

BRITISH MEDICAL JOURNAL

LONDON SATURDAY FEBRUARY 19 1949

THE COST OF THE NATIONAL HEALTH SERVICE

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In the Beveridge Report, 1942 (Appendix A, p. 201), the cost of a comprehensive health service for Great Britain was estimated by the Government Actuary at roughly £170 million. On a basis of population Scotland's share can be taken at £19 million, leaving £151 million for England and Wales. The National Government White Paper, 1944 (Cmd. 6502, Appendix E, p. 84), gave £132 million for England and Wales. The service contemplated was, however, incomplete, because it left £6 million to be provided for voluntary hospitals out of voluntary contributions and because "it would probably be several years before the net expenditure on the new dental services reached £10 million and on the new ophthalmic services £1 million"—a prediction very soon to be shown false. Allowing £4 million for a contemporary estimate for these two services, we get £142 million for a complete service. The White Paper, however, assumed the existence of 520,000 hospital beds, a figure which the subsequent hospital surveys showed to be an overestimate. The actual figures cannot be stated with precision, since in two out of the ten surveys the number is not stated. Calculating from the remaining eight, we may take the number of non-existent beds as 86,000. The White Paper estimate of £86 million for the total cost of the hospital services would therefore, if accurate, be £71 million, giving for the complete service £127 million.

The National Health Service Bill, 1946 (Financial Memorandum, p. iv), reckoned the cost of a complete service at £152 million. Two years later the Minister of Health, in answer to Sir Ernest Graham-Little (*Hansard*, April 8, 1948), gave an estimate of £230 million at current costs. The corrected estimates for a comprehensive service are therefore as shown in Table I.

TABLE I.—*Estimates for England and Wales; Adjusted for a Comprehensive Service in All Cases*

Year	Authority	£M
1942	Beveridge Report	151
1944	White Paper	127
1946	N.H.S. Bill	152
1948	Minister of Health	230

These figures take no account of projected capital expenditure. Health centres (2,000 at £187,000 each) will cost £374 million excluding site values and cost of equipment; the 69,000* extra hospital beds needed according to the Hospital Surveys will cost £345 million. Adding the cost of rebuilding, renovating, and re-equipping existing hospitals, we reach a figure far in excess of £1,000 million. Even though the capital cost be spread over a number of

*This figure is, as I shall show, a gross underestimate. Moreover it does not include mental beds.

years, the annual charge, including the cost of servicing, will reach an astronomical figure. What a commentary on our vaunted conquest of disease!

Meanwhile our faith in the official estimates, already shaken by their remarkable antenatal rise, is shattered by such neonatal estimates as have come in. The ophthalmic service is reckoned to be costing £20 million and the dental service £28 million, so that these two services alone are costing one-third of the Beveridge estimate and one-fifth of the 1948 estimate for the whole service. Let us therefore examine in retrospect the sequence of thought culminating in the present set-up, paying particular attention to the Beveridge Report, its *fons et origo*. We shall then see that all the official predictions are totally unreliable—(1) because they ignore the effect of the ageing of the population, (2) because they ignore the intrinsically expansive nature of hospital practice, and (3) because they are based on a false conception of health and disease.

It should be borne in mind that, according to the Beveridge Report (p. 162), "the primary interest of the Ministry of Social Security is . . . in finding a health service which will diminish disease by prevention and cure." On p. 104 it foresees that "there will actually be some development of the service and as a consequence of this development a reduction in the number of cases requiring it." These two factors are expected to cancel each other, leaving the cost for Great Britain in 1965 unchanged at £170 million. The author therefore seems to have had little faith in the ability of his scheme to fulfil its purpose. Later opinions were only slightly more realistic. The White Paper (Appendix E, p. 81) foresaw that the 1938-9 cost would be "considerably increased" owing to "some expansion of accommodation and services," higher prices and wages, and payment for specialist services in the voluntary hospitals. The Bill (Financial Memorandum, p. i) expected that "considerable capital expenditure on the provision and expansion of hospital and other accommodation would be necessary as well as a high rate of expenditure and upkeep of existing buildings and renewal of equipment," but put this down to the arrears which had accumulated during the war.

The Ageing of the Population

One needs no medical training to know that the need for medical attention increases with age. Lord Beveridge evidently realized it, for he emphasizes the necessity of providing for the increasing risks of later life, and assures us (p. 8) that he has taken the ageing of the population into account. Yet in predicting a diminution in the need for treatment he ignores the warning which glaringly confronts him in his own Report. The relevant figures are shown in Table II.

TABLE II.—*Estimated Population of Great Britain by Age Groups (from the Beveridge Report, p. 91)*

	1941*		1971		Difference	
	No.	% of Total	No.	% of Total	In Nos.	In % of Total
Under 15	9,573,000	20.6	7,600,000	16.5	-1,973,000	-4.1
Men 15-64; Women 15-59, both inclusive	31,421,000	67.5	28,804,000	62.6	-2,617,000	-4.9
Men 65 and over; Women 60 and over	5,571,000	12.0	9,576,000	20.8	+4,005,000	+8.8
Total	46,565,000		45,980,000			

* I go back to 1941 because that year is the nearest to the date of publication of the Beveridge Report and because no provision has been made for the change which have since occurred.

How could anyone fail to see that the addition of 4,000,000 to the pensionable group must result in a considerable increase in the incidence of disease? For the estimation of this increase certain data are available.

1. *Incidence of Degenerative Diseases.*—Holingsworth and Klem (1943) found that in people over 65 in the United States the incidence of degenerative diseases was 86.4 per 1,000. Assuming a similar incidence in this country, the number of sufferers would rise from 483,000 in 1941 to 829,000 in 1971, an increase of 72%.

2. *Domiciliary Attendance.*—In the United States Collins (1940) found that domiciliary attendance on people over 65 and on younger people was in the proportion of 6.0:2.7. The figures for this country given in the Registrar-General's Quarterly Returns are roughly the same. Simple calculation shows that if all medical treatment were domiciliary the amount for the whole population would increase by $\frac{2.7}{3.0}$, or 9.5%, from this cause alone.

3. *Bed-provision for the Chronic Sick.*—An investigation carried out by the Surrey County Council on behalf of the hospital surveyors of the London Area showed that of the beds for the chronic sick 75% were occupied by people over 64, and 25% by younger people. The number of beds needed is estimated in the different surveys at between 1.2 and 2.0 per thousand. Taking the lower figure, Table III shows that the increase needed between 1941 and 1971 is 28,000.

TABLE III.—*Beds Required for Chronic Sick (On a Basis of 1.2 per Thousand)*

Year	Men over 64 and Women over 59			Others			Total Beds
	No.	% of Popn.	Beds	No.	% of Popn.	Beds	
1941	5,571,000	12.0	42,000	40,994,000	88.0	14,000	56,000
1971	9,576,000	20.8	72,000	36,404,000	79.1	12,000	84,000

Similarly, taking the higher figure, the increase is 47,520. Whatever the figure, the increase is 50%.

Lord Beveridge seems to have visualized a population after an active life of successive illnesses and restorations to health entering into healthy old age which eventually terminates in clinically blameless death. The hospital surveyors of the Eastern Area hope for a diminution in the incidence of degenerative diseases for improved home care and earlier diagnosis. But it has yet to be proved that home care is more economical than institutional treatment, and we have little evidence that earlier diagnosis will make tissues less liable to degenerate or old bones less liable to break. It is obvious to everyone that to our powerlessness to prevent these occurrences must be added our remarkable progress in retarding malignant and degenerative processes, and that, although this progress must itself in due course become retarded, we have still a long way to go before the limit of our achievements is reached. We shall certainly see a more widespread application of radio-

therapy and physiotherapy, which, whether really effective or not, will be valued, and therefore demanded, for the psychological satisfaction which they give not only to the recipients but also to their relatives. The transference, so to speak, in 30 years of 4,000,000 from the younger to the pensionable age group (a number which may well be increased by medical progress) cannot fail to impose a heavy economic strain on a working population diminished by 2,600,000 according to the official estimates, which, it should be noted, take no account of the further reduction that will result from Government-sponsored emigration on a large scale and from the raising of the school-leaving age to 16. We may derive a grim consolation from the easing of the burden owing to the diminution of 1,970,000 in the number of children under 15.

The Expansion of Hospital Practice

Prior to the last war the medical services undertaken by the State, apart from the activities of the Medical Research Council, were practically confined to the institutional treatment of chronic sickness, infectious and mental diseases, tuberculosis, and to part of general practice. With the exception of the surgical treatment of tuberculosis the cost of these was almost static, fluctuating only with the cost of living. Any undue rise in the cost of the general practitioner service could be checked by penalties for over-prescribing. When the State proposed to undertake the treatment of the acute sick it was assumed that this too was almost static. "There will be *some* development of the service," says the Beveridge Report. "There will be *some* expansion of accommodation and services provided (e.g., for cancer)," says the White Paper [*italics mine*].

These comforting words betray a singular ignorance of the most outstanding characteristic of the voluntary hospitals—namely, that their activities were determined by the application of science, which, as I have shown (Roberts, 1948), resulted in the expansion with accelerating velocity of every branch of their work without exception. The growing demands made upon them they met by spending up to and often beyond their income, proudly displaying their adverse balances as a measure of their success and as a basis for appeals for more generous support. There was therefore every reason to suppose that when their financial embarrassments were removed their expansion would be still further accelerated. But owing to defective historical sense none of the official publications show any realization of this state of affairs, though it must have been obvious if only from experience gained in the Emergency Medical Service. Estimates were based on the then existing expenditure plus the amount due to arrears which had accumulated during the war. Had they been based on the *rate of growth* they would have furnished a more reliable indication of the magnitude of future commitments.

Misconceptions about the Nature of Disease

To sociologists disease has always appeared as something which causes poverty. It is one of the five "giants" (to quote the Beveridge Report) which threaten social security through the cost to the invalid and the economic consequences to him and to his dependants. Hence the first steps at mitigation were concentrated, in the National Insurance Act, on the wage-earner. In the Beveridge Report this view of disease receives its fullest expression. This can be seen in the repeated emphasis on "restoration to health" and the importance of rehabilitation. Steps must be taken "to prevent interruption or destruction of earning power from leading to want." According to the International Labour Office the principal object of sickness insurance is to restore health and working capacity. On this simple view the community can be divided into two

groups: those who are well and able to work, and those who are unwell and unable to work. Disease is something people recover from, and the doctor's duty is to expedite that recovery so that they may resume their labours.

For taking this restricted view sociologists cannot be blamed. Untrained in biology and medicine, they are incapable of seeing health and disease in their proper setting. The fault lies in ourselves. In what is known as Social Medicine we have joined hands with them in investigating the effect of social conditions upon health, but we have neglected the wider problem. We have failed to formulate any doctrine embodying the true relation between medicine and all the elements of which civilization is composed—human nature, social progress, standard of living, and control over Nature. This extremely intricate relation we must now make an effort to unravel, a task we can best perform by taking one by one the delusions under which the sociologists labour.

What is Health?

The Beveridge Report, as we have seen, conceives ill-health as something which threatens social security. But when it comes to the means of treating ill-health it discards this restricted conception for one which is all-embracing. "For every citizen there must be available whatever medical treatment he requires, in whatever form he requires it, domiciliary or institutional, general, specialist, or consultant. . . ." We thus have in the same Report two widely differing conceptions, and it is in the gulf which separates them that the Health Service is most likely to founder. It therefore seems desirable to try to define health. The anonymous writers of the *Report on the British Health Services* in the Political and Economic Planning (P E P) Series (1937, p. 395) state that "we can hardly claim scientifically to know what health is." Their self-confessed incapacity, however, does not deter them from expounding, in common with many other writers, the popular fiction of "positive health." This seems to be a permanently ecstatic state which will inevitably ensue from the removal of adverse social conditions, from more intensive health propaganda, the training of more and better doctors, and the building of bigger and brighter hospitals.

Maintaining that health can be regarded only as a neutral or zero state, I suggest the following definition:

Within the limitations of diagnosis good health exists, (1) when the separate organs of the body are functioning within the recognized normal range, and when the integration of their functions permits growth and physical and mental activity within the normal range; (2) when the activity of the micro-organisms for which the body is the natural habitat are sufficiently counteracted so that they are prevented from impairing functional powers; and (3) when the physical and mental stimuli constantly arriving from the environment do not appear to impair structure or function at the moment, and, though individually subliminal, do not appear to be exerting a cumulative effect in impairing them in the future.

Whatever its imperfections, this definition is, I think, at least realistic. It recognizes that the fight against disease is one aspect of the struggle for existence, like the quest for food and for protection against the violence of Nature. This struggle, so far from becoming easier, must inevitably become harder at every step owing to our inherent moral and physical infirmities, our mortal nature, and the bounds of time and space. We cannot conquer Nature, for the simple reason that we are ourselves part of Nature; we can only come to terms with her, and she drives a hard bargain.

Social and Economic Conditions

"It is necessary to remember," says P E P, "that there are often two alternative policies for dealing with ill-health

—either to treat the cases or to deal with the social and economic conditions producing the cases." If by "social and economic conditions" is meant poverty I can only reaffirm categorically that with the possible exception of tuberculosis none of the major diseases and few of the minor ailments are in any degree attributable to this cause. Housing conditions are still deplorable in many places, but preventive medicine, by making the slums, as it has made the jungle, more habitable, has made their abolition less insistent. As regards psychological disorders, can we, influenced by the prevailing philosophy of determinism, indefinitely attempt to adjust the environment to the individual, bearing in mind the function of the environment in the formation of character? Does our growing knowledge of the workings of the mind keep pace with the new problems for ever arising in an age when the increasing complexity of civilization inevitably breeds new sources of friction in human relations and when increasing self-consciousness makes man more critical of his environment though not more critical of himself? "The fault, dear Brutus. . ."

Industrial diseases present a similar problem. If our task were confined to the elimination of those which have long existed it would be formidable enough. We must remember, however, that industry is not static. Scientific discovery leads society to engage itself in the production of ever more complex chemical substances the ill-effects of which are discovered only by experience. Even more formidable are the risks involved in the industrial uses of x rays and γ radiation, and in the production of isotopes and radioactive substances. The protection of employees and the prevention of contamination of air, water, and earth require a cleansing ritual which is fantastically elaborate. Nor is it merely a matter of disease which is immediately apparent, for there is reason to fear the advent of pathological effects delayed by years and even the possibility of danger to succeeding generations. As man, spurred by curiosity and the struggle to survive, penetrates ever more deeply into Nature's secrets she exacts an ever heavier toll. With these increasing hazards, which become a progressively more integral part of industrial life, medicine strives frantically to keep pace. Danger is always one move ahead of prevention.

Disease and Working Capacity

"Disease and accidents must be paid for in any case, in lessened power of production and in idleness" (Beveridge Report, p. 158). This sweeping statement is a travesty of the truth. It ignores all those conditions which have no effect on earning power—minor and localized skin diseases, such as digital warts and birth-marks, minor errors of refraction in the illiterate, the loss of a tooth, and baldness (for which wigs are supplied in duplicate), to name only a few of the vast number for which correction is now being demanded. It ignores the fact that medicine is a luxury as well as a necessity. It ignores the coexistence of incurable neurosis with unimpaired functional efficiency. We all know the neurotic woman who, when asked whether her symptoms interfere with the performance of her household duties, replies with an indignant denial, the very suggestion being a reflection both on her sense of duty and on her capacity for martyrdom.

Underlying this view is the assumption that health is something which all desire. I once heard a distinguished sociologist speak of a friend as "enjoying ill-health." From his sympathetic tone it was clear that he was using the expression in its figurative sense and that he was ignorant of its true and literal meaning. This humourless view seems to be general among sociologists. The writers of

PEP say: "Many of the costs of ill-health cannot be measured in money. The subjective element in the endurance of pain and sickness cannot be estimated. It is impossible to say what contribution might in happier circumstances be made to the community by that regrettably large body of persons who 'enjoy indifferent health,' whose energy is all absorbed in struggling through the daily round."

An associated idea is that health is an end in itself. Health, however, is not an end but a means to an end, the end being the full life, though it does not follow that the full life which results is necessarily the good life. Good health is, I imagine, as essential to a burglar as it is to a bishop. But if health is a means to an end there must be an end worth having. At the present stage of civilization the best way to diminish the vast amount of imagined ill-health is the removal of sources of frustration and the encouragement of initiative, independence, and self-respect.

The Standard of Living

National prosperity, it is believed, is necessarily increased by the advancement of medicine. The truth is that it is both increased and diminished. It is increased by treatment which secures without disproportionate expense complete recovery in the young and middle-aged; it is diminished by measures which promote the survival of the unfit without making them fit and by those which merely prolong invalidism at a level incompatible with functional efficiency. The question is, which of these two actions predominates? I believe it depends upon the stage of development to which medicine and civilization have attained. At lower stages the effect is a pure enrichment of society, but, as civilization advances, the opposite factor exerts an increasing back-lash until at a certain point national prosperity is threatened. I do not say that we have reached this point, but we are certainly moving towards it. We are cured of the simpler and cheaper diseases to fall victim later on to the more complex and more expensive. This is the price which society pays for lengthening the expectation of life.

It is hoped that as the Health Service improves the need for it will diminish, and that this factor should lower the cost (Beveridge Report, p. 104). This is another way of saying that disease still threatens security because treatment is inadequate. Study of the past gives no grounds for this belief. The phenomenal development of hospital practice has, as I have shown (Roberts, 1948), involved an increase in cost per patient far exceeding the rise in the cost of living, a fact which disproves the contention that the increase is due to the more widespread dissemination of existing facilities. The determining factor is the increasing application of science, which, if given free play, will without any doubt always outrun provision. In 1860 England and Wales, with a population of 20,000,000, had just under 11,000 doctors, practically all of whom were general practitioners. Their average income was certainly not more than £500. The total amount spent by patients was thus £5,500,000, including the cost of drugs. To-day the general practitioner service is costing more than £40 million excluding the cost of drugs and administration. In 1860 hospitals, except in large cities, were small and cheaply run, and in country towns almost non-existent. Workhouse infirmaries administered only the barest medical necessities. The country's total medical bill must have been well under £10 million.

It can indeed be laid down as a law, that in a free economy the cost of medical treatment rises with the standard of living. This is because medicine is more successful in treatment than in cure; because medicine is

partly a luxury and its cost therefore rises with the amount spent on other luxuries, as Dickinson (1947) has shown, because those engaged in medicine are themselves part of society and share its fortunes; and because medical progress and a rise in the standard of living are both due to the same cause—the advancement of science. Science, which gave us radium and penicillin also gave us television, and the electric washer. It follows that in a free economy if the standard of living were to fall the cost of medical treatment would fall with it. In a planned economy there is no knowing what would happen; it would all depend on the planners. Certain it is that if an attempt were made to maintain or increase the cost of medical treatment the fall in the standard of living would be catastrophically accelerated.

Let us here note one very significant fact. Just at the moment when the provision of individual economic security is accomplished comes the realization of the precariousness of our national economic security. This is reflected in (among other ways) the change of emphasis in appeals for voluntary support. It being no longer necessary to shock us into generosity with pictures of disease and consequent poverty or of poverty and consequent disease, our feelings are harrowed by statistics showing how disease impedes national recovery. The Empire Rheumatism Council, for instance (*The Times*, Nov. 3, 1948), tells us that 3,000,000 weeks of work are lost each year by the insured population through rheumatic disease. The meaning of this should be clear to all. It is that from the struggle for existence there is no escape. Nature sees to that. Legislation can remove it from the individual but only by transferring it to the State.

The Moral Implications

"It is a logical corollary to the receipt of high benefits in disability that the individual should recognize the duty, to be well and to co-operate in all steps which may lead to diagnosis of disease in early stages when it can be prevented" (Beveridge Report, p. 158). This obligation, which incidentally can be read as a direct encouragement to abuse the Service, means more than refraining from malingering, a subject on which writers on industrial medicine are eloquent. It means that citizens will arm themselves with the moral shield and buckler against disease; that they will conquer the lusts of the flesh; that they will suffer neither, their bones to be broken in drunken brawls nor their livers to become cirrhotic by chronic addiction; that they will not use their disabilities to tyrannize over their fellow-men; that they will always allow themselves to be made efficient members of society by surgical operation rather than remain permanent charges on the community by their refusal; and that they will think twice and even three and four times before sending for the doctor. The stability of the Health Service in fact requires a tremendous moral uplift like of which mankind has never seen, an uplift, which even ministerial supplications will be powerless to achieve. Failing this happy transformation of human nature the true logical corollary is the application to our weaker brethren, and perhaps to us all, of measures which, to put it mildly, will be anything but pleasant.

Medicine Considered as a Commodity

Sociologists maintain that medical treatment is above economic considerations. The Beveridge Report (p. 162) says that full prevention and curative treatment must be available "without an economic barrier at any point." According to Levy (1944), "economy in medical treatment contradicts the very foundation of medical science." This, however, is true only in regard to treatment which results in partial or complete restoration of functional efficiency;

its application to complaints which do not impair functional efficiency and to diseases which are incurable and which cause total and permanent incapacity is a different matter. It will clarify our minds if we consider the differences and resemblances between medicine and other commodities—food, clothing, housing, and fuel. The chief differences are these: First, the direct cost of medical treatment is an addition to normal requirements. Secondly, allowing for individual variation in the conception of what is essential and what is extravagant, and for the fact that the luxuries of to-day become the necessities of to-morrow, the minimum requirements of other commodities can be at least roughly assessed. We know the amount of clothing, fuel, and food needed to keep us warm, dry, and well nourished. In contrast, the need and value even of the essentials of medicine are usually impossible to assess.

Thirdly, we know the cost of food and clothing; we can find out exactly the cost of repairing a house or a coat and we have a reasonable guarantee that the repair will be successful. In medicine we have no such assurance. The cost cannot be estimated nor can a cure be guaranteed. When an article reaches obsolescence we can decide whether to repair it or buy another; with our bodies we have no option, and the chances that repair will be successful diminish with the years. Fourthly, though fancy articles command fancy prices, the cost of food, fuel, and clothing is in normal times subject to little fluctuation, since it depends on the cost of labour and raw materials and is regulated by the law of supply and demand. Medicine, however, contains within itself the means of its own expansion—namely, the expansion of science on which it is based—an expansion beyond the control of market conditions and of which the only certainty is that it will continue indefinitely.

The resemblances, if less obvious, are no less real. Medicine, like other commodities, consists of a core of essentials surrounded by inessentials extending to luxury and extravagance. Illness makes many people less able to pay the cost of treating it, but it also makes them less able to pay for rent, food, and clothing. The means of providing all these commodities, including medicine, comes from the same sources—personal and national wealth.

The consequences of failing to understand these differences and of ignoring the resemblances are plain for all to see. At a time when food and clothing are rationed, when the housing shortage causes immense difficulties, and when the coal shortage constitutes the gravest threat to our standard of living, medical treatment is provided in abundance with no regard to economy. In unemployment pay, old-age pensions, and the death gratuity, where costs can be readily determined, the benefits are based on the minimum needed to keep our bodies in reasonable comfort and in due course to bury them with reasonable decorum. Moreover, for entrants of advancing years there is a minimum period of contribution before full benefits can be obtained, so that many people have to be helped by National Assistance. But in regard to sickness, the cost of which cannot be ascertained with anything approaching accuracy and of which the only certainty is that it will increase with accelerating speed, the State has underwritten an unlimited liability.

Conclusions

I believe that through ignorance and miscalculation in its preparation the cost of the Health Service has been grossly underestimated, that when in full operation it will be not less than £500 million, and that in future years it will rise to an even higher figure. Whatever the exact figure, I am firmly convinced that at the present rate of expenditure it will involve us in national ruin. The

alternative is hardly less comforting. It is that a limit will be set by shortage of personnel and materials. This means (mark it well!) that medicine will be rationed and controlled, and there is no reason for supposing that nationalized medicine possesses any moral superiority rendering it immune from the vices which rationing and control invariably bring in their train.

There have been occasions when nations have been decimated by disease. They have often recovered, but changed in social structure. The Black Death, for instance, by creating a shortage of labour destroyed the feudal system. In the twentieth century civilization is faced with a threat unique in its history, the existence of more ill-health than it can afford, due not to any temporary calamity but paradoxically to the advance of civilization itself. Society has opened a new Pandora's box, releasing new diseases of its own creation and with them innumerable new methods of treating all the diseases which it cannot cure.

The stupendous problem thus created calls for the exercise of the highest intelligence. Our duty as a profession is clear. We must teach our students and the lay public that the fight against disease is part of the struggle for existence; that medicine is not above economic law but strictly subject to it; that the claims of health, so far from being absolute, are relative to national well-being; that the country will get not the finest Health Service in the world but the Health Service which it deserves. We must not allow absorption in the daily round to prevent us from counteracting the hysterical clap-trap of demagogues, the impracticable visions of idealists, or the false premises of academic theorists. We must proclaim the faith that is in us, the faith inspired not by the Blue Books but by the bedside, not by Sidney Webb but by Hippocrates, not by the London School of Economics but by the Island of Cos.

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The Poisons Board has made certain recommendations to the Secretary of State for the further amendment of the Poisons List and of the Rules made under Section 23 of the Pharmacy and Poisons Act. He therefore proposes to make Statutory Instruments which will effect the following changes in the law relating to poisons: 6-morpholino-4: 4-diphenylheptane-3-one and its salts will be added to Part I of the Poisons List. Dinitrocresols will be taken out of Part I and added to Part II of the Poisons List. Bis-bis-dimethyl-aminophosphonous anhydride, diethyl-paranitrophenyl thiophosphate, hexaethyl tetrophosphate and tetraethyl pyrophosphate will be added to Part II of the Poisons List. 6-morpholino-4: 4-diphenylheptane-3-one will be included in the First and Fourth Schedules to the Poisons Rules. Dinitrocresols will be exempt from the restrictions which apply to First and Fourth Schedule poisons when sold in the form of agricultural and horticultural insecticides or fungicides. Such preparations will be excluded from the general exemption from control of all substances containing dinitrocresols and not being preparations for treatment of human ailments; they will be the only preparations containing dinitrocresols and subject to the control of the poisons law which may be sold by listed sellers of poisons. The four phosphorous compounds named will be exempted from control when sold in any form other than agricultural or horticultural insecticides or fungicides. These preparations, and the similar preparations containing dinitrocresols, will be subject only to the restrictions imposed by their being included in Part II of the Poisons List and in the Seventh Schedule to the Poisons Rules. The form of words with which they are to be labelled will draw attention to the danger of using the preparation in an enclosed place and of allowing it to come into contact with the skin. Rule 30 will be extended to include insulin in the list of poisons which may be manufactured under the supervision of a duly qualified medical practitioner.