arranged privately.	Medical staff and any consultant on active list of the Hospital.	—	Yes.	(a) Medical staff. (b) No limit, but intended for patients of moderate means.	2·3/4	48	17·4	47
—	*Wembley* (C) ...	*20*	*4*	*2-bed (2 m. 2 f.).*	*3½ gns. to 5 gns.*	*Arranged privately.*	*Any practitioner.*	—	*See column* (8).	(a) *Secretary on recommendation of Medical staff.* (b) *Yes; limit.* (c) *Secretary.*	—	(D)	—	—
48	Woodford ...	23	2 4	2-bed. 1-bed.	3 gns. 6 gns. (D)	Arranged privately.	Any practitioner.		*See* column (8).	(a) Medical staff. (b) Yes; limit. (c) Patient's practitioner and Matron.	1·1/6	55	7·0	48

† *See* note † on page 42.

Notes: (A) Hostel of St. Luke—For the Clergy of the Anglican Communion and their families only.

(B) Hostel of St. Luke—Patients are admitted under class (*a*), (*b*) or (*c*), according to their means.

(C) Wembley—New Hospital opened in June, 1928.

(D) Woodford—Non-local residents are charged 4 gns. in the 2-bed wards and 7 gns. in the 1-bed wards.

Hospitals for Women.†

No.	Hospital.	Total beds normally available 31.3.28.	Pay Beds normally available 31.3.28	Number of Pay Beds in each ward (and classification, if any).	Normal weekly charge: guineas. See note* on p. 42.	Procedure as regards medical fees.	By whom patient is attended.	Arrangements as to services of Resident Medical Officer.	Whether patient's practitioner can keep in touch.	(a) By whom patient is admitted. (b) Whether any financial limitation. (c) By whom financial suitability is determined.	Average occupied Pay Beds 1926 compared with Pay Beds available. 31.12.26.	Pay Bed patients admitted 1926.	Average period of residence of Pay Bed patients in days 1926.	No.
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)
49	Chelsea	97	6 12	6-bed (curtains). 4-bed (curtains) (18 f. gynæcological).	5 gns.	Arranged privately, but with Secretary's cognizance. Maximum operation fees including anæsthetics 36 gns.	Medical staff.	Available free.	Yes—may visit and attend operations.	(a) Medical staff. (b) Yes; limit. (c) Medical staff.	14·1/18	226	23·7	49
50	Elizabeth Garrett Anderson	75 (A)	1 3	1-bed. (4 f.)	3 gns. 4 gns.	No fees are allowed.	Medical staff.	Available free.	Yes—may visit and attend operations.	(a) Secretary on recommendation of medical staff. (b) Inability to meet Nursing Home and Surgeon's Fees. (c) Medical staff.	2·6/4	56	17·0	50
51	Florence Nightingale	38	16 4 18	8-bed (curtains). 2-bed (curtains). 1-bed (38 f. and ch.).	2 gns. 4 gns.	Arranged privately Maximum operation fee 20 gns.	Any surgeon.	—	Yes—by correspondence.	(a) Acting Committee. (b) Inability to meet Nursing Home Fees. (c) Acting Committee.	28·3/38	461	22·4	51
52	Grosvenor ...	37	3	1-bed (3 f. gynæcological).	4 gns.	Arranged privately.	Medical staff.	—	Yes—may visit.	(a) Secretary on recommendation of medical staff. (b) No limit, but intended for patients of moderate means.	1·9/3	34	20·2	52
53	Hospital for Women	80	12	12 cubicles. (3 walls and curtain) (12 f. gynæcological).	5 gns.	Surgeon's fees up to 20 gns. are sanctioned by the Committee of Management.	Medical staff.	Attends daily: Initial fee 10s. 6d., otherwise available free.	Yes—by arrangement with Medical Officer.	(a) Medical Officer. (b) Inability to meet Nursing Home and Surgeon's Fees. (c) Medical Officer.	10·3/12	174	22·5	53
54	St. Saviour's ...	21	6 6 6 3	12-bed (no curtains) (curtains) 6-bed. 1-bed. (21 f.)	2 gns. 3 gns. 4 gns. to 5 gns.	No fees are allowed.	Medical staff.	—	Yes—may visit.	(a) Medical staff. (b) Yes; limit. (c) Sister Superior.	11·2/21 (B)	141	31·3	54
55	Samaritan Free ...	70	9	3-bed (curtains) (9 f. gynæcological).	6 gns.	Arranged privately.	Medical staff.	Available free.	Yes—may visit and attend operations.	(a) Medical staff. (b) No limit, but intended for patients of moderate means.	1·7/9 (C)	34	18·0	55
56	South London ...	113	4 14 4	2-bed. 14-cubicles 1-bed. 22 f.	4 gns. 5 gns. 6 gns.	Arranged privately. (D)	Medical staff.	Available free.	Yes.	(a) Secretary on recommendation of medical staff. (b) Yes; limit. (c) Recommending Consultant; Committees of associations maintaining beds for the use of members; Secretary.	16·0/22	256	20·0	56

† *See* note † on page 42.

Notes: (A) Elizabeth Garrett Anderson—Including 35 beds temporarily closed during rebuilding.
(B) St. Saviour's—Open only 10 months in 1926.
(C) Samaritan Free—Open only four months in 1926.
(D) South London—Patients paying only 4 gns. do not pay Medical Fees.

Other Special Hospitals.

No.	Hospital.	Total beds normally available 31.3.28.	Pay Beds normally available 31.3.28.	Number of Pay Beds in each ward (and classification, if any).	Normal weekly charge: guineas. See note* on p. 42.	Procedure as regards medical fees.	By whom patient is attended.
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
57	All Saints' (Genito-Urinary)	30	2	2-bed (2 m. sp.).	5 gns.	Arranged privately.	Medical staff.
58	Belgrave (Children)	74	12	12-bed. (12 ch.).	3 gns.	Arranged privately. Maximum operation fees: major 30 gns., minor 15 gns.	Medical staff.
59	Central London Ophthalmic	40	3	1-bed. (3 sp.).	4 gns. to 6 gns.	Arranged privately.	Medical staff.
60	Central London (Throat, Nose and Ear)	43	6	2-bed. (6 sp.).	5 gns. (B)	Arranged privately.	Medical staff.
61	City of London Maternity	71	7	1-bed (7 f. maternity).	5 gns.	No fees are allowed.	Medical staff.
62	Clapham Maternity	50	4	1-bed (4 f. maternity).	3 gns.	Arranged privately.	Medical staff, or any medical woman, at Director's discretion.
63	Golden Square (Throat, Nose and Ear)	73	3	1-bed. (3 sp.)	6 gns.	Fees are paid through Secretary-Superintendent, with exceptions in certain cases.	Medical staff.
64	Gordon (Rectal)...	29	8 4 4	4-bed. 2-bed. 1-bed (16 sp.)	3 gns. 4 gns.	Arranged privately.	Medical staff.
65	Hospital for Consumption (Brompton)	326	8 12 15 4 3 1	8-bed. 6-bed. 5-bed. 4-bed. 3-bed. 1-bed (24 m. 19 f.).	4 gns.	Arranged privately.	Medical staff.

Notes: (A) Belgrave—Open only five months in 1926.

(B) Central London (Throat, Nose and Ear)—Reduced charge of 4½ gns. is frequently made.

Arrangements as to services of Resident Medical Officer.	Whether patient's practitioner can keep in touch.	(a) By whom patient is admitted. (b) Whether any financial limitation. (c) By whom financial suitability is determined.	Average occupied Pay Beds 1926 compared with Pay Beds available 31.12.26.	Pay Bed patients admitted 1926.	Average period of residence of Pay Bed patients in days 1926.	No.
(9)	(10)	(11)	(12)	(13)	(14)	(15)
Available free.	Yes.	(a) Medical staff or Secretary. (b) Inability to meet Nursing Home and Surgeon's Fees. (c) Medical staff or Secretary.	?	?	?	57
Available free.	Yes—by consultation with medical staff.	(a) Secretary. (b) Yes—Parent's income £700. (c) Secretary.	? (A)	9	? (A)	58
Available free.	Yes—may visit.	(a) Medical staff. (b) Yes: limit. (c) Surgeon recommending admission.	1·2/4	47	9·0	59
Available free.	Yes—may visit.	(a) Medical staff and Secretary. (b) Inability to meet Nursing Home Fees. (c) Secretary.	3·2/6	106	11·0	60
Available free.	Information as to the case is given.	(a) Matron or Secretary. (b) No limit, but intended for patients of moderate means.	7·0/7	121	21·0	61
Available free.	No.	(a) Medical staff, Secretary or Matron. (b) No limit, but intended for patients of moderate means.	?	21	?	62
Available free.	Yes.	(a) Medical staff and Secretary-Superintendent. (b) Inability to meet Nursing Home Fees.	(Not opened until December, 1926)			63
Available free.	Yes—through House Surgeon.	(a) Almoner. (b) Inability to meet Nursing Home Fees. (c) Secretary and Almoner.	?	124	19	64
Available free.	Yes—by interview or correspondence with medical staff, or Resident Medical Officer.	(a) Secretary, on recommendation or approval of medical staff or Resident Medical Officer. (b) Yes; limit. (c) Lady Almoner and Committee of Management.	37·5/43	228 (c)	57·0	65

(c) Hospital for Consumption—In addition to these 228 patients, 42 patients paying 3 gns. per week were treated at the Frimley Sanatorium.

Other Special Hospitals—*continued.*

No.	Hospital.	Total beds normally available 31.3.28.	Pay Beds normally available 31.3.28.	Number of Pay Beds in each ward (and classification, if any).	Normal weekly charge: guineas. See note* on p. 42.	Procedure as regards medical fees.	By whom patient is attended.	Arrangements as to services of Resident Medical Officer.	Whether patient's practitioner can keep in touch.	(a) By whom patient is admitted. (b) Whether any financial limitation. (c) By whom financial suitability is determined.	Average occupied Pay Beds 1926 compared with Pay Beds available 31.12.26.	Pay Bed patients admitted 1926.	Average period of residence of Pay Bed patients in days 1926.	No.
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)
66	Jewish Maternity	26	3	1-bed (3 f. maternity).	6 gns.	Arranged privately.	Medical staff.	—	No.	(a) Secretary. (b) No limit.	(Not opened until 1927)			66
67	London Fever ...	190	24	1-bed (24 sp.).	7 gns. to 10 gns.	No fees are allowed.	Medical staff.	Available free.	Yes—may visit.	(a) Secretary. (b) No limit.	?	?	?	67
68	London Lock (Male) (A)	38	2	1-bed (2 m. sp.).	2 gns.	Arranged privately.	Medical staff.	Available free.	Yes.	(a) Medical staff or Secretary. (b) Inability to meet Nursing Home Fees.	0·2/2	8	11·0	68
69	National Heart ...	46	1	1-bed (1 sp.).	5 gns.	Usually no fees.	Medical staff.	Available free.	Yes—may visit.	(a) Secretary on recommendation of medical staff. (b) Inability to pay more than 5 gns. per week. (c) Secretary and medical staff.	1·0/1	11	33·0	69
70	National, Queen Square, Nervous Diseases.	195	15 13 12	15-bed (curtains) (15 f.). 13-bed. 12-bed (25 m.) (40 sp.).	3 gns. or less according to means.	No fees are allowed.	Medical staff.	Available free.	Information is given by medical staff.	(a) Medical staff or Admission Committee. (b) Inability to meet Nursing Home Fees.	37·0/40	267	50·0	70
71	Royal Eye ...	46	2	1-bed (1 m. sp., 1 f. sp.).	5 gns.	Arranged privately.	Medical staff.	Available in an emergency.	Not usually.	(a) Medical staff. (b) Yes; limit. (c) Medical staff.	0·4/4	9	16·3	71
72	Royal National Orthopædic	180	7	7-bed (curtains) (7 f. & ch. sp.).	4 gns. to 6 gns. according to means.	Arranged privately. Maximum operation fee: 30 gns.	Medical staff.	Available free.	No.	(a) Medical staff. (b) Inability to meet Nursing Home and Surgeon's Fees.	4·7/7	110	15·5	72
73	Royal Waterloo...	127	2 6 1	2-bed (2 ch.). 6-bed. 1-bed (7 f.).	3½ gns. 5 gns. 7 gns.	Arranged privately.	Medical staff.	Available free (may be remunerated by medical staff).	Yes.	(a) Medical staff and Secretary. (b) Not intended for wealthy patients. (c) Discretion of patient's practitioner.	(Not opened until 1927)			73

Note: (A) London Lock (Male)—Arrangements have recently been made for paying patients to be admitted into ten beds in a Genito-Urinary Ward in the Female Hospital, and for Medical Fees to be charged to patients paying 5 gns. per week.

Other Special Hospitals—*continued.*

No.	Hospital.	Total beds normally available 31.3.28.	Pay Beds normally available 31.3.28.	Number of Pay Beds in each ward (and classification, if any).	Normal weekly charge: guineas. See note* on p. 42.	Procedure as regards medical fees.	By whom patient is attended.	Arrangements as to services of Resident Medical Officer.	Whether patient's practitioner can keep in touch.	(a) By whom patient is admitted. (b) Whether any financial limitation. (c) By whom financial suitability is determined.	Average occupied Pay Beds 1926 compared with Pay Beds available 31.12.26.	Pay Bed patients admitted 1926.	Average period of residence of Pay Bed patients in days 1926.	No.
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)
74	St. Mark's (Rectal)	72	6 4	2-bed. 1-bed (10 sp.).	5 gns. 6 gns.	Arranged privately.	Medical staff.	Attends daily. Initial fee: 1 gn., otherwise free.	Yes—by arrangement with Hon. Surgeon and Resident Surgical Officer.	(a) Medical staff and Secretary. (b) Intended for patients of limited means. (c) Secretary and/or Committee of Management.	(Not opened until 1927)			74
75	St. Paul's (Genito-Urinary)	27	1 5	1-bed (1 f. sp.). (In General Ward) (curtains) (5 m. sp.).	5 gns.	Arranged privately.	Medical staff.	Available free.	Yes.	(a) Medical staff and Secretary. (b) Inability to meet Nursing Home Fees.	(Not opened until 1928)			75
76	St. Peter's (Stone)	32	6	6-bed (6 m. sp.).	5 gns.	Arranged privately. Maximum Surgeon's fee: 30 gns.	Medical staff.	Attends daily: fee 10 per cent. of Surgeon's fee (minimum, 1 gn.).	Yes—may attend operations, and subsequent dressings, as spectator.	(a) Medical staff. (b) Inability to meet Nursing Home and Surgeon's fees. (c) Medical staff or Secretary.	4·2/6	53	29·0	76
77	Seamen's (Tropical Diseases)	58	12 10 6 8 2 12	12-bed. 10-bed. 3-bed. 2-bed. 2-bed. 1-bed (50 sp.).	3 gns. to 4 gns. 5 gns. 7 gns.	Payable according to a scale based on income.	Medical staff.	Available free.	Yes—at discretion of medical staff.	(a) Secretary on recommendation of medical staff, Indian Medical Board, Colonial Office, or Ministry of Pensions. (b) No limit.	35·3/50	520	?	77
78	South-Eastern (Children)	60	4	4-bed (4 ch.).	3 gns. (A)	Arranged privately.	Medical staff or otherwise at Medical Officer's discretion.	Available free.	Yes—by telephone.	(a) Medical staff and Matron. (b) Discretion of Doctor and Matron.	0·8/3	33	9·0	78
79	Stoke Newington	33	1 4 3	(In General Ward.) 2-bed. 1-bed (8 f. sp.).	2½ gns. 3½ gns. (B)	Arranged privately.	Any practitioner.	—	*See* column 8.	(a) Medical staff and Matron. (b) No limit, but intended for patients of moderate means.	?	49	?	79
80	Victoria (Children)	130	9 3	9-bed. 3-bed (12 ch.).	5 gns.	Arranged privately.	Any consultant of a recognised London Hospital, or Resident Medical Officer.	Available free.	Yes.	(a) Secretary, Matron and Resident Medical Officer. (b) No limit.	4·0/12	137	10·7	80

Notes: (A) South Eastern—Reduced charge of 2 gns. is sometimes made.

(B) Stoke Newington—Reduced charges of 2 gns. and 3 gns. are sometimes made.

APPENDIX III.

SUMMARY OF REPLIES TO QUESTIONNAIRE.

HOSPITALS WITH SCHEMES FOR ADDITIONAL PAY BEDS, MARCH 31, 1928.

NOTE.—*The extensions referred to in columns 4 to 7 may also add ordinary beds, as well as the pay beds of which the figures are given.*

(1) Hospital.	(2) Total beds normally available 31.3.28.	(3) Pay beds normally available 31.3.28.	(4) Number of pay beds to be added by future extensions. Building in hand.	(5) Building fund begun.	(6) Definite future scheme.	(7) Future scheme under consideration or suggested.	(8) Temporary pay beds in column 3 to be deducted.	(9) Net additional pay beds.
General Hospitals with Schools.								
King's College	356	62	—	80	—	—	62	18
Middlesex	368	—	—	51*	—	—	—	51
Royal Free	268	9	—	—	30-40	—	—	30-40
St. Bartholomew's	701	—	—	—	80-100	—	—	80-100
St. Mary's	290	—	—	—	25-100	—	—	25-100
St. Thomas's	621	40	—	—	100	—	—	100
Westminster	234	14	—	—	—	?	—	?
General and other Hospitals with Resident Medical Officers.†								
Acton	50	6	9 (?)	—	—	—	—	9 (?)
Kensington, Fulham and Chelsea	19	—	—	6	—	—	—	6
London Temperance	136	5	—	—	20	—	5	15
Miller	120	—	6-9	—	—	—	—	6-9
Poplar	116	—	—	—	—	?	—	?
Putney	42	—	7	—	—	—	—	7

Royal Northern	305	38	—	—	—	?	(*a*)	?
St. Andrew's Dollis Hill	52	52	—	24	12	40	—	76
St. John's, Lewisham	102	3	—	—	50	—	—	50
Seamen's (Dreadnought)	250	20	—	10–12	—	—	—	10–12
Woolwich	112	32	—	—	40	—	—	40
General Cottage and other Hospitals without Resident Medical Officers.†								
Brentford	(21)‡	—	(4)‡	—	—	—	—	4
East Ham	25‖	—	4‖	—	—	—	—	4
Forest	28	8	—	4	—	—	—	4
Harrow	40	—	—	—	—	4	—	4
Hostel of St. Luke (Clergy)	30	30	—	6	—	—	—	6
Wembley§	(20)§	—	(4)§	—	—	—	—	4
Hospitals for Women.								
E. G. Anderson	75	4	2	—	—	22	—	24
South London	113	22	8	—	—	—	—	8
Other Special Hospitals.								
Bermondsey Medical Mission (Wom. & Ch.) ...	9	—	2–4	—	—	—	—	2–4
Central London Ophthalmic...	40	3	—	12	—	—	—	12
City of London Heart and Lungs	185	—	—	—	—	?	—	?

(*a*) When the new beds are added 21 of the present beds will be deducted.

* Including some beds for patients of Middlesex Cancer Hospital.

† *See* note † on page 42.

‖ In new Hospital of 80 beds in course of construction.

‡ New Hospital opened May 19, 1928.

§ Opened June 2, 1928.

(1) Hospital.	(2) Total beds normally available 31.3.28.	(3) Pay beds normally available 31.3.28.	(4) Number of pay beds to be added by future extensions: Building in hand.	(5) Building fund begun.	(6) Definite future scheme.	(7) Future scheme under consideration or suggested.	(8) Temporary pay beds in column 3 to be deducted.	(9) Net additional pay beds.
Other Special Hospitals—*(continued)*.								
City of London Maternity	71	7	—	—	—	12	—	12
General Lying-in	45	—	—	—	—	5	—	5
Golden Square (Throat, Nose and Ear) ...	73	3	20	—	—	—	—	20
Hospital for Epilepsy	82	—	—	—	15	—	—	15
Infants	50	—	—	20	—	—	—	20
London Lock (Male	38	2	—	—	—	17	—	17
Middlesex Cancer	90	—	—	—*	—	—	—	—
Mount Vernon	147	—	12	—	—	—	—	12
National Heart	46	1	—	—	—	10–20	—	10–20
Paddington Green (Children's)	42	—	—	—	—	?	—	?
Queen Charlotte's (Maternity)	75	—	—	12	—	—	—	12
Royal London Ophthalmic	120	—	—	15	—	—	—	15
Royal National Orthopædic	180	7	6	—	—	—	—	6
Royal Westminster Ophthalmic	42	—	14	—	—	—	—	14
Western Ophthalmic	18	—	—	—	15	—	—	15
NET TOTALS (after deductions in col. 8) ...	—	—	98–103	178–180	382–487	110–120+?		768–890+?

* *See* Middlesex Hospital, page 62.

APPENDIX IV.

GEOGRAPHICAL DISTRIBUTION OF PAY BEDS IN LONDON

ACCORDING TO DISTANCE FROM ST. PAUL'S.

Within each zone the Hospitals are arranged approximately in order, West, North, East, South.

For notes and other particulars relating to each Hospital, see Appendix II for existing Pay Beds, and Appendix III for proposed additional Pay Beds.

Zone round St. Paul's.	General and Cottage Hospitals.† (With reference number to Appendix II.)	Total beds, March 31st, 1928.	Existing pay beds, March 31st, 1928.	Proposed additional pay beds.*	Special Hospitals. (With reference number to Appendix II.)	Total beds, March 31st, 1928.	Existing pay beds, March 31st, 1928.	Proposed additional pay beds.*
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Miles. 0–3	S.W.				S.W.			
	6 Westminster	234	14	?	52 Grosvenor (Wom.)	37	3	—
					Infants	50	—	20
					64 Gordon (Rectal)	29	16	—
	W.C., W., N.W.				W.C., W., N.W.			
	Middlesex	368	—	51	76 St. Peter's (Stone)	32	6	—
	14 Italian	58	5	—	68 London Lock (M.)	38	2	?
	16 Lond. Homœop.	172	19	—	63 Golden Sq. Throat	73	3	20
	40 Hostel St. Luke (Clergy)	30	30	6	75 St. Paul's (Skin)	27	6	—

* Columns 5 and 9 contain the number of pay beds proposed to be provided in schemes where either building or the collection of funds has begun (Appendix III, Columns 4 and 5). Where two figures are given in Appendix III, the mean is taken. Other schemes (Appendix III, Columns 6 and 7) are indicated by ?.

† See note † on page 4.

Zone round St. Paul's.	General and Cottage Hospitals.† (With reference number to Appendix II.)	Total beds, March 31st, 1928.	Existing pay beds, March 31st, 1928.	Proposed additional pay beds.*	Special Hospitals. (With reference number to Appendix II.)	Total beds, March 31st, 1928.	Existing pay beds, March 31st, 1928.	Proposed additional pay beds.*
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Miles. 0–3 (*contd.*)	W.C., W., N.W.—*continued.*				W.C., W., N.W.—*continued.*			
	5 Univ. Coll.	515	8	—	Roy. West. Ophth.	42	—	14
	17 Lond. Temperance	136	5	?	53 H. for Women	80	12	—
	3 Royal Free...	268	9	?	69 Nat. Heart	46	1	?
					55 Samn. Free (Wom.)	70	9	—
					Q. Charlotte's Maternity	75	—	12
					Western Ophth.	18	—	?
					51 Florence Nightingale (Wom.) ...	38	38	—
					70 Nat. Queen Sq. (Nerv.)	195	40	—
					72 R. N. Orthopædic	180	7	6
					54 St. Saviour's (Wom.)	21	21	—
					77 Seamen's (Trop.)	58	50	—
					West End (Nerv.)	80	—	?
					50 E. G. Anderson (Wom.)	75	4	2
					59 Cent. Lond. Ophth.	40	3	12
					60 Cent. Lond. Throat	43	6	—
	E.C., N., E.				E.C., N., E.			
	St. Bart's.	701	—	?	67 London Fever	190	24	—
	42 Mildmay Mem.	30	4	—	74 St. Mark's (Rectal)	72	10	—
	10 German	160	10	—	Roy. Lond. Ophth.	120	—	15
					61 City Maternity...	71	7	?
					79 Stoke Newington (Wom.)	33	8	—
					City Heart and Lungs	185	—	?
					66 Jewish Maternity	26	3	—
	S.E.				S.E.			
	1 Guy's	643	31	—	Bermondsey Med. Mn. (Wom. & Ch.)	9	—	3
	4 St. Thomas's	621	40	?	71 Royal Eye	46	2	—

					58 Belgrave (Ch.)	74	12	—
					73 Roy. Waterloo (Ch. and Wom.) ...	127	9	—
					General Lying-in	45	—	?
			175	57+?			302	104+?
3–7	Kensn., Fulh. & Chel.	19	—	6	80 Victoria (Ch.)	130	12	—
25	West London	226	26	—	49 Chelsea (Wom.)	97	18	—
	St. Mary's	290	—	?	65 H. Consumption	326	43	—
26	Willesden	109	15	—	Paddn. Green (Ch.)	42	—	?
12	H. of St. John & St. Eliz.	134	28	?	H. for Epilepsy	82	—	?
21	St. Andrew's (Dollis Hill)... ...	52	52	24	57 All Saints' (Gen.-Ur.)	30	2	—
11	Hampstead...	122	20	—				
20	Roy. Northern	305	38	?				
39	Hornsey	48	16	—				
44	P.E. Wood Green	55	7	—				
	Pr. of Wales's (Tottenham) ...	198	—	?				
9	Connaught (Walthamstow) ...	100	10	—				
19	Q. Mary's (West Ham)	160	4	—				
	East Ham	25	—	4§				
	Poplar	116	—	?				
30	Blackheath...	30	2	—	78 S. Eastern (Ch.)	60	4	—
23	Seamen's (Dr'dn't.)	250	20	11				
	Miller	120	—	7				
22	St. John's (Lewm.)	102	3	?				
2	King's Coll.	356	62	18				
43	Norwood	32	2	—				
24	Weir (Balham)	30	4	—	62 Clapham Maty.	50	4	—
8	Bolingbroke	120	15	—	56 S. London (Wom.)	113	22	8
	Putney	28	—	7				
			324	77+?			105	8+?

* Columns 5, 9 and 11 contain the number of pay beds proposed to be provided in schemes where either building or the collection of funds has begun (Appendix III, Columns 4 and 5). Where two figures are given in Appendix III, the mean is taken. Other schemes (Appendix III, Columns 6 and 7) are indicated by ?.

§ In new Hospital of 80 beds in course of construction.

† See note † on page 42.

Zone round St. Paul's.	General and Cottage Hospitals. (With reference number to Appendix II.)	Total beds, March 31st, 1928.	Existing pay beds, March 31st, 1928.	Proposed additional pay beds.*	Special Hospitals. (With reference number to Appendix II.)	Total beds, March 31st, 1928.	Existing pay beds, March 31st, 1928.	Proposed additional pay beds.*
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Miles.								
over 7	46 St. John's (Twick'm.)	20	1	—	Mount Vernon	147	—	12
	Brentford	(21)‖	—‖	(4)‖				
	7 Acton	50	6	9(?)				
	37 Hanwell	16	1	—				
	15 K. E. Mem. (Ealing)	104	8	—				
	Wembley†	(20)†	—†	(4)†				
	Harrow	40	—	?				
	38 Hendon	51	5	—				
	35 Finchley	55	9	—				
	47 Victoria (Barnet)	33	4	—				
	34 Enfield	53	2	—				
	36 Forest	28	8	4				
	48 Woodford	23	6	—				
	13 Ilford	64	14	—				
	28 Woolwich	112	32	?				
	33 Eltham	26	4	—				
	45 Phillips Homœop....	18	2	—				
	31 Bromley	42	4	—				
	29 Beckenham	40	8	—				
	32 Carshalton	31	8	—				
	18 Nelson (S. Wimbledon)	62	14	—				
	27 Wimbledon...	56	10	—				
	41 Kingston	23	3	—				
			149	21+?			—	12

* Columns 5, 9 and 11 contain the number of pay beds proposed to be provided in schemes where either building or the collection of funds has begun (Appendix III, Columns 4 and 5). Where two figures are given in Appendix III, the mean is taken. Other schemes (Appendix III, Columns 6 and 7) are indicated by ?.

‖ Opened May 19th, 1928.

† Opened June 2nd, 1928.

APPENDIX V.

PRESENT HOSPITAL CHARGES.

PART 1.

NUMBER OF PAY BEDS AT VARIOUS CHARGES.

(See paragraphs 35 to 39 of Report.)

TABLE A.

NUMBER OF PAY BEDS AT FIXED CHARGES.

GROUP.‖	Number of Beds at each charge.												Total Beds.
	Free.	2 gns.	2½ gns.	3 gns.	3½ gns.	4 gns.	4½ gns.	5 gns.	6 gns.	7 gns.	8 gns.	9 gns.	10 gns. or more.	
General Hospitals with schools ...	—	—	—	—	—	—	—	78	59	3	12	6	6	164
Other General Hospitals with R.M.O. ...	10*	—	46	37	34	38	28	60	53	—	1	2	1	310
Hospitals without R.M.O. ...	—	2	—	31	—	19	2	8	23	8	—	—	—	93
Hospitals for Women ...	—	26	—	13	—	28	—	44	13	—	—	—	—	124
Special Hospitals	—	2	—	33	—	56	—	56	10	13	—	—	—	170
Total Beds ...	10*	30	46	114	34	141	30	246	158	24	13	8	7	861

TABLE B.

NUMBER OF PAY BEDS AT VARIABLE CHARGES.

GROUP.	Number of Beds at each charge.											Total Beds.
	0—3 gns.	0—7 gns.	2—7 gns.	2—8 gns.	3—4 gns.	3—5 gns.	4—5 gns.	4—6 gns.	6—8 gns.	7—10 gns.	8—15 gns.	
General Hospitals with schools	—	—	—	—	—	—	—	—	—	—	—	—
Other General Hospitals with R.M.O.	—	—	—	20	—	4	—	—	8	—	16	48
Hospitals without R.M.O.	—	30	2	—	—	1	—	—	—	—	—	33
Hospitals for Women ...	—	—	—	—	—	—	3	—	—	—	—	3
Special Hospitals... ...	40	—	—	—	36	—	—	10	—	24	—	110
Total Beds ...	40	30	2	20	36	5	3	10	8	24	16	194

TABLE C.

NUMBER OF PAY BEDS AT FIXED AND VARIABLE CHARGES COMBINED.

(Variable charges being taken at the mean.)

GROUP.	Number of Beds at each charge.†										Total Beds.
	Free.	2 gns.	3 gns.	4 gns.	5 gns.	6 gns.	7 gns.	8 gns.	9 gns.	10 gns. or more.	
General Hospitals with schools...	—	—	—	—	78	59	3	12	6	6	164
Other General Hospitals with R.M.O.	10*	2	81	76	108	53	8	1	2	17	358
Hospitals without R.M.O.	—	2	31	50	12	23	8	—	—	—	126
Hospitals for Women ...	—	26	13	28	47	13	—	—		—	127
Special Hospitals... ...	—	42	33	93	65	10	13	—	4	—	280
Total Beds ...	10*	72	158	247	310	158	32	13	32	23	1,055

TABLE D.

TOTAL NUMBER OF PAY BEDS AT FIXED AND VARIABLE CHARGES COMBINED.

(Variable charges taken at the minimum, mean and maximum respectively.)

—	Number of Beds at each charge.†										Total Beds.
	Free.	2 gns.	3 gns.	4 gns.	5 gns.	6 gns.	7 gns.	8 gns.	9 gns.	10 gns. or more.	
(*a*) Variable charges taken at the minimum ...	80*	54	199	188	276	166	48	29	8	7	1,055
(*b*) Variable charges taken at the mean (as Table C)	10*	72	158	247	310	158	32	13	32	23	1,055
(*c*) Variable charges taken at the maximum ...	10*	32	198	211	284	168	56	41	8	47	1,055

PART 2.

RATES OF CHARGE FOR DIFFERENT KINDS OF ACCOMMODATION.

(See paragraphs 40 to 42 of Report.)

TABLE E.

GENERAL TABLE OF DIFFERENT CHARGES.

TYPE OF WARD.	Number of Beds at each charge.†										Total Beds.
	Free.	2 gns.	3 gns.	4 gns.	5 gns.	6 gns.	7 gns.	8 gns.	9 gns.	10 gns. or over.	
1-bed or cubicle	10*	4	49	78	166	139	32	13	32	23	546
2-bed	—	6	10	66	22	2	—	—	—	—	106
3–8-bed	—	16	33	81	60	17	—	—	—	—	207
Over 8 beds in each ward	—	46	66	22	62	—	—	—	—	—	196
Total Beds ...	10*	72	158	247	310	158	32	13	32	23	1,055

TABLE F.

CHARGES FOR 1-BED WARDS OR CUBICLES AT DIFFERENT KINDS OF HOSPITAL.

GROUP.‖	Number of Beds in 1-bed Wards or Cubicles at each charge.†										Total Beds.
	Free.	2 gns.	3 gns.	4 gns.	5 gns.	6 gns.	7 gns.	8 gns.	9 gns.	10 gns. or over.	
General Hospitals with schools	—	—	—	—	30	49	3	12	6	6	106
Other General Hospitals with R.M.O.	10*	2	37	7	82	53	8	1	2	17	219
Hospitals without R.M.O.	—	—	7	38	12	23	8	—	—	—	88
Hospitals for Women ...	—	—	1	24	29	4	—	—	—	—	58
Special Hospitals... ...	—	2	4	9	13	10	13	—	24	—	75
Total Beds ...	10*	4	49	78	166	139	32	13	32	23	546

TABLE G.

CHARGES IN 2-BED WARDS AT DIFFERENT KINDS OF HOSPITAL.

GROUP.	Number of Beds at each charge.†										Total Beds.
	Free.	2 gns.	3 gns.	4 gns.	5 gns.	6 gns.	7 gns.	8 gns.	9 gns.	10 gns. or over.	
General Hospitals with schools	—	—	—	—	—	2	—	—	—	—	2
Other General Hospitals with R.M.O.	—	—	—	36	6	—	—	—	—	—	42
Hospitals without R.M.O.	—	2	6	12	—	—	—	—	—	—	20
Hospitals for Women ...	—	4	—	4	—	—	—	—	—	—	8
Special Hospitals... ...	—	—	4	14	16	—	—	—	—	—	34
Total Beds ...	—	6	10	66	22	2	—	—	—	—	106

TABLE H.

CHARGES IN 3–8-BED WARDS AT DIFFERENT KINDS OF HOSPITAL.

GROUP.	Number of Beds at each charge.†										Total Beds.
	Free.	2 gns.	3 gns.	4 gns.	5 gns.	6 gns.	7 gns.	8 gns.	9 gns.	10 gns. or over.	
General Hospitals with schools	—	—	—	—	—	8	—	—	—	—	8
Other General Hospitals with R.M.O.	—	—	—	33	20	—	—	—	—	—	53
Hospitals without R.M.O.	—	—	15	—	—	—	—	—	—	—	15
Hospitals for Women ...	—	16	6	—	18	9	—	—	—	—	49
Special Hospitals... ...	—	—	12	48	22	—	—	—	—	—	82
Total Beds ...	—	16	33	81	60	17	—	—	—	—	207

TABLE K.

CHARGES IN WARDS WITH OVER 8 BEDS AT DIFFERENT KINDS OF HOSPITAL.

GROUP.	Number of Beds at each charge.†										Total Beds.
	Free.	2 gns.	3 gns.	4 gns.	5 gns.	6 gns.	7 gns.	8 gns.	9 gns.	10 gns. or over.	
General Hospitals with schools	—	—	—	—	48	—	—	—	—	—	48
Other General Hospitals with R.M.O.	—	—	44	—	—	—	—	—	—	—	44
Hospitals without R.M.O.	—	—	3	—	—	—	—	—	—	—	3
Hospitals for Women ...	—	6	6	—	—	—	—	—	—	—	12
Special Hospitals... ...	—	40	13	22	14	—	—	—	—	—	89
Total Beds ...	—	46	66	22	62	—	—	—	—	—	196

* The Column headed "Free" includes 10 beds for Priests and Nuns at the Hospital of St. John and St. Elizabeth.

† In Tables C to K, beds at varying rates are taken at the mean rate (except in D (*a*) and (*c*)), and rates at odd half-guineas are included with the next higher guinea. The exact rates can be obtained from Appendix II, column 6.

‖ For explanation of grouping of hospitals see note † on page 43.

APPENDIX VI.

SUMMARY OF REPORT ON COST OF PAY BEDS, PREPARED BY Mr. HUGH MACRAE, C.A., SECRETARY TO THE HOSPITAL ECONOMY DEPARTMENT OF THE KING'S FUND.

PART I. MAINTENANCE COST.

1. This part of the report is based on figures contained in the replies of the Hospitals to question 14 in the questionnaire issued by the Pay Beds Committee, and on further information received from the Hospitals relative to these figures.

2. Many of the Hospitals were unable to render any separate accounts in respect of their pay beds, whilst those rendered by others were regarded as referring to too few occupied beds to be of any value for comparative purposes.

3. Twenty-three Hospitals rendered returns which were regarded as suitable for comparative purposes, although some were based on estimated figures. The figures of these Hospitals will be found in the accompanying table. As some of the Hospitals requested that their figures should be regarded as private and confidential, the names of the Hospitals are not published, but merely indicated by letters of the alphabet.

4. A special questionnaire issued to the Hospitals brought to light the fact that there was no uniformity in the practice of the Hospitals with regard to the charges for extra services. As the general practice appears to be for the patients to pay direct for the services of an anæsthetist and for extra nurses, the figures of certain Hospitals have been adjusted to exclude the cost of these two services in order to show more comparable figures. It was not found possible to adjust the costs or receipts in respect of any other services.

5. An examination of the detailed weekly costs per pay bed showed that in a few cases these were returned by the Hospitals as being less than the weekly cost of the other beds in the same Hospitals. In some instances this may reflect the true position, but in others it may be due to imperfections in the figures of pay bed cost. It has been assumed that the latter is the more general case, and in each instance the pay bed cost returned by the Hospital has been added to, so as to make it at least equal to the cost of the ordinary beds under each heading of expenditure, and the figures shown in the table have been arrived at after thus adding to the figures returned by the Hospitals.

6. A comparison of the figures of cost in the table, with the cost per ordinary bed at each Hospital, shows that the average weekly cost per pay bed exceeds the average cost of the ordinary bed to the following extent :—

	£ s. d.
4 General Hospitals with Medical Schools	1 18 1
19 other Hospitals	0 16 7
23 Hospitals with Medical Schools, and other Hospitals (combined average)	0 16 1

7. After making the adjustments referred to in paragraphs 5 and 6, the average cost of a pay-bed patient, exclusive of rent (or interest on capital) and appeal expenses, is as follows :—

	No. of hospitals.	Average weekly cost. £ s. d.	Average weekly receipts. £ s. d.
General Hospitals with Medical Schools	4	5 19 5	6 6 7
Other Hospitals	19	3 16 9	3 17 10
Hospitals with Medical Schools, and other Hospitals (combined average)	23	4 6 3	4 8 11

8. The above figures of cost can only be regarded as of value if it be assumed that, in taking the average of a considerable number of Hospitals, the imperfections in some of the individual costs cancel one another, and that the average cost shown represents the cost of a hypothetical patient receiving an average service. The actual service rendered at different Hospitals necessarily varies, both in extent and in form. The higher cost at the teaching Hospitals is not peculiar to their pay beds. It is partly due to the greater number of special departments for diagnosis and treatment and does not include any part of the cost of the Medical School.

9. The weekly cost at the 19 other Hospitals varies between £3 1s. 2d. and £4 15s., while the average cost for these 19 Hospitals is £3 16s. 9d. This emphasises the danger of applying the average cost to any individual Hospital.

10. The columns showing the average weekly receipts, with the resultant surplus or deficit, have been included in the table, as the receipts have, in some cases, a bearing on the cost.

In the case of Hospital "P," the complete figures of receipts are not available. The figures of this Hospital have therefore been omitted from the average receipts and surplus.

It will be noticed that, as regards the "Other Hospitals," the receipts vary between £2 13s. 2d. and £7 14s. 5d. a week, and that there is a tendency for the cost to be higher where the receipts are higher, but that Hospitals with the highest receipts also show the largest surpluses.

In some Hospitals there are two or more classes of accommodation with different rates of charge. Also in some cases patients unable to pay the full charge are admitted at less than the standard charge, and in others, patients who can afford to do so pay more. These all contribute to produce differences in the ratio of receipts to costs.

11. The examination of the figures of expenditure on pay beds showed that there was a great want of precision and completeness in the data possessed by most of the Hospitals.

It seems very desirable that each Hospital should know definitely whether pay-bed patients pay for the whole of their cost or whether they receive treatment paid for in part from other sources.

SCHEDULE TO PART I.

WEEKLY COSTS, RECEIPTS, AND SURPLUS OR DEFICIT PER OCCUPIED PAY BED AT 23 SELECTED HOSPITALS.

Group. (1)	Hospital. (2)	Average weekly costs (excluding Interest, Rent and Appeals). (3)	Average weekly Receipts. (4)	Surplus. (5)	Deficit. (6)
I. GENERAL HOSPITALS WITH MEDICAL SCHOOLS: (arranged in descending order of number of pay beds occupied).		£ s. d.	£ s. d.	£ s. d.	£ s. d.
Total number of pay beds occupied daily=77·7	A	6 4 10	6 3 6	—	0 1 4
	B	5 9 1	5 11 5	0 2 4	—
	C	6 4 0	7 19 0	1 15 0	—
	D	6 0 7	6 9 2	0 8 7	—
	Averages	5 19 5	6 6 7	0 7 2	—
II. OTHER HOSPITALS: (arranged in descending order of number of pay beds occupied).					
Total number of pay beds occupied daily=272·0	E	3 14 3	2 18 10	—	0 15 5
	F	3 6 9	3 11 8	0 4 11	—
	G	4 11 5	3 2 6	—	1 8 11
	H	3 16 3	4 13 6	0 17 3	—
	I	4 7 11	4 1 9	—	0 6 2
	J	4 5 2	4 0 4	—	0 4 10
	K	4 11 0	5 2 5	0 11 5	—
	L	4 1 0	5 7 5	1 6 5	—
	M	3 1 2	2 13 2	—	0 8 0
	N	3 3 7	3 16 0	0 12 5	—
	O	4 4 3	4 16 2	0 11 11	—
	P	3 4 2	(1 12 3)	—	—
	Q	3 17 2	3 17 3	0 0 1	—
	R	3 3 10	3 8 10	0 5 0	—
	S	4 15 0	5 12 3	1 17 3	—
	T	3 11 1	4 10 2	0 19 1	—
	U	4 10 4	7 14 5	3 4 1	—
	V	3 18 1	5 19 9	2 1 8	—
	W	3 8 2	4 3 2	0 15 0	—
	Averages	3 16 9	3 17 10*	0 1 1*	—
I and II combined=349·7 beds.	Combined Averages	4 6 3	4 8 11*	0 2 8*	—

* Excluding Hospital "P." (See para. 10.)

PART II. CAPITAL COST.

1. This part of the report deals with the replies from Hospitals to question 16 in the questionnaire issued by the Pay Beds Committee, and with similar information gathered from other sources.

2. An examination of the data available emphasises the fact that as there is no standard Hospital there can be no standard capital cost per bed.

3. Many factors affect the capital cost of a pay Hospital, a few of which are:—

(i) Position and nature of site, e.g., buildings to be purchased and demolished, area, accessibility, levels and contour, subsoil, drainage and sewage disposal facilities, water supply, etc.;
(ii) Materials employed and standard of building work, quality and extent of equipment and furniture provided;
(iii) General lay-out, e.g., architectural effect, pavilion or block type, provision for future developments, number of floors, height of rooms, etc.;
(iv) Whether self-contained or added to an existing building;
(v) Nature of accommodation provided for patients, e.g., single rooms, or open wards, space allowed for each bed, etc.;
(vi) Size and variety of special departments, staff quarters, etc.;
(vii) Statutory requirements, e.g., building line, height, etc.;
(viii) Date of construction.

4. The cases reviewed herein show that there is no great difference in the capital cost of building a Hospital or Ward for providing pay beds and of building an ordinary Hospital. Generally the beds in a Pay Hospital are allotted more room than in an ordinary Hospital, but this is not always the case. A considerable part of the cost of any General Hospital is in respect of space used for out-patient or casualty work which is not required at a Pay Hospital. If the space saved by not having any out-patient department is regarded as equal to the additional space required to give each bed more room, then the cost of a Pay Hospital would only exceed the cost of an ordinary Hospital similarly situated to the extent that the former was a more luxurious building, or more expensively furnished. For the above reasons, and because the data with regard to the capital cost of pay beds are very meagre, the cost of ordinary Hospitals, and of beds other than pay beds, is reviewed herein.

5. Some of the schemes considered cost £2,000 and more per bed, but there is ample evidence of complete Hospital units provided at figures well below £1,000 per bed.

Though the costs vary enormously, it may be roughly estimated as a general conclusion that a complete pay-bed Hospital of economic size could in some circumstances be built and equipped at a cost of something less than £1,000 per bed.

6. Where pay beds are added to an existing Hospital the cost per bed in respect of the bed space added would be about one quarter of the cost of a Pay Hospital. As schemes for adding pay beds usually include other accommodation, such as sanitary and other ward annexes, and possibly separate kitchens, nurses' rooms, etc., the cost per bed will lie somewhere between the cost of the additional bed space and the cost of a complete Hospital unit.

7. The information on which the foregoing conclusions are based is contained in tables which are briefly described in the Schedule below.

Schedule to Part II.

A. *Replies from Hospitals to the Questionnaire.*

All the Hospitals in London with pay beds were asked in Question 16 on the Questionnaire to state the capital cost if known, but very few were able to do so.

The returns received show that the estimated cost per pay bed of buildings and equipment varies between £375 at St. Thomas's, built in 1908, and £1,219 at University College (Royal Ear), built in 1927, both exclusive of nurses' quarters. The figures of cost per bed are merely the results obtained by dividing the total expenditure relative to pay beds as returned by the Hospitals, by the number of beds, and are not comparable as the accommodation provided varies and in many cases the figures are based on estimates.

The only Hospitals making returns of capital cost which may be regarded as complete units and to that extent comparable are Florence Nightingale, Seamen's (Tropical Diseases), and the Hostel of St. Luke, where the capital cost per bed exclusive of site was £764, £1,212 and £1,141 respectively.

B. *Minutes of Evidence.*

The evidence heard by the Pay Beds Committee on the subject of the cost of new pay beds does not state whether the figures quoted include the cost of site, nor is it clear in all cases whether they include a residence for the necessary nursing staff.

Proposed schemes are referred to in the Minutes of Evidence, the estimated costs of which were given as follows :—St. Thomas's (Q. 25), £2,500 per bed ; King's College (Q. 544), £813 per bed ; St. Bartholomew's (Q. 1294), £1,600 per bed ; Middlesex (Q. 1507), £1,814 per bed.

C. *Recent building schemes submitted to the King's Fund.*

Recent building schemes submitted to the King's Fund include the following Hospitals, and illustrate the estimated cost of new complete Hospital units of various types :—Plaistow Maternity (38 beds), £494 per bed ; Wembley (24 beds), £729 per bed ; Brentford (19 beds), £751 per bed ; East Ham (80 beds), £938 per bed.

D. *Articles in the "Hospital Gazette."*

The "Hospital Gazette" refers to Bradford Royal Infirmary where a complete Pay Bed unit of 73 beds is expected to cost £1,030 per bed. Amongst the other complete Hospital units mentioned are Alton Infirmary built at a cost of £360 per bed, and the Queen's Hospital, Birmingham, built at a cost of £833 per bed.

E. *Costs in the United States.*

The information with regard to the cost of providing beds in the United States shows that in New York the average cost of all the Hospitals representing 32,000 beds was only £500 per bed for site and buildings, excluding equipment. Dr. Goldwater's evidence before the Committee was that a complete pay bed Hospital could be built for £1,000 per bed, but that a more luxurious building with single rooms provided with private bath and toilet might cost £2,000 per bed.

F. *Cubic capacity as a guide to cost.*

A valuable method of estimating the cost of a building commonly adopted by architects is to consider the cubic space required, and to multiply this by the cost per cubic foot, which is found to be fairly uniform for buildings of similar construction.

To apply this method of cost it is necessary to consider

(1) The ward space required by each bed,
(2) The ratio of ward space to the rest of the Hospital, and
(3) The cost per cubic foot.

The Tables submitted to the Committee give some figures with regard to ward space per bed. The figures vary greatly, but seem to indicate that from 1,000 to 1,200 cubic feet at an ordinary Hospital, and from 1,300 to 1,600 cubic feet at a pay Hospital, would be a justifiable estimate of the ward space required per bed.

The ratio of the ward space to the rest of the Hospital must vary with the extent and nature of the special departments. Dr. Goldwater, in his evidence before the Pay Beds Committee, indicated that in a pay Hospital the bed space occupied one fourth of the Hospital.

At the following Hospitals without out-patient departments the proportion of the entire building used as wards is as follows :—Florence Nightingale, 20 per cent.; Wembley, 30 per cent.; Hostel of St. Luke, 30 per cent.

At two Hospitals with out-patient departments it was found that after deducting the space used for out-patients the space used for wards was 26 per cent. and 28 per cent. of the remaining space.

It has been found impossible to get accurate data with regard to Hospital measurements, but from the information collected it would appear that the cost of recent Hospital buildings including equipment is about 2s. 6d. per cubic foot.

Applying these measurements and costs it will be seen that at a pay-bed Hospital, where from 1,300 to 1,600 cubic feet of space is allowed for each bed, where the bed space occupies one-fourth of the Hospital, and where the cost of construction and equipment does not exceed 3s. per cubic foot, the cost would be from £780 to £960 per bed. Any economy effected in any of the above three factors will materially reduce the cost per bed.

APPENDIX VII.

A SCALE OF MEDICAL AND SURGICAL FEES: EXTRACT FROM THE "LANCET," JULY 17, 1920.

Handed in by Mr. Thorpe (*Q.* 999).

"CONSULTATION FEES."

"Whatever changes may have occurred in the methods and habits of Consulting Physicians and Surgeons, or in the circumstances of the patients sent to them for advice, their fees have remained unchanged for a generation or more, as far, that is, as the discreet cloud of mystery that surrounds Consultation Fees admits of clear comparison. We know that the traditional two-guinea fee, when it represented a vastly greater purchasing power than it now does, was often reduced in the case of the patient whose financial handicap was indicated to the Consultant by the family Doctor who sent him. But we imagine that the handicapping was always to the disadvantage of the Consultant, who drew no larger fee whatever the affluence of patients who visited him. In contrast therewith, a sliding scale of fees has always been in use by the General Practitioner of Medicine, because his knowledge of the financial standing of his various patients was generally no less intimate than that of their physical frailties. Naturally, this cannot be the case to the same extent in Consulting Practice, and may account for the anomaly of the fixed fee. It is an arrangement which, to speak frankly, has worked none too well in the past, and with the redistribution of wealth which has recently taken place is likely to work still less well in the future. We called attention, a fortnight ago, to an experiment in graduating Consultation Fees initiated at the suggestion of a London business house. The scheme contemplated for a person with an income of £350 or under a reduction of the operation fee to 10 per cent. of the normal, and of the fee for Consultation and treatment to 25 per cent. The rest of the scale is given in brief as follows :—

Adjusted Income.	(*a*)	(*b*)	Adjusted Income.	(*a*)	(*b*)
Under £350	10%	25%	Under £700 ...	30%	45%
,, £400	12½%	27½%	,, £800 ...	40%	50%
,, £450	15%	30%	,, £900 ...	45%	55%
,, £500	20%	35%	,, £1,000 ...	50%	66⅔%
,, £600	25%	40%	,, £1,500 ...	60%	Full.

The 'adjusted income' shewn in the first column includes any private means, as well as the salary of the employee, and is to be ascertained by deducting one-fifth of the total income on account of a wife, and one-tenth on account of each child or other dependent member of the household. Columns (*a*) and (*b*) represent a proportion of fees payable for (*a*) Operations; (*b*) Consultations, Treatment, or Nursing Home Fees. A minimum of one guinea is fixed for a single visit.

"It will be seen that the full Consultation Fee will not be paid until the patient has an income of more than £1,000 a year, and the full Operation Fee not until his income exceeds £1,500 a year. Seeing that a series of Physicians, Surgeons, and Specialists of repute have accepted these conditions, it is evident that some, at all events, of those in Consulting Practice in London are prepared to admit that their normal fee is in the nature of a maximum, the important question being, having regard to the modesty of the maximum, for how many patients it is applicable, and, in particular, for how many is it too low. The scale outlined above, be it noted, only defines the proportion of the fee payable, without fixing its actual amount. It is open, therefore, for any Physician or Surgeon accepting such an arrangement to fix the normal at any level which he chooses; and obviously if he is to accept the reduced fee in a large proportion of the cases in which he previously received the full one, it would be only fair for the Consultant, especially for the Consulting Physician, to place his normal at a higher level than that of the now usual 2, 3 or 5 guineas, and in so doing obtain from the affluent a proper equivalent for his skilled advice.

"In the scheme we have quoted, the employer makes inquiry into the patient's income, including any private means which he may possess. Inquisition of this sort would, we think, be found to be

resented, except as applied impersonally to the staff of large business firms. In other cases it seems to us that the income-tax return might be used, instead of, for example, any employer's voucher. The information given by a patient to his medical attendant is already of so confidential a nature that he need hardly hesitate to disclose to him also the amount of his net income. This information would still remain between the Surveyor, the Doctor and the patient, and the patient would not be taking his employer into his confidence. Such a system would enable the principle of graduating consulting fees to be carried out on a larger scale than that at present suggested."

APPENDIX VIII.

PROFESSIONAL ASSOCIATIONS AND OTHER SOCIETIES REPORTING A DEMAND FOR PAY BEDS.

Artists' General Benevolent Institution.
Association of Assistant Mistresses in Secondary Schools.
Association of Head Mistresses.
Association of Retired Naval Officers.
Benevolent Fund of the Institution of Civil Engineers.
Chartered Institute of Secretaries.
Chartered Society of Massage and Medical Gymnastics.
Civil Service National Whitley Council.*
Incorporated Association of Assistant Masters in Secondary Schools.
Incorporated Society of Auctioneers and Landed Property Agents.
Independent Schools Association.
Lady Grover's Hospital Fund for Officers' Families.
London Teachers' Association.
Medical Aid Society for Necessitous Gentlewomen.
Musicians' Benevolent Fund.
National Union of Teachers.
Officers' Families Fund.
Professional Classes Aid Council.
Royal Patriotic Fund Corporation.
Society of Engineers.
Society of Incorporated Accountants and Auditors.
Surveyors' Institution.

APPENDIX IX.

PAY BEDS IN OTHER COUNTRIES.

MEMORANDUM BY MR. E. A. H. JAY, *Secretary to the Propaganda Committee of the King's Fund.*

The following report, which has been prepared from information received from various sources, seems to show that the need for Hospital accommodation for paying patients has been felt in nearly every country, and in most cases provision has been made.

The information shows that, almost universally, Hospitals are now regarded as institutions available for all classes, payment being in accordance with the means of the patient and the type of accommodation provided, while the Hospital is reimbursed out of public or voluntary funds, as the case may be, in respect of persons who are unable to pay anything, or only a small contribution.

In France and Italy, it appears that before the War persons of the middle class did not resort much to the Hospitals, but this is no longer the case.

In Germany, classification of patients has become much more elaborate, and a special effort is being made to obtain uniformity in this respect.

Generally speaking, the fees charged suggest that it is not the practice to provide accommodation for the really rich, except in the United States, where the highest charge is £4 6s. 8d. per day, and Canada and Japan, where it is 20 guineas per week. In the United States and Canada the accommodation at these rates includes such extras as separate sitting-room, bathroom, and lavatory.

In several countries, notably in Denmark, insurance schemes are a special feature.

In Australia, New Zealand, and South Africa, Hospital organisation is not so far advanced, but there is evidence that accommodation for middle class patients is becoming an urgent problem.

AUSTRALIA.

VICTORIA AND NEW SOUTH WALES.

Hospitals.—(*a*) Maintained chiefly by Government subsidy; (*b*) There are also a few Hospitals controlled by religious denominations or similar agencies. In Melbourne each denomination has established at least one such Hospital.

Classification of Patients.—The tendency is not to grade the patients but to provide one or two small wards for their accommodation.

* The first Report of the Nursing Homes Committee, of the Civil Service National Whitley Council, contains calculations suggesting an operation rate of not less than 2 per cent. for men and a considerably larger rate for women. The Report also contains a suggested insurance scheme for Civil Servants (H.M. Stationery Office 1928, 63–9999).

(*a*) Speaking generally, there is not any provision of special beds in public Hospitals for patients who can pay for medical attention.

(*b*) These Hospitals provide for the class able to pay a reasonable amount for maintenance and medical aid but unable to pay ordinary private Hospital fees. One fairly large Hospital in New South Wales has some beds for paying patients.

Charges.—No normal scale of payments.

QUEENSLAND.

Hospitals.—Cottage Hospitals have been established in country districts with Government assistance, and to these most people in the district subscribe.

Classification of Patients.—Observations regarding classification of patients in public Hospitals in Victoria and New South Wales apply also to this State.

Charges.—Patients are entitled to medical attention and maintenance in return for their subscription. Admitted irrespective of financial position and treated by resident (not honorary) staff.

TASMANIA.

Hospitals.—Hospitals public, and supported almost entirely by the Government.

Classification of Patients.—Observations regarding classification of patients in public Hospitals in Victoria and New South Wales apply also to this State.

Charges.—Proportionate to capacity to pay.

GENERAL.

Throughout Australia there is a great demand for middle class accommodation.

Source of information.—Commonwealth of Australia, per Dr. C. L. Park, Chief Medical Officer Australia House, Strand, London.

AUSTRIA.

Hospitals.—(*a*) Public: maintained by State or township; (*b*) Private.

Classification of Patients.—Three classes: (1) single rooms; (2) with 3 to 6 beds; (3) with 8 to 20 beds.

Charges.—

	In Public Hospitals.	*In Red Cross Hospitals.*
(1)	9s. 4d. (Extra for treatment.)	9s. 4d.
(2)	7s. 0d. (Fixed sum for medical advice and treatment.)	5s. 10d.
(3)	5s. 0d.	Men 4s. 1d., Women 4s. 5d., Children 2s. 11d.

Remarks.—The fees for third class patients are generally paid by insurance societies or municipalities. The middle classes in Austria are nearly all third class patients, but there are exceptions.

Sources of information.—Bundesleitung der Oesterreichischen Gesellschaft von Roten Kreuz, Vienna, per Dr. J. Lanberger, Member, Chief Sanitary Council, Chief Sanitary Department, Austrian Red Cross, and Associated Vienna Mutuals.

BELGIUM.

Hospitals.—(*a*) Public; (*b*) Private; (*c*) Sanatoria.

Classification of Patients.—(1) In separate rooms; (2) In ordinary wards.

Charges.—In (1) in Public Hospitals: 30—40 francs (3s. 9d.—5s.) per day.
in Private Clinics: 60—70 francs (7s. 6d.—8s. 9d.) per day.
In (2) in Public Hospitals: 18—25 francs (2s. 3d.—3s. 1d.) per day.
in Private Clinics: 20—25 francs (2s. 6d.—3s. 1d.) per day.

Remarks.—Persons who belong to insurance societies have part of the fee refunded (often as much as 50 per cent.). In the case of institutions run entirely by such societies, no fees are paid.

Source of information.—Direction Générale, Croix Rouge de Belgique.

CANADA.

Hospitals.—(*a*) Municipal; (*b*) Private.

Classification of Patients.—(1) Private; (2) Semi-private; (3) General ward.

Charges.—(1) (*a*) Quarters, including bedroom, sitting-room, balcony and bath: $100 (20 guineas) per week.
(*b*) Private rooms, from $30 to $50 (6 to 10 guineas) per week, depending on locality and institution;
(2) $25 to $30 (5 to 6 guineas) per week: payment according to means. (For private and semi-private patients there is an extra charge for operation theatre, X-rays, anæsthetist's fees, and special nursing.)

Remarks.—Admission is on the order of the attending physician. In Hospitals where there are a large number of "public" or non-paying patients, financial assistance has to be obtained from the Government and from the municipalities.

Source of information.—High Commissioner for Canada, Canadian Building, Trafalgar Square, London.

CZECHO-SLOVAKIA.

Hospitals.—(*a*) Public Hospitals administered by (i) the State; (ii) the Rural District; (iii) the Municipality;

(*b*) Private Hospitals established by (i) large manufacturing firms for the staff and workmen; (ii) insurance societies; (iii) various religious orders; (iv) private associations.

Classification of Patients.—Class I. ... Single room.
„ II ... 3-or 4-bed wards.
„ III ... General wards.

Charges.—Class I ... ... 8s. per day (approx.).
„ II ... ... 4s. 4d.–6d. „

Necessitous patients are either admitted free or paid for by the Municipality in cases where the Hospital does not provide free treatment. Other patients in the general wards pay what they can.

Remarks.—In Czecho-Slovakia there are insurance schemes (sick funds) in connection with different trades. These provide for maintenance and treatment in Hospital. Sick funds run a certain number of Hospitals themselves. In other cases they defray the cost. This includes medical fees, operations, radium treatment, etc.

Sources of information.—Czecho-Slovak Legation.

DENMARK.

Hospitals.—State or Municipal.

Classification of Patients.—(i) In general wards; (ii) in private wards (1 bed). The State Hospital at Copenhagen contains about 50 rooms with 1 bed, and Municipal Hospitals have a similar arrangement. There are no wards with 2 beds, but some with 3, the charges for which are the same as in the general ward.

Charges.—(i) General ward: 1 kr. 20 oere (1s. 3½d.) per day (local residents);
10 kr. (10s. 10d.) (non-local);
10 kr. (10s. 10d.) (foreigners);
(ii) Private ward: 12 kr. (13s.) (local residents);
18 kr. (19s. 6d. (non-local);
24 kr. (26s.) (foreigners).

Children under one year pay only half the above. These charges include cost of operations, doctors' fees, etc. Patients in small wards (3 beds) are charged the same fee as in the ordinary wards.

Remarks.—On account of members of insurance societies, the Hospital is paid 60 oere (8d.) per day, or 30 oere (4d.) for children under 5. After a certain period the treatment is free. The charges of 60 oere (8d.) and 1 kr. 20 oere (1s. 3½d.) cover only 4–5 per cent. and 10 per cent. of the cost of maintenance, respectively. In Denmark a considerable proportion of the population are members of insurance societies, which are a special feature. The private wards in Copenhagen are nearly always full.

Sources of information.—Director, Health Division, League of Red Cross Societies. Director of State Public Health Services, Copenhagen. Letter from Dr. K. M. Nielsen, Directeur des Hopitaux, enclosing pamphlet written by himself on Les Hopitaux Municipaux de Copenhague. Pamphlet on system of Insurance Societies in Denmark.

FRANCE.

Hospitals.—Chiefly State or Municipal.

Classification of Patients.—A more elastic system has been introduced since the War. This includes special provision for persons of the middle class for whom the charges in private clinics are too high.

Charges.—Range from a few francs per day to full cost (maintenance, surgical operations, medicaments, etc.).

Remarks.—These charges are recoverable by legal action. Patients pay no fees to the medical staff. Information regarding Hospital provision for the middle classes is to be found in a brochure entitled: "L'assistance aux personnes de condition moyenne et l'assistance partielle," by M. Leon Noel.

Sources of information.—Comité Central de la Croix-Rouge Française, Paris. Director-General, Administration Générale de l'Assistance Publique à Paris.

GERMANY.

Hospitals.—Administered by Public Insurance and Public Health Authorities. There are also a certain number of Red Cross and other Private Hospitals. About half the Hospitals in Germany are provided by the organisation for "Free Welfare Services."

Classification of Patients.—65 per cent. have three classes.
11 per cent. „ two „
24 per cent. „ one class.

(First class patients have single rooms; and second class patients, rooms with 2 beds.)

Charges.—In State Hospitals in Berlin third class patients are charged 5.7 marks (5s. 8½d.) per day. The fixing of charges for first and second class patients is left to the Municipalities. These vary from 8 to 10 marks (8s.—10s.) (second class) and from 10 to 15 marks (10s.—15s.) (first class).

Remarks.—The Hospitals provided by "Free Welfare Services" have to balance their budgets by receipts from first and second class patients. The charges for the third class cover only 75 per cent. of the outlay. The tendency is to make the wards smaller and smaller for third class patients, as well. See "The German Hospital System, 1923," by Privy Councillor Dr. Alter, and Brochure; "Freie Wohlfahrtspflege," Nov. 1926.

Sources of information.—German Embassy; Deutches Rotes Kreuz, Berlin.

HOLLAND.

Hospitals.—Not stated whether public or voluntary.

Classification of Patients.—

(*a*) In Netherlands Red Cross Hospital, the Hague :

1st class A : Private room with telephone and bath ;
„ „ B : „ „ without „ „
2nd „ A : Private room.
„ „ B : Room with 2 beds ;
3rd „ : General ward.

(*b*) In Heiliges Joannes de Deo Hospitals, the Hague :

1st class : Private room ;
2nd „ A : „ „
„ „ B : Room with 2 beds ;
3rd „ : „ „ several beds ;
4th „ : General ward.

Charges.—(*a*) 1st class A : £1 13s. 4d. per day ;
„ „ B : £1 5s. per day ;
2nd „ A : 13s. 4d.—16s. 8d. per day ;
„ „ B : 10s. per day ;
3rd „ : 5s.—8s. 4d. per day ;
(*b*) 1st class : £1 per day ;
2nd „ A : 15s. per day ;
„ „ B : 10s. per day ;
3rd „ : 7s. 6d. per day ;
4th „ : 5s. 10d. per day.

Remarks.—(*a*) These charges do not include (1) operation theatre, (2) dressings and special baths, (3) wine and mineral waters, (4) private nurse ;

(*b*) These charges do not include (1) physicians' fees, (2) operation theatre, (3) special laboratory analyses, (4) dressings, (5) medicine, (6) laundry, (7) wine and mineral waters.

Sources of information.—League of Red Cross Societies (information obtained from the Red Cross Hospital and the Hospital St. Jean de Dieu, at the Hague).

ITALY.

Hospitals.—(*a*) State or Municipal ; (*b*) Private corporations (charitable institutions).

(The present Government is abolishing management committees even for Hospitals under (*b*), and appointing an administrator responsible to the " Prefetto," the representative of the Government in each province, with a Consultative Committee.)

Classification of Patients.—Patients may be divided into two classes : (*a*) Necessitous (stated to be such by the municipal authorities) ; (*b*) All others.

Charges.—Municipal authorities contribute a fixed sum in respect of " necessitous " patients treated by the Hospitals. All patients, except those certified as " necessitous," are expected to defray the cost of their keep at a fixed sum per diem. Charges vary according to Hospital, but may be estimated at between 35 or 40 lire (7s. 8d.—8s. 9d.) per diem.

Remarks.—There are many private nursing homes, which charge very much less than in this country, so that the difficulty for the middle class has not been so great. Charges in this case vary from 40 lire per diem upwards. This figure, however, does not include medical and/or surgical attendance as in the case of Hospitals.

Source of information.—Secretary, Italian Hospital.

JAPAN.

Hospitals.—(*a*) State ; (*b*) Municipal ; (*c*) Charitable Associations (*see also Remarks*).

Classification of Patients.—

Class I : Single room ;
„ II : Room with 2 beds ;
„ III : „ „ 4—6 beds ;
„ IV : General ward ;
„ V : „ „

Charges.—Class I : £3 per day (approximate) ;
„ II : £1 10s. per day (approximate) ;
„ III : 14s.—15s. per day (approximate) ;
„ IV : 6s. per day (approximate) ;
„ V : Free.

Remarks.—Charges include medical fees, operation theatre, etc., but a special charge is sometimes made for operations of an exceptional character. Hospitals administered by the State, municipal authorities or charitable associations are either (*a*) for the poor only (Class V), or (*b*) for all classes. Patients in Classes I, II, III are also treated in institutions run by private individuals. These also are known as Hospitals, and are on a rather larger scale than nursing homes in this country. Some of these admit Class IV as well ; and in some cases doctors treat patients in this latter class without charging any fee.

It is stated that, in 1925, the number of patients of Class V in the Hospitals administered by municipal authorities was 78,080, while the total of the patients of other classes in the same Hospitals was 1,710,131. Patients in Class V are in some cases available for inspection by students and for post-mortem examinations. The majority of the Hospitals in Japan are administered by voluntary associations, or are under private management. The most important charitable institution is the Sai-Sei-kwai (Society of Relief), established in 1911 at the instance of the Emperor Meiji, who contributed 1,500,000 Yen for this purpose. Under this institution, there are hospitals in many districts. In Japan, the family tie is very strong, and relations frequently pay the fee if the patient himself is unable to do so. Cost of living is higher than before the War, but not so high as in this country.

Source of information.—Japanese Embassy.

NEW ZEALAND.

Hospitals.—Dominion divided into 45 districts, each with a "Hospital and Charitable Aid Board," under the supervision of the Department of Health.

Classification of Patients.—No definite policy. Basic principle is that beds are primarily for the needy. An agitation for the provision of private wards is now going on.

Charges.—Average fee charged is £3 3s. per week (full cost of treatment being about £1 per day). (About one-quarter of the Hospital expenditure is met by patients' payments, and about one-twenty-fifth by voluntary contributions.)

Remarks.—Hospital Boards are subsidised by Department of Health on £1-for-£1 basis.

Sources of information.—Extract from Official Year Book, 1927; brochure entitled "Striking Facts and Records," issued by New Zealand Department of Health; per the Secretary to the Department at the office of the High Commissioner for New Zealand, New Zealand Government Offices, Strand, London.

NORWAY.

Hospitals.—(*a*) Local authorities; (*b*) private corporations; (*c*) individuals. (Also Government Hospitals at Oslo and Bergen.)

Classification of Patients.—In Municipal Hospitals private wards are provided for persons who prefer them and are able to pay the prescribed fee.

Charges.—There is a tariff of charges, with a lower rate for local residents. Patients from other cities or countries pay the full cost price, but no more.

Remarks.—The Government subsidise both Municipal and Private Hospitals, and travelling allowances are paid to patients who have to come long distances to reach the Hospital.

Sources of information.—Norges Røde Kors; Det Kongelige Department for Sociale Saker; Director of Government Hospital, Oslo (Dr. Sinding Larsen).

SOUTH AFRICA.

Hospitals.—Not stated whether public or voluntary.

Classification of Patients.—

(1) Single-bed ward;
(2) 2-bed ward;
(3) General ward.

Charges.—Average charge in the Transvaal:—

Single ward	22s. 6d. per day	inclusive.
2-bed ward	17s. 6d. „	

(In the other provinces the charges are somewhat less.)

Extra charge up to £2 2s. is made for operation theatre; and X-ray treatment, massage, and electrical treatment are also extras.

Remarks.—Private patients have the privilege of choosing their own medical man, and are liable to him for fees. The food is in some cases slightly better, and extras are usually allowed more freely. More visitors are allowed in the private wards. The receipts far more than cover the expenditure incurred, including interest and sinking fund charges on capital. There is a considerable demand for this kind of accommodation throughout South Africa (except in Durban, where cheap nursing accommodation is available for 15s. per day upwards), and the accommodation is much less than the demand.

Source of information.—Authorities in Pretoria, per Mr. Stanley Eales, South Africa House, Trafalgar Square, London.

SWEDEN.

Hospitals.—(*a*) State; (*b*) Counties; (*c*) Municipal authorities; (*d*) Private (a very few only).

Classification of Patients.—

(1) Single rooms;
(2) Rooms with 2 beds;
(3) Ordinary wards.

Charges.—(1) A fee slightly exceeding the actual cost;
(2) Approximately equivalent to the cost;
(3) Fourth or fifth of the cost, necessitous patients being paid for by Boards of Guardians.

Remarks.—Patients in (1) and (2) are supplied with somewhat more expensive food. They also pay a medical fee. The medical staff receive no remuneration for treatment in the case of ward-patients.

Sources of information.—Comité Central de Direction de la Croix-Rouge Suédoise. State Department of Health, Sweden, per League of Red Cross Societies.

SWITZERLAND.

Hospitals.—(*a*) Cantonal and Municipal; (*b*) Private.

Classification of Patients.—

(i) Necessitous persons who are treated free;
(ii) Persons with limited means who pay according to their ability;
(iii) Well-to-do persons, for whom separate rooms are provided at "first class" charge.

Charges.—(*a*) Maximum charge varies from 12s. 6d. to 19s. 6d. in the Public Hospitals;
(*b*) Some of the private Hospitals are entirely free and supported by donations and collections. Others take persons of limited means at a very small charge.

Sources of information.—Comité International de la Croix-Rouge, Geneva. Pamphlets: Règlement pour les Malades en Chambres Particulières; Rapport de la Commission Administrative de l'Hôpital Cantonal de Genève, 1925.

UNITED STATES.

Hospitals.—(*a*) Municipal; (*b*) Voluntary.

Classification of Patients—

(1) Private;
(2) Semi-private (middle class);
(3) Charity.

(This classification applies mainly to the voluntary Hospitals, but a few municipal Hospitals have now begun to take semi-private patients.)

In the 63 non-municipal general Hospitals in New York for which information is available:—

11.1 per cent. of the patients are accommodated in private rooms;
17 " " " semi-private rooms;
71·9 " " " public wards.

Charges.—(1) Private room (some with separate bathrooms and lavatories): average charge from 11 or 12 dollars (45s. or 49s. approximately) per day. Charges range up to 20 dollars (£4 6s. 8d. approximately) per day for special accommodation;
(2) Either cubicles or small wards (2, 3 or 4 beds): average charge something less than £8 or £9 a week;
(3) Ordinary wards: either free or payment according to means (cost 4–6 dollars per day).

Remarks.—The proportion of paying patients is much larger in America than in this country. In New York the improvement of Hospitals and the advancement of medical science and practice have led to the larger utilisation of Hospital facilities by all classes of the community.

The introduction of private pavilions for rich patients is said to have had a most beneficial effect. The high fees paid by these patients help to pay for those who are unable to defray the cost of their maintenance, and the highest medical skill and nursing is available for all classes.

The proportion of patients who pay nothing at all does not, as a rule, exceed 20 per cent.

According to a report of the United Hospital Fund for the year 1922, covering 66 Hospitals (in New York City), 67 per cent. of the total income was derived from payments by patients and from the City for care and treatment of "public charges." The aggregate income from endowments amounted to 16 per cent., leaving only 17 per cent. to be raised from voluntary contributions. In addition to the income from private and semi-private patients, there has been an increase in the number of paying patients in the ordinary wards, and the percentage of "public charges" has fallen from 23 per cent. in 1911 to 10 per cent. in 1922.

It is usual for patients accommodated in private wards and paying for their maintenance to be charged for medical treatment on a scale regulated by the "Social Services System," to which our Lady Almoners are the nearest equivalent.

Sources of information.—Oral evidence from Dr. Goldwater, Director of Mount Sinai Hospital, New York, and Dr. J. W. McNee, D.S.O., M.D., D.Sc., F.R.C.P. (Minutes of Evidence, Q. 1352–1447; 798–895). "The Hospital Situation in Greater New York; Report of a Survey of Hospitals in New York City by the Public Health Committee of the New York Academy of Medicine."

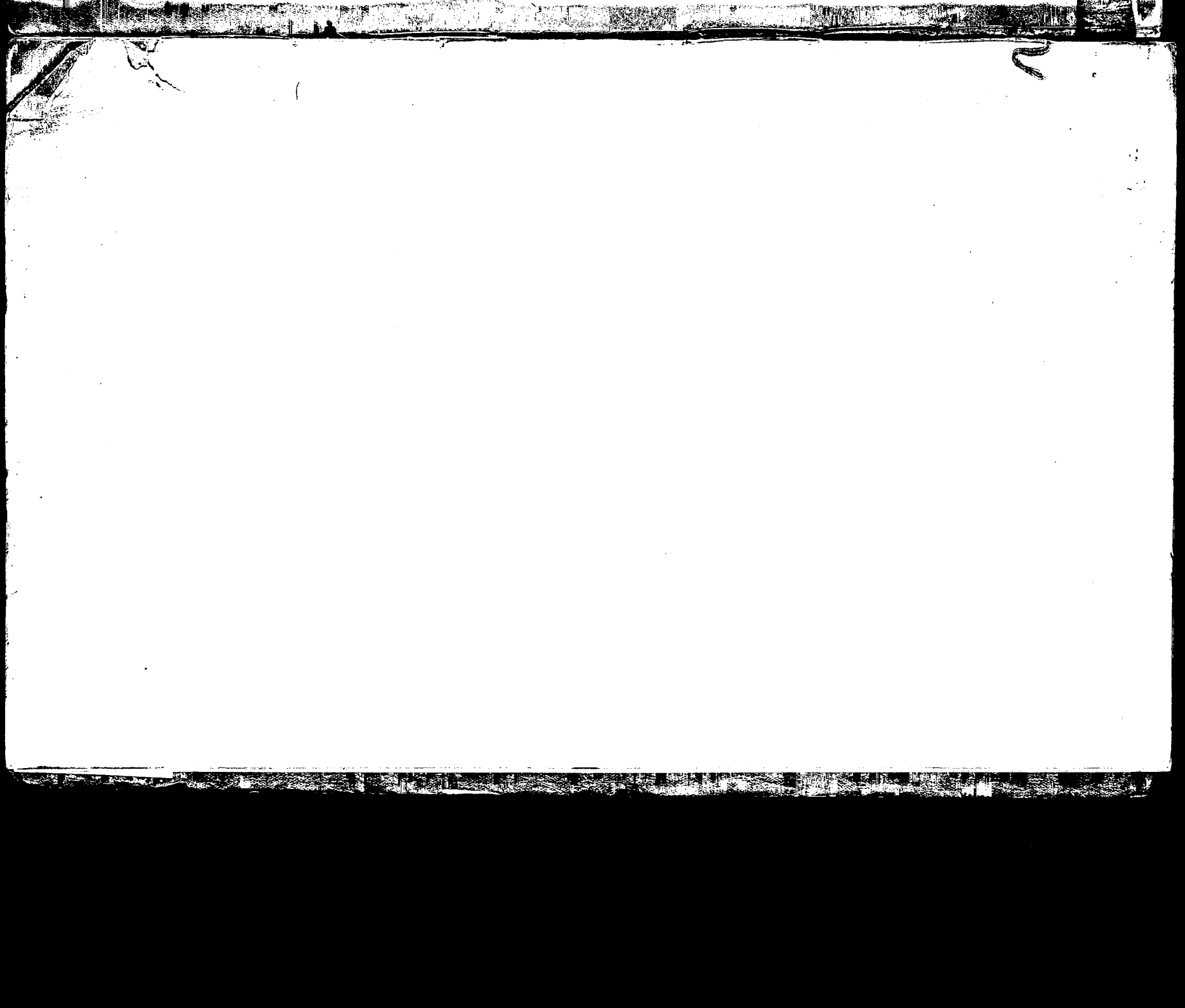
APPENDIX X.

LIST OF WITNESSES.

Arranged in order of date.

(The third column will serve as an index to the marginal references in the Report.)

Witness.	Page of Minutes (Part II).	Question Numbers.
WALLACE, Sir CUTHBERT, K.C.M.G., C.B., F.R.C.S., St. Thomas's Hospital ROBERTS, Mr. G. Q., St. Thomas's Hospital ... ... McLEAN, Dr. WILLIAM WALTER, M.R.C.S., L.R.C.P., St. Thomas's Hospital	1	1–77
EASON, Mr. HERBERT LIGHTFOOT, C.B., C.M.G., M.D., M.S., Guy's Hospital	5	78–197
WHITE, Mr. G. B. MOWER, F.R.C.S., Royal Northern Hospital ... ... PANTER, Mr. GILBERT, Royal Northern Hospital	12	198–307
CARLING, Mr. E. ROCK, F.R.C.S., Westminster Hospital ... ... POWER, Mr. CHARLES M., Westminster Hospital	16	308–398
PRITCHARD, Dr. H., West London Hospital ... ... MADGE, Mr. H. A., West London Hospital	20	399–463
BUXTON, Mr. ST. JOHN D., F.R.C.S., King's College Hospital ... ... BEDWELL, Mr. C. E. A., King's College Hospital	22	464–567
GREENWOOD, Dr. E. CLIMSON, Hospital of St. John and St. Elizabeth ... HOBBS, Mr. F. DUDLEY, Hospital of St. John and St. Elizabeth ...	27	568–645
DEAS, Dr. F., Nelson Hospital ... ... PORTER, Miss E. M., Nelson Hospital	30	646–724
WIART, Rt. Rev. Mgr. CANON CARTON DE, St. Andrew's Hospital Dollis Hill	32	725–797
McNEE, Dr. J. W., D.S.O., M.D., D.Sc., F.R.C.P. (experience in U.S.A. and Canada)	35	798–895
ANDERSON, Sir ALAN G., K.B.E., British Provident Association... ... DENMAN, Mr. T., British Provident Association	38	896–945
CHADBURN, Miss M. M., M.D., B.S., South London Hospital for Women RIDLER, Miss M. E., South London Hospital for Women	41	946–994
THORPE, Mr. C. H., Freemasons Hospital	46	995–1045
BURROUGHES, Mrs. F. G., Florence Nightingale Hospital ... ... JOHNSON, Dr. HILDA, Florence Nightingale Hospital	50	1046–1086
ECCLES, Mr. W. McADAM, F.R.C.S., Royal College of Surgeons	52	1087–1139



KING EDWARD'S HOSPITAL FUND FOR LONDON.

SUPPLEMENT

TO

APPENDIX II

OF

REPORT OF PAY BEDS COMMITTEE.

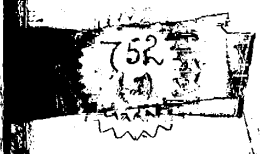
A. ALTERATIONS SINCE MARCH 31, 1928.

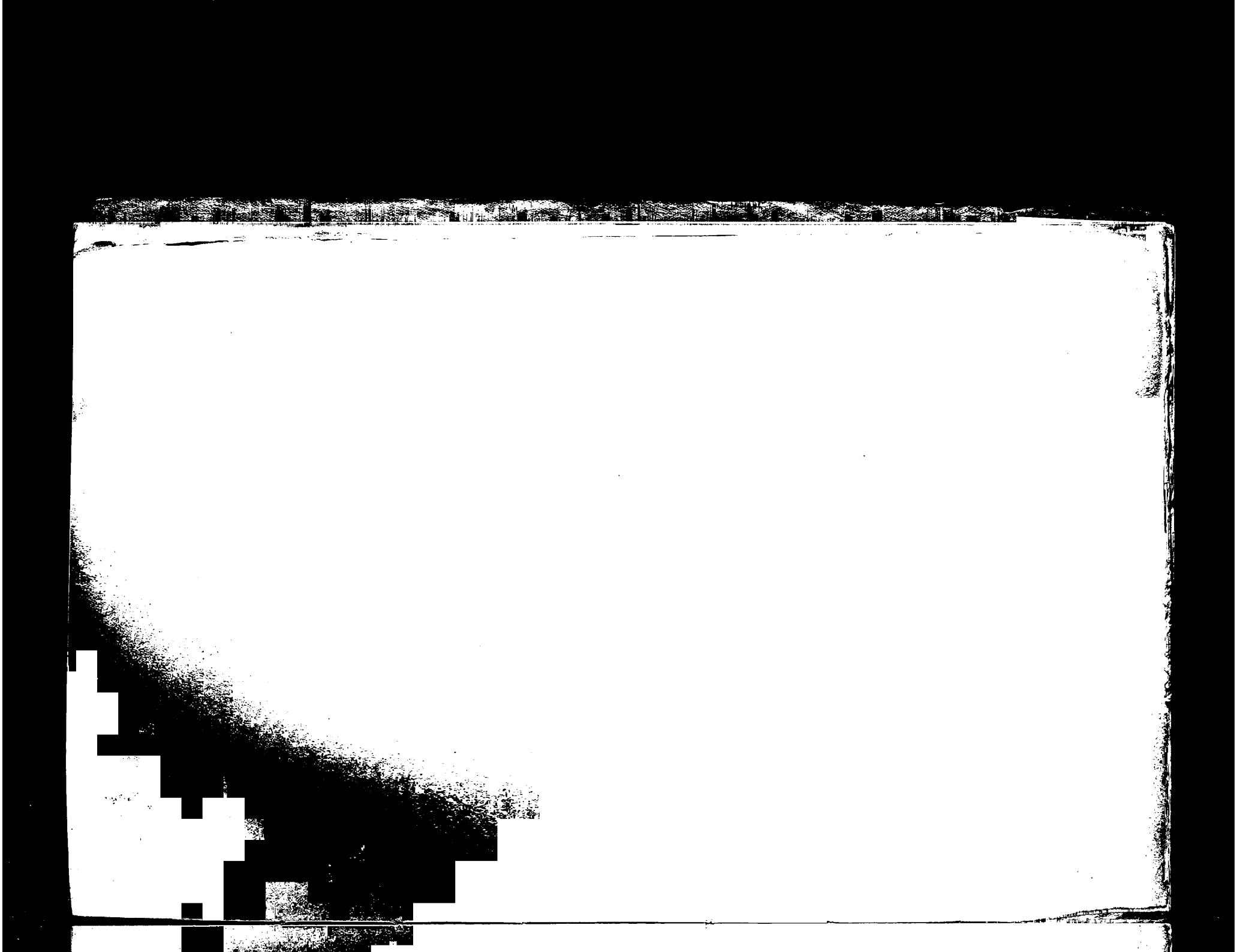
B. ADDITIONS SINCE MARCH 31, 1928.

MAY, 1929.

LONDON:
PRINTED AND PUBLISHED FOR KING EDWARD'S HOSPITAL FUND FOR LONDON BY GEO. BARBER & SON LIMITED, FURNIVAL STREET, HOLBORN, E.C.4, AND CURSITOR STREET, CHANCERY LANE.

Free and Post free.





In order to bring up to date the particulars of Pay Bed Accommodation in London Hospitals shown in Appendix II of the Report of the Pay Beds Committee* the following alterations and additions are necessary.

The details given in A should be substituted for those shown in Appendix II, and the particulars given in B should be added to those shown in the Appendix. Appendix II and this supplement read together summarise the existing Pay Bed Accommodation. For detailed information regarding a particular Hospital application should be made to the Secretary of the Hospital.

---

* Report of Pay Beds Committee: Part I—published for King Edward's Hospital Fund for London by Geo. Barber & Son Limited, Furnival Street, Holborn, E.C.4. Price 1s., post free 1s. 5d.

A. ALTERATIONS TO APPENDIX II

of Report of Pay Beds Committee, viz.:—

Alterations to details shown in columns (4), (5) and (6) in respect of Hospitals that provided Pay Beds prior to 31st March, 1928. The following particulars should be substituted for those shown in Appendix II.

Col. (1) No.	Col. (2) Hospital.	Col. (4) Pay Beds normally available May, 1929.	Col. (5) Number of Pay Beds in each Ward (and classification, if any).	Col. (6) Normal weekly charge : guineas.
2	King's College	48	24-bed (curtains).	5 gns.
		6	2-bed	6 gns.
		11	1-bed (31 m., 32 f., 2 ch.).	8 gns.
3	Royal Free	9	1-bed (3 maternity).	8 gns.
8	Bolingbroke	5	5-bed (5 f.).	4 gns.
		2	2-bed (2 m.).	
		8	1-bed.	6 gns.
11	Hampstead	7	7-bed (7 f.).	3½ gns.
		8	4-bed.	
		2	1-bed.	6 gns.
		4		7 gns.
19	Queen Mary's	2	2-bed.	5 gns.
		4	1-bed.	
23	Seamen's (Dreadnought)	8	4-bed.	3 gns. to 4 gns.
		12	3-bed (20 m.).	
25	West London (B)	8	2-bed.	4 gns.
		18	1-bed.	5 gns.
35	Finchley (E)	4	2-bed.	3 gns.
		3	1-bed.	4 gns.
		1		5 gns.
		1		6 gns.

(B) *West London.*—Minimum Medical Treatment Fees are 3 gns. for first week and 2 gns. per week subsequently.

(E) *Finchley.*—For Local Residents only, except in emergencies.

Col. (1) No.	Col. (2) Hospital.	Col. (4) Pay Beds normally available May, 1929.	Col. (5) Number of Pay Beds in each Ward (and classification, if any).	Col. (6) Normal weekly charge : guineas.
40	Hostel of St. Luke (E)	8 23	2-bed. 1-bed.	(*a*) Free. (*b*) From 10/6. (*c*) Up to 7 gns.
44	Passmore Edwards	6	1-bed.	4 gns. (minimum).
50	Elizabeth Garrett Anderson	6 2	6 cubicles (partitions). 1-bed (2 maternity).	4 gns. 4 gns. to 6 gns.
52	Grosvenor	2 3	2-bed. 1-bed (3 gynæcological).	2½ gns. (E). 4 gns.
56	South London	4 14 4	2-bed. 14 cubicles (partitions and curtains). 1-bed.	4 gns. 5 gns. 6 gns.
63	Golden Square (Throat, Nose and Ear)	4 18 2	4 cubicles. 1-bed. 2-bed.	5 gns. 6 gns. 1 gn. per day.
64	Gordon	8 4 4	4-bed 2-bed. 1-bed.	3 gns. 5 gns.
72	Royal National Orthopædic	7 5	7-bed (curtains). (7 f. and ch.). 5-bed (curtains) (5 m.).	4 gns. to 6 gns.
73	Royal Waterloo	2 6 1	2-bed. 6-bed. 1-bed (7 f.).	3 gns. 5 gns. 7 gns.
75	St. Paul's	10 1	(In General Ward) (curtains) (10 m.). 1-bed (1 f.).	5 gns.

(E) *Hostel of St. Luke.*—A Resident Medical Officer has been appointed recently.

(E) *Grosvenor.*—Patients paying only 2½ gns. do not pay Medical Fees.

B. ADDITIONS

of Report of Pay

Details in respect of Hospitals that have provided Pay Beds since 31st March,

(1) No.	(2) Hospital.	(3) Total beds normally available May, 1929.	(4) Pay Beds normally available May, 1929.	(5) Number of Pay Beds in each ward (and classification, if any).	(6) Weekly charge: guineas.	(7) Procedure as regards medical fees.
	General and other Hospitals with Resident Medical Officers.					
81	East Ham Memorial	100	4	1-bed.	4 gns. (minimum).	Arranged privately.
82	Miller	151	8	1-bed.	5 gns.	Arranged privately.
83	Putney	52	7	1-bed.	5 gns.	Arranged privately.
	Other Special Hospitals.					
84	Bermondsey Medical Mission ...	20	2 1	2-bed. 1-bed.	2 gns. 5 gns.	Arranged through Matron.
85	Mount Vernon (Cancer)	147	12	1-bed.	5 gns. (minimum).	Arranged privately.
86	Royal Westminster Ophthalmic	42	14	1-bed.	6 gns. (B).	Arranged privately.

(B) *Royal Westminster Ophthalmic*—Charges are reduced to 5 gns

TO APPENDIX II

Beds Committee, viz.:—

1928. The following particulars should be added to those shown in Appendix II.

(8) By whom patient is attended.	(9) Arrangements as to services of Resident Medical Officer.	(10) Whether patient's practitioner can keep in touch.	(11) (*a*) By whom patient is admitted. (*b*) Whether any financial limitation. (*c*) By whom financial suitability is determined.	(12) No.
Medical staff.	Available free in an emergency.	No, except by courtesy in individual cases.	(*a*) Medical staff, Matron or Secretary.	81
Medical staff.	Available free.	Yes.	(*a*) Secretary on recommendation of medical staff. (*b*) Intended for patients of moderate means. (*c*) Patient's practitioner.	82
Medical staff.	Available free.	Yes, in consultation with medical staff.	(*a*) Special Committee. (*b*) Inability to meet Nursing Home Fees. (*c*) Special Committee.	83
Medical staff.	Attends daily.	Yes.	(*a*) Medical staff. (*b*) No limit.	84
Any consultant.	Available free.	Yes, by arrangement with the Resident Medical Officer.	(*a*) Secretary. (*b*) Inability to meet Nursing Home and Surgeon's Fees.	85
Medical staff.	Attends daily. Fee 1 gn.	Yes.	(*a*) House Surgeon, on request of medical staff. (*b*) No limit.	86

per week from date of admission for a longer stay than two weeks.