

MUNICIPAL  
HEALTH  
SERVICES

by

Norman Wilson



THE NEW  
TOWN AND COUNTY HALL SERIES

Among the most important of the functions of local authorities are those which are concerned with the prevention of disease and the improvement of health. The foundations of a sanitary environment were laid in the latter part of the last century. During the present century attention has been increasingly directed to the individual, and an ever-widening range of services has been made available to him. Many of these services are provided and administered by local authorities, and hence to a considerable degree are under local control. A great deal of public health legislation is permissive. This is reflected in remarkable variations in the extent and efficiency of services as between some local authorities and others, which our informed public interest could do much to reduce.

*Municipal Health Services* gives an account of the powers in regard to the personal health services which are possessed by local authorities; describes the manner in which these powers are exercised; and deals with principles and methods of administration and organisation. Since the range of the health services depends upon the type of local authority entrusted with them, it is with those provided by the county borough, which has the widest power, that the book is more particularly concerned.

*THE NEW  
TOWN AND COUNTY HALL SERIES*

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No. 3

**MUNICIPAL  
HEALTH SERVICES**

**GENERAL EDITOR**

**J. H. WARREN**

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**No 1. THE ENGLISH LOCAL GOVERNMENT SYSTEM**

**by J. H. WARREN**

**No 2. A HISTORY OF LOCAL GOVERNMENT**

**by K. B. SMELLIE**

# MUNICIPAL HEALTH SERVICES.

by

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## FOREWORD

THOUGH the word municipal may perhaps more properly relate to boroughs only, it has been used for convenience to denote Local Authorities generally.

The Government's proposals for a national health service had not been made public at the time the book was going through the press.

N.W.

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## CHAPTER I

### *Introduction*

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MANY of the services for which Local Authorities are responsible promote or tend to promote the health of their citizens. They include the provision of houses, open spaces, playing fields and swimming baths as well as the inspection of food, water and drugs, the disposal of sewage and refuse, hospitals, clinics and various forms of medical care. It is not the aim of this book to deal with all of these services, though they are of great importance for physical well-being, but with those whose only function is the prevention or cure of ill-health. Of these, services concerned with the establishment and maintenance of a sanitary environment will not be considered, essential though they are. It is the various forms of provision made specifically for the individual member of the community rather than for the community as such which will be described and discussed. These are what are usually termed the personal health services, which have been and still are in a constant state of extension and development. It is certain that this process will continue.

The deplorably insanitary conditions of rapidly-growing industrial towns towards the end of the eighteenth century prompted various groups of public-spirited citizens to urge Parliament to pass regulative legislation. Their appeals were powerfully reinforced by an invasion of cholera from the continent in 1831, which was responsible for the creation as an emergency measure of a Consultative Board of Health under the Privy Council, empowered to issue regulations designed to limit the spread of the disease.

Epidemic diseases were the subject of much concern to the Boards of Guardians, since they had to give medical relief and relief to persons made destitute as a result of illness. Edwin Chadwick, one of the Poor Law Commissioners, was especially impressed by the close connection between disease and pauperism and became convinced that by reducing the one the other would also be diminished. As a consequence of investigations carried out on behalf of the Commissioners in the Metropolitan area, Parliament instructed the Commissioners to carry out a large-scale inquiry into environmental conditions throughout the country. The result was embodied in the famous Report on the Sanitary Conditions of the Labouring Population of Great Britain, published in 1842. The Report declared that the widespread prevalence of disease was due to the grossly insanitary conditions in which the working classes lived, and made it obvious therefore that in the development of measures to protect the public health the first need was environmental improvement. The reports of the Royal Commission appointed in 1842 to inquire into the state of large towns and populous districts led to the passing of the Public Health Act 1848. This Act created a General Board of Health: local Boards could be or in certain circumstances had to be established. The Nuisances Removal and Diseases Prevention Act of the same year gave powers for the summary abatement of nuisances (e.g. uncollected piles of household refuse) prejudicial to health. The powers given to the Privy Council to operate special measures during dangerous epidemics had to be exercised during the cholera outbreaks of 1848 and 1853.

Due partly to the hostility of vested interests and partly to a general dislike of any form of central control the General Board of Health was abolished in 1858, and its functions handed over to the Privy Council. A fourth outbreak of cholera in 1866 was largely instrumental in

the appointment of the Royal Sanitary Commission in 1869 to inquire into the administration of the sanitary laws. Its Report recommended the creation of a strong central body. This recommendation was ignored, the public health functions of the Privy Council being handed over to the Poor Law Board, renamed the Local Government Board, but not reorganized and with no expert staff. Two Acts of great importance resulted, however. By the Public Health Act 1872, municipal boroughs were made urban sanitary authorities and rural Boards of Guardians rural sanitary authorities: each authority had to appoint a Medical Officer of Health. The Public Health Act 1875 included comprehensive provisions for improved environment, which remains to-day as the basis of our sanitary system.

The latter part of the century was notable for the development of measures for the direct control of infectious disease. In London the Metropolitan Poor Law Act 1867 grouped unions and parishes into sick asylum districts in which separate hospital accommodation was provided for the infectious and non-infectious sick. These hospitals later came under the control of the Metropolitan Asylums Board, which went out of being when its functions were transferred to the London County Council under the Local Government Act 1929. Outside London powers to build infectious diseases hospitals under the Public Health Act 1875 were conferred upon the urban and rural sanitary authorities.

The close association of the developing public health service with the poor law began to weaken towards the end of the last century; but the tie is still unbroken, since public assistance authorities are responsible for medical care of the destitute sick if provision cannot be made by way of legislation other than the Poor Law Act 1930.

During the nineteenth century the reform of public

health was, therefore, mainly in connection with the creation of a sanitary environment and the control of infectious disease by the isolation of patients in specially-provided hospitals. Several factors have conspired in the twentieth century to direct the State's activities towards the care of the health of the individual. Increasing medical knowledge is one of them; the spread of new social and political ideas is another; a more enlightened self-interest on the part of the better favoured economic classes is not of least importance. It has become more and more recognized that while the absence of insanitary conditions is the first requirement if good health is to be achieved, positive measures to provide safeguards for and assistance to the individual who cannot obtain them out of his own resources must be introduced as well, since ill-health springs also from causes other than environmental. In part this recognition follows from a philanthropic belief that society has responsibilities to its less fortunate members. In part it is based upon a growing conviction that it is more effective and more economical to provide essential services upon a collective than on an individualistic basis.

Voluntary effort has played an important part in the development of the personal health services, just as it had done over a century ago in the campaign for improved sanitation. Thus it was from the various charitable institutions founded in Edinburgh in the eighteenth and nineteenth centuries for providing treatment for the sick poor that there sprang the first tuberculosis dispensary, the inspiration of Dr. (later Sir Robert) Philip. The National Association for the Prevention of Consumption was formed in London in 1898 to make widely known the infectious character of the disease and to spread information about its nature and treatment. In 1904 delegates from the Association and the Hospital Saturday Fund established a national committee to provide sanatoria for workers suffering from tuberculosis.

Similarly, it was the Midwives' Institute, founded in 1881, which played a large part in the movement for the state registration of midwives, and which promoted the first Bill for this purpose in 1890. Health visiting was originally begun in an organized manner by the Ladies' Sanitary Reform Association of Manchester and Salford in 1862. The work was at first carried out by voluntary workers, but it was soon found necessary to employ salaried staff: in the 1890s they were placed under the direction of the Medical Officers of Health and the salaries of some of the visitors were paid by the Local Authorities. The activities of the Association included weekly meetings of mothers for instruction on personal hygiene and infant management, which were the forerunners of the "Schools for Mothers" later organized on a growing scale by other voluntary organizations. The need for home visiting as well as sick nursing in the home strongly commended itself to Florence Nightingale. The National Society of Day Nurseries, established in 1906, was largely instrumental in the inclusion of day nurseries among the agencies concerned with maternity and child welfare for which grants were made available to Local Authorities and voluntary bodies by the Local Government Board in 1914. The pioneer work of Margaret and Rachel McMillan in connection with nursery schools is well known.

These movements in their turn generally came into being as a result of the contributions to medical knowledge of doctors and other scientific workers, who demonstrated by practical application the value of their views and enlisted the support of public-spirited people to spread knowledge of them over a wider field. Men like Dr. Philip in connection with the treatment of tuberculosis and Dr. J. W. Ballantyne in connection with antenatal care are two of the many whose professional skill and humanitarian zeal influenced greatly the origin and development of the

personal health services. The work of members of the medical profession and of voluntary organizations must, therefore, be kept in mind as the background to the brief account which follows of the beginnings and growth of these services as publicly-provided services.

The Midwives Act 1902 was the first legislative attempt to minimize the risks of child-bearing. It required that after a period all entrants into midwifery should be trained and certified. Subsequent Acts have had the effect of making it impossible for a woman during pregnancy or confinement to be without the services of a midwife because of poverty or any other reason, or to be without medical care if this is necessary.

Before the passing of specific legislation in 1915 a number of Local Authorities had established maternity and child welfare centres towards the cost of which the Government made grants, and those which had adopted the Notification of Births Act 1907 had instituted a system of health visiting. The Notification of Births (Extension) Act 1915 not only made notification universally compulsory: it gave powers to Local Authorities to provide maternity and child welfare services, and made grants available for certain items. The high rate of rejection on medical grounds of men examined for military service had impressed upon thoughtful members of the public the need to take more steps to protect child health. The Maternity and Child Welfare Act 1918 extended the powers to include young children up to the age of five who were not in attendance at school, and required Local Authorities to appoint a Maternity and Child Welfare Committee. Local Authorities were prohibited from authorizing a general domiciliary service by medical practitioners. The provisions of the 1918 Act are embodied in the Public Health Act 1936.

Public concern over the condition of the nation's

physique at the beginning of the century (partly exposed, as it was during the 1914-18 war, by the recruiting office) led to the appointment in 1902 of a Royal Commission to consider physical training in Scotland and an Inter-Departmental Committee to investigate the physical conditions of certain classes of the population in England. As a result of these inquiries a Departmental Committee of the Board of Education was set up to consider the provision of medical inspection of school children and of meals. Its report was published in 1906. Parliament acted quickly. In the same year the Education (Provision of Meals) Act was passed, which empowered Local Education Authorities to provide meals free of charge in the case of children who by reason of lack of food were unable to derive benefit from their education. Expenditure was not to exceed an amount equal to a rate of  $\frac{1}{2}$ d. in the £; this limit was dispensed with by an amending Act in 1914.

Certain forms of medical treatment for school children had been possible under various Acts (e.g. Public Health Act 1875). The Education (Administrative Provisions) Act 1907 enabled Local Education Authorities to make arrangements, with the approval of the Board of Education, to attend to the health and physical education of children in elementary schools. In addition, they were required to carry out a medical examination of all entrants to these schools and at such other times as the Board might require. A medical department of the Board was set up to supervise the work of inspection and treatment. The Education Act 1918 extended these powers and duties to embrace children attending secondary schools. The 1944 Act requires Local Education Authorities to provide all necessary medical treatment free of cost, and milk and meals for all pupils in schools and county colleges maintained by them.

The first effective step in the attack upon tuberculosis

was taken when poor law medical staff were required by Regulations issued in 1908 to notify cases of pulmonary tuberculosis to the Local Authority. By 1912 all cases of tuberculosis of all kinds were made notifiable. The National Insurance Act of 1911 created sanatorium benefit for insured persons and gave powers to Insurance Committees to extend this benefit to dependants. In 1913 the Public Health (Prevention and Treatment of Disease) Act regularized the rather doubtful legal powers of Local Authorities in regard to the treatment of tuberculosis, and made it lawful for the county council or any sanitary authority to make arrangements to provide treatment subject to the sanction of the Local Government Board. The dual responsibility of Insurance Committees and Local Authorities in regard to sanatoria was ended by the Public Health (Tuberculosis) Act 1921, which relieved Insurance Committees of their powers and made county and county borough councils the only authorities for sanatorium and other treatment and authorized them to make arrangements for after-care. The Public Health Act 1936 repealed and re-enacted most of the legislation dealing with tuberculosis.

For a considerable time before the creation of Boards of Guardians by the Poor Law Act 1834 parishes had established the practice of giving medical relief to the destitute, although no specific provisions authorized them to do so. The Poor Law Commissioners in 1837 instructed the Guardians to make arrangements for the administration of medical relief in their districts and to appoint medical officers for this purpose. It was not, however, until 1867 that an institutional service especially for the sick poor was begun. This took the form of infirmaries maintained separately from workhouses or of sick wards in or attached to workhouses. As institutional care was provided under the poor law it was only available to the destitute; but the definition of destitution was gradually



broadened. During this century it was accepted that a person, though able to procure food and shelter out of his own resources, might be destitute in the sense that he was unable to secure for himself or his family essential medical attendance or treatment. As a consequence hospital accommodation became more and more widely available. In 1930 approximately 130,000 beds under the control of the Boards of Guardians were transferred to county and county borough councils.

Together with an increase in accommodation went an improvement in hospital conditions, particularly in regard to nursing. The ceaseless energies of Florence Nightingale had led to the introduction of training for nurses in the voluntary hospitals, and a consequent increase in efficiency; but it was only in 1864 that qualified nurses were first appointed to a poor law infirmary (the Brownlow Hill Institution in Liverpool). Nevertheless, it was not until thirty years later that by order of the Local Government Board the employment of pauper inmates as nurses was prohibited.

The first legislative attempt to control venereal diseases was the Contagious Diseases Act 1864, whose operation applied only to naval and military stations. As a result of widespread opposition, with which the name of Josephine Butler is prominently associated, this and a succeeding Act were repealed in 1886. No further steps were taken officially until growing apprehension about the prevalence of venereal diseases led to the appointment of a Royal Commission in 1913, whose terms of reference included the submission of methods by which the diseases could be alleviated and prevented. The recommendations of its Report, published in 1916, led to the issue of the Public Health (Venereal Diseases) Regulations in the same year. County and county borough councils were directed to provide facilities for the diagnosis and treatment of the

diseases. In the following year the Venereal Diseases Act prohibited treatment by unqualified persons and advertisements of preparations purporting to treat any form of venereal diseases. Local Authorities' treatment centres were first opened in 1917: in a few years these numbered nearly two hundred, attendances exceeding three millions.

The public health services sprang from the realization that avoidable illnesses caused a high incidence of destitution and thus imposed a heavy burden of expenditure for poor relief. Attempts to reduce this burden by regulative legislation and by the provision of gratuitous medical care for the sick poor, therefore, commended themselves to an age which on principle believed that as far as possible every man should be free to pursue what he thought to be his own interest and that no man should have provided for him what otherwise he would strive to provide for himself. In this sense, therefore, the public health services were preventive from their inception, even though prevention of illness was regarded almost wholly as a means of curtailing the amount of money raised by way of the poor rate. Throughout the latter half of the last century, legislation was designed to prevent illness by removing the insanitary conditions in which it was propagated, by insisting upon minimum standards in the building of houses, and by isolating cases of infectious disease in hospitals. Although the services which provide for the needs of the individual necessarily have to concern themselves with the alleviation and cure of illness, they are nevertheless essentially preventive in character. The notification of a case of tuberculosis makes it possible to apply treatment in the earlier stages when arrest or cure may be possible. It also allows for the examination of contacts, who may be advised about precautionary measures; while the observance of the rules of hygiene on the part of the sufferer, or his removal to a sanatorium, limit the danger of infection to those in close

association with him. Maternity and child welfare clinics are primarily centres for medical supervision and for instruction in the art of keeping well, and for the early detection of conditions which if neglected may cause serious trouble. Free or cheap milk is supplied to mothers and children for the purpose of preserving bodily fitness and so adding to the power of resistance to disease. Routine medical inspection of school children affords excellent opportunity for the education of parents in the maintenance of their children's health, and, as in the case of the maternity and child welfare clinic, enables incipient disabilities to be discovered and appropriate treatment to be provided. Prompt treatment of dental defects may prevent the later development of conditions which will cause loss of physical efficiency and productive capacity. Immunization against diphtheria and miniature mass radiography are only the latest, though perhaps more immediately obvious, manifestations of the bias towards prevention rather than cure as the aim of the public health services. It is to be expected that further extensions will be in the direction of providing the periodical medical examination which is now available only for sections of the population.

It is not possible to assess with any approach to accuracy the consequences of a hundred years of public health legislation in terms of reduced mortality or improvement in health. Certain diseases, like cholera and typhus, have been virtually eliminated as a result of better sanitary environment. The death rate from other diseases, with one or two notable exceptions, has steadily declined. Infant mortality has been cut by two-thirds in the last seventy years, a remarkable saving of young life. A similar reduction in the number of deaths from tuberculosis has been recorded in the same period. As a consequence of the fall in mortality rates, the expectation of life at birth

has gone up by many years since the beginning of the century. There are far fewer positive means by which improvements in standards of health may be measured; yet all evidence suggests that the average citizen of to-day is in all respects much better equipped physically as well as less subject to early death than his forbears were when the first Public Health Act was passed nearly a hundred years ago. A comparison of the average height and weight of school children over a period of years, for instance, shows appreciable increases in both respects. The public health services can claim a considerable share in these achievements; yet it would be wrong not to recognize the contribution made by other factors. Better housing, higher standards of living and the spread of education have played an important part, and in future they will undoubtedly play a still more important part. In the field of health education, certainly, much more requires to be done both by the Ministry of Health and Local Authorities. The continuous education carried out in clinics and at school medical inspection is of great value; but education through the medium of lectures, film shows, exhibitions, leaflets and posters should be materially extended. It is also important that greater provision should be made in school curricula for the teaching of physiology and personal hygiene. It is the responsibility of the community to provide the conditions which make good health possible of achievement, and so to order its affairs as to give to each of its members the ability to secure an adequate diet, sufficient clothing and decent living accommodation. The closer society approaches to this not unattainable ideal, the less important relatively becomes the whole apparatus of preventive and curative medicine.

**PART ONE**  
**THE SERVICES DESCRIBED**

## CHAPTER II

### *The Welfare of Mothers and Young Children*

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BEFORE 1902 any woman, with or without training or knowledge, could engage in midwifery as a means of earning a livelihood. The Midwives Act of that year was the first legislative expression of concern for the welfare of the mother and of the child before and immediately after birth. It created the Central Midwives Board to be responsible for the general practice of midwifery, to examine prospective midwives, to issue certificates to successful candidates and to frame rules for the conduct of midwives. After 1905 no woman could enter the profession unless she were certified and registered. The Act went a long way towards raising the standard of midwifery; but a number of obstacles stood between many mothers and their need for all necessary medical care before, during and after their confinement. These have mostly been removed by succeeding Acts (in 1918, 1926 and 1936), although the discretionary powers in some respects given to Local Authorities have produced the same disparities in regard to midwifery as are to be found in other health services.

The Local Authorities responsible for the supervision of midwives are the county and county borough councils and certain county district councils. Those district councils which maintain their own maternity and child welfare scheme and employ a whole-time Medical Officer of Health may apply to the Minister of Health to have this function delegated to them (Local Government Act 1929). The Minister must consult the County Council concerned;

and has power to revoke any order for transfer which has been made (certain county district councils to whom the function of supervision was delegated under the Midwives Act 1902 continue to exercise it). Shortly before the War forty-four district councils were supervising authorities: thus, apart from county and county borough councils, only a small proportion of welfare authorities have responsibility for midwifery.

All midwives who intend to practise must notify their supervising authority (or authorities, if they practise in the area of more than one) at the time of beginning such practice and in January in each year thereafter; or, if they are not normally practising, must report every occasion when they have acted. By means of these notices the Medical Officer of Health is enabled to compile a register of all midwives practising in his area. The register can be employed to keep a record in respect of each midwife of the number of her cases, the times she acted as a maternity nurse, the occasions on which she sent for medical help and other relevant information.

By her rules she must inform the Medical Officer (on forms with which she is supplied) when she calls in a doctor to a patient and for what reason; of a still-birth or of a death, no doctor being in attendance; of having laid out a dead body; of liability to be a source of infection; and of the substitution of artificial for breast feeding. In the case of an independent midwife (i.e. not employed by the Local Authority) suffering from or having been in contact with a person suffering from an infectious disease she may (there is no legal requirement) be compensated by the Local Authority for loss of income during the period when she is suspended from practice.

Supervision of the midwife (whether she be in independent practice or employed by a Local Authority or a voluntary body) is carried out in her own home and at the

home of her patients during the conduct of a case. Her written record of her attendance upon her patients and her bag and instruments may be inspected. Serious dereliction of duty may be reported to the Central Midwives Board, which has power to remove from the Roll and so prohibit continuance of practice. The actual work of supervision is undertaken by an officer or officers of the Local Authority. By regulations made by the Ministry of Health under the Midwives Act 1936, new appointments of medical and non-medical supervisors must (since June 1st, 1937) be of persons with recent and special practical experience of midwifery.

The Midwives Act 1936 made supervising authorities responsible for there being an adequate salaried midwifery service in their areas, either (where this was not the case) by employing their own staff or by entering into arrangements with such bodies as District Nursing Associations to make up any deficiency. In consequence most urban supervising authorities employ a salaried staff, while counties make payment of some kind to voluntary bodies for the services they provide. Midwives, therefore, may be either independent practitioners making a living by charging fees, or those paid directly or indirectly out of public funds, and enjoying usually much better financial and other conditions. These are now in accordance with the Rushcliffe scales, and are calculated to make the profession much more attractive to the woman who has had nursing as well as midwifery training. For the nurse on the general register, the period of midwifery training was raised shortly before the war from six months to a year and for the lay woman from eighteen months to two years.

The supervising authority is required by the Midwives Act 1936 (under rules made by the Central Midwives Board) to arrange for each practising midwife to attend a residential refresher course of four weeks at the expense of



the authority at least once every seven years. Similarly, midwives employed as supervisors must attend at intervals of not less than five years.

Where the Minister has made an order to that effect, no person in the supervising authority's area who is neither a certified midwife nor on the general register of nurses may act as a maternity nurse (i.e. under the direction of a doctor) for gain. Such an Order may be made when the Minister is satisfied that an adequate midwifery service exists. In 1939 Orders were in operation in 88 areas.

Since salaried midwives are entitled to regular off-duty time, steps have to be taken to ensure that on such occasions a patient is not unable to secure a midwife's services. Arrangements must therefore be made so that when the midwife with whom a patient is booked is not available, access to a colleague is obtained without delay. This can be secured by the operation of a rota system. It is necessary also, to avoid some midwives having materially more cases than others, for a system of booking to be arranged, giving to the patient as far as is practicable the right to the midwife of her choice.

Before the establishment of a salaried midwifery service, supervising authorities were empowered to pay, in whole or in part, the fees of midwives for their attendance upon financially necessitous mothers. The Midwives Act 1936 enables authorities to remit all or part of the fees in similar circumstances. In the case of the independent midwife, she applies in advance for her fee to be paid. The financial position of the patient can then be investigated and a statement of income submitted to the appropriate committee, which can recommend or (where the power has been delegated by the council) authorize payment. It is usual for an income scale to be applied. A similar procedure is adopted for the remission of the normal fee

where a salaried midwife has been engaged. Practice varies between Local Authorities when a patient whose income is below the scale prescribed receives maternity benefit. When Local Authorities take the view that the benefit is the property of the wife, it is disregarded in the computation of means; others, however, expect all or part of it to be paid over.

A midwife, as stated, must in certain circumstances summon medical aid to her patient. The Midwives Act 1918 enacted that the fee of a doctor so summoned must be paid (according to a schedule of charges laid down by the Minister) by the Local Authority, without prejudice to its right to recover wholly or in part from the patient. It is convenient for doctors to be provided with forms specifying the particulars of their attendance for submission as an account for their services. The ability of the patient to refund the fee is determined, as in the case of the midwife's fee, by the application of an income scale.

Experience has shown that it is not always wise to accept an unsupported statement of income by the applicant. Though the procedure may cause considerable clerical work it is well to ask verification from the husband's employer or from the Assistance Board or the Public Assistance Authority, as the case may be. It is not necessary where the husband is drawing unemployment insurance benefit since this amount is fixed and known.

Some Local Authorities make provision for the general practitioner summoned by a midwife to be able, in his turn, to call in a specialist, whose fee (at an agreed rate) is paid by the Local Authority.

Apart from the measures taken to secure improved midwifery, Parliament has given wide powers to Local Authorities to make provision in other ways for the welfare of mothers and young children. These are now contained in Section 204 of the Public Health Act 1936. The extent

to which the powers are used differs very greatly, partly because of varying needs and partly because some Local Authorities are more energetic than others in their use of them. It is only possible, therefore, to present a general picture of maternity and child welfare services, very few of which are made available by all Local Authorities concerned with them.

Antenatal care is provided not only by the midwife but also at antenatal clinics. Midwives are expected to encourage their patients to attend these clinics, whose main function is to keep watch over the normal woman's pregnancy and to advise upon her manner of life during this period. Treatment may be provided for minor ailments; but more serious conditions are referred for treatment elsewhere. The doctor in charge may be a full-time Assistant Medical Officer, with other duties to perform (e.g., school medical inspection); or a part-time general practitioner, paid an annual salary or (more generally) so much per session. In rural areas, where attendance at a clinic might involve considerable travel for patients, the county council may arrange to pay general practitioners to make periodical visits to expectant mothers in their homes.

Arrangements may be made through the clinic for women to be "followed up" by the health visiting staff, especially where they are negligent in their attendance or where other forms of help may be required.

Women suffering from abnormal conditions are referred from the clinic to their own doctor, or to hospital, or to a consultative clinic. The latter may be staffed by a specialist or may be held in co-operation with a maternity hospital in the vicinity. Treatment of abnormalities may be provided either at the Local Authority's hospital or by arrangement at a voluntary hospital; in the latter case payment in some form or other is made to the hospital by the Local Authority.

The Report on an Investigation into Maternal Mortality (1937) emphasized strongly the need for close co-operation between the antenatal clinic and all persons in whose care a woman may be during her pregnancy and confinement. Such co-operation may be materially achieved if the medical staff at the clinics are also on the staff of maternity hospitals or general hospitals which have maternity blocks, though such an arrangement frequently may not be practicable.

The power given to Local Authorities to provide extra nourishment to necessitous expectant mothers still remains with them, although the National Milk Scheme of the Ministry of Food in fact meets the needs of the vast majority of women. Nevertheless, the Local Authority may grant (subject to a means test) a further supply if this is considered to be necessary. It may also provide meals, though there are very few cases indeed where this is done.

The National Milk Scheme provides for the supply of one pint of milk a day to expectant mothers during the last months of pregnancy, to nursing mothers and to children up to the time of going to school (except when they are breast fed). The milk costs 2d. a pint, or nothing when the income is below 40/- in the case of man and wife, with an extra 6/- for each dependant child, or when the head of the household is in receipt of poor relief, an allowance from the Assistance Board or a supplementary old age pension. Forms of application are obtainable at local food offices. On these the number and age of children must be stated and (where milk is applied for without cost) particulars of income. Forms have to be endorsed by a responsible person, and the condition of an expectant mother has to be certified by a doctor, midwife or health visitor. When an application has been approved by the milk officer, a permit is issued which entitles the applicant to have the milk delivered by the retailer of the applicant's choice.

If a doctor certifies in the case of a child under one year that dried instead of liquid milk is required, one pound of dried milk at equivalent cost is supplied.

Dental care may form part of the services available for the expectant mother. This may be undertaken by the school dental staff or by arrangement with a hospital. Shortage of dentists, however, has hitherto greatly restricted this important type of treatment.

Residence in a convalescent home (either before or after confinement) is very beneficial in the case of overtired women living in poor circumstances, but little in fact has been done to make this possible.

For the expectant mother who is ill (not necessarily arising out of her pregnancy) the services of a nurse in the home may be provided. Very few Local Authorities maintain their own staff for this purpose; most make arrangements (where any such scheme is in operation) with District Nursing Associations, and pay either an annual sum or a sum for each visit. Similar provision may be made for the nursing of cases of puerperal fever and puerperal pyrexia, and of children under the age of five suffering from various illnesses.

Welfare authorities are empowered to provide maternity homes and hospitals and to admit women free or at reduced cost where economic circumstances make this course necessary. Maternity accommodation is also provided in the poor law hospitals transferred to county and county borough councils by the Local Government Act 1929. Voluntary maternity hospitals and general hospitals with maternity wards may be subsidized by Local Authorities. There is a growing demand on the part of women for hospital confinement, though the Scottish Departmental Committee on Puerperal Mortality and Morbidity (1924) was of opinion that except for abnormal cases and for cases where conditions were unsuitable, confinement should

best take place at home (provided, of course, that a midwife and if necessary a doctor were in attendance). Just before the War nearly a third of all births occurred in hospital.

Under the provisions of the Public Health Act 1936, persons carrying on maternity homes must be registered with the Local Authority (the county or county borough council). Registration may be refused if the home is not under the superintendence of a qualified nurse or midwife, or if any of the staff are not qualified (except in the case of pupil midwives); or if the premises are unsuitable. The home must be open to inspection at all reasonable times, and the registration may be cancelled. Appeal against refusal to register or cancellation of registration may be made to a court of summary jurisdiction. Hospitals or institutions not carried on for profit may be exempted by the Local Authority from the provisions of the Act. The Local Authority may make by-laws prescribing the records to be kept of patients, of children born and so forth.

Medical supervision and expert advice (and sometimes medical treatment) is as necessary after the confinement as before. Yet postnatal clinics are few in comparison with antenatal clinics, and where they are provided much less use is made of them. This is no doubt partly because the midwife continues in daily attendance for fourteen days after the birth, and can give a certain amount of advice.

It is illegal (Public Health Act 1936) for a woman to be employed in a factory or workshop for four weeks after the birth of a child.

One further service remains to be mentioned, as it is one which is being considerably extended, not only for the benefit of the mother of a newly-born child. This is the provision of domestic help during the lying-in period, either free or at a charge graded to ability to pay.

Advice on birth control may be given within certain

limitations. These confine it to women for whom pregnancy or further pregnancy would be inadvisable on medical grounds. Instruction may be given at ordinary or special clinics, or arrangements may be made to refer cases to voluntary clinics or private doctors on varying bases of payment. Members of the Local Authority's staff may not be penalized if for religious or other reasons they are not prepared to be associated with the giving of information about contraception.

Cases of puerperal fever, puerperal pyrexia and ophthalmia neonatorum must be notified by the doctor in attendance to the Medical Officer of Health.

The foundation of the infant welfare service is Section 203 of the Public Health Act 1936, which requires that births should be notified to the Local Medical Officer of Health within thirty-six hours of their occurrence. As a result the Medical Officer has a continuous record of births, which enables each home to be visited by a health visitor (after the fourteenth day, i.e., when the midwife's period of attendance is over) and advice about the care of the baby and information about the welfare services to be given. The health visitor thus plays a very important part, not only acting as a link between the mother and the clinic but as a counsellor and educator whose periodical calls are in most cases greatly welcomed.

The responsibility of the infant welfare service extends to children up to the age of going to school, when they pass into the care of the school medical authority. For various reasons, much greater attention has been paid to the infant up to about eighteen months old than to children over this age. In the eyes of both Local Authorities and parents, generally speaking, babies are more obviously in need of medical supervision and in an expanding service they naturally were the first recipients of care. Older children in consequence have been considerably neglected, and as

a result great numbers have entered upon their school lives with physical defects, often irremediable, that could have been effectively dealt with in the incipient stage. Recent years have seen the beginning of attempts to extend to the "toddler" the facilities that have been available for his younger brother and sister. Practical difficulties stand in the way of doing this: not only shortage of medical staff and premises, but the call upon the time of the housewife who may find it hard to attend a clinic with the baby one afternoon and with an older child on another. The development of nursery schools, where regular medical supervision is provided, will do very much to protect and enhance the health of the under-fives, and so bridge the large gap which undoubtedly exists in the health services.

The purpose of the infant welfare clinic, as in the case of mothers' clinics, is the provision of regular medical supervision. It is a centre to which the healthy baby should be taken so that it may remain healthy, and not merely a source of medical advice and treatment during illness. For this reason mothers are urged to take their babies each week during the early months and at lengthening intervals thereafter, unless there is particular need to attend more frequently.

Since the weight of the baby is a valuable index of its progress, regular weighing is important; according to the Ministry of Health's instructions, this should be carried out by the nursing staff and not entrusted to voluntary helpers, who have other useful tasks to perform.

The chief function of the clinic, therefore, is to keep a watchful eye on the growing infant and to advise its mother on feeding, hygiene and similar matters. When medical treatment (except of a trivial character) is required, the mother is referred to the family doctor, or, in case of need, may be offered such facilities as may be provided by the Local Authority. The Ministry of Health



has urged that these should be those which are available for school children. In practice (except in regard to orthopædic treatment) not very much is done, although dental and optical treatment (especially for strabismus) is of great importance.

Local Authorities may provide hospitals for sick or ailing children, or wards in other hospitals for these cases, and may subsidize institutions belonging to voluntary organizations which make similar provision. Children commonly dealt with are those suffering from marasmic conditions.

During the War, the already large number of infants who had been immunized against diphtheria was greatly increased. Immunization is effected without charge to parents, and may be carried out by the medical staff at infant welfare clinics or by arrangement with private practitioners. The material is supplied without cost to Local Authorities by the Ministry of Health. Vaccination is performed by Public Vaccinators, who must be appointed by county and county borough councils; they are private practitioners paid by the council at a rate fixed by the Ministry of Health.

The councils of counties, county boroughs and certain county districts are responsible for the administration of the sections of Part VII of the Public Health Act 1936 dealing with the protection of child life. These sections supersede similar provisions in the Children and Young Persons Act 1932, as they in their turn had replaced those in the Children Act 1908. The sections deal with children under the age of nine who are maintained for reward by persons other than parents or near relatives. Any such person taking a child for the first time must give not less than seven days' notice to the Local Authority. Failure to give the necessary notice constitutes an offence. In certain circumstances (e.g. when a person has had a con-

viction for cruelty) the Local Authority may refuse to allow the foster child to be taken. In other circumstances (e.g., if the premises are overcrowded or the person through ignorance is adjudged unfit to have the care of the child) a court of summary jurisdiction may, on the application of the Authority, make an order for the removal of the child to a place of safety until he can be put into the care of relatives or other arrangements made for him. This procedure applies both to a child who is about to be received or is being kept in such conditions.

Foster parents are required to notify change of address and the removal or death of the child. No insurance on the life of a foster child may be taken out. Anonymous advertisements offering to undertake the care of children are illegal.

It is the duty of the Local Authority to appoint one or more persons as child protection visitors to undertake the visitation of the homes of foster children to ensure that they are being cared for properly and to give any necessary advice to the foster parents. One such visitor must be a woman. A large Authority may make special appointments of visitors: most Authorities entrust the work to the health visiting staff. If a philanthropic body has placed out children with foster parents, its staff may be authorized to carry out the work of inspection.

Certain premises (e.g. those of a reputable children's home) may be exempted by the Local Authority from visitation.

The taking of children for reward should not be confused with the legal adoption of children. When payment is made for maintenance, as in the case of the foster child, there is the danger that as little of the money as possible will be spent on the child. For this reason, safeguards must be provided. In the case of an adopted child, payment is illegal: there is no likelihood, therefore, of improper

treatment for the sake of gain, and in consequence no need for visitation.

The London County Council is responsible for the supervision of midwives. Metropolitan Borough Councils and the City Corporation are welfare authorities under the Public Health (London) Act 1936.

## CHAPTER III

### *The Health of the School Child*

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SINCE its inception in 1907 the school medical service has undergone constant expansion and development, a process which will be greatly accelerated by the provisions of the Education Act 1944, which requires that any necessary medical treatment must be provided free of cost. It has not been possible, and still is not possible, to give domiciliary treatment; but it appears probable that school children, with all other members of the community, will be entitled to this in the proposed reorganization of the country's medical services. Those non-county borough and urban district councils which were made Local Authorities for elementary education by the Education Act 1902 have now lost their powers, county and county borough councils alone being Local Education Authorities under the new Act. The councils of certain non-county boroughs and urban districts may, however, claim the power to have delegated to them the functions of the county council and so act as divisional executives. The purpose of this provision (1st Schedule of the 1944 Act) is to preserve local interest by allowing some share in local administration and to enlist the co-operation of persons with special knowledge of local circumstances. Councils applying for this power must be councils of non-county boroughs or urban districts with populations of not less than sixty thousand on June 30th, 1939, or with at least seven thousand pupils on the rolls of elementary schools on March 31st, 1939.

The Education (Administrative Provisions) Act 1907 was passed not only because of public concern over the

extent of physical inefficiency but because of the realization that children could not properly benefit from their education if they were medically unfit. It not only gave power to Local Education Authorities to make arrangements sanctioned by the Board of Education for attending to the health of children in public elementary schools, it made it their duty to submit children to medical inspection on admission to school and at such other times as the Board might require.

This systematic medical inspection with a view to the discovery of and advising parents about physical defects has always formed the basis of the school medical service.

Experience soon showed, however, that medical inspection alone would not necessarily result in treatment being obtained. Accordingly there developed arrangements for "following-up" cases of reported defect to ascertain from parents whether the advice given by the school doctor had been adopted, and children taken where necessary to a hospital or a private practitioner.

Provision of treatment by the Local Authority in the early days was mainly for the minor ailments of childhood—skin affections, cuts, septic sores and the like—which require dressing and attention by a nurse under the direction of a doctor. Later, however, other forms of treatment of a specialized nature not within the scope of the private practitioner and too costly to be secured from a specialist were introduced, and ear, nose and throat, orthopaedic and eye clinics were established. Schemes of dental inspection and treatment were introduced soon after the 1914-18 war.

The Education Act 1918 extended the powers and duties applicable to elementary school children to secondary school children. The 1921 Act imposed a duty on Local Education Authorities to provide medical treatment for elementary school children and gave them power

to do so for secondary school children. The 1944 Act extends the duty of conducting medical inspection to include the inspection of secondary school children. Provision is also made for the medical inspection and treatment of pupils attending county colleges, and for Local Education Authorities, if they so wish, to arrange for the medical inspection of senior pupils (i.e. over twelve and under nineteen) at other educational establishments maintained by them.

Regulations made by the Minister (Handicapped Pupils and Medical Services Regulations 1945) require that pupils shall be medically inspected as soon as possible after admission to a maintained school (i.e. a county school or voluntary school); during the last year of attendance at a maintained primary school or secondary school; and on such other occasions at these schools and county colleges as the Minister may direct. Local Authorities may arrange to carry out inspections more frequently with the Minister's approval. The inspection to be carried out during the last year in school is an improvement on the former procedure, when (so far at any rate as children attending elementary schools was concerned) the third and final inspection was made when children had reached the age of twelve. Since they did not leave school for another two years, and in many cases, because of the development of central schools, for a longer period than that, there was the possibility that children might start work with unsuspected defects which a later inspection would have detected and which might therefore have received attention. Some Local Authorities, in view of this, arranged for a further inspection as near as possible to the fourteenth birthday. These systematic inspections of all children in certain age-groups are known as routine inspections. Inspections for special purposes (e.g. nutritional surveys) or at the request of teachers or parents may also be carried out.

Before a routine inspection is undertaken, a list of the children to be examined has to be obtained from the school. This is so that the time required for the work can be estimated for the purpose of administrative arrangements, and so that notices to parents inviting their attendance can be sent out. Such attendance is very valuable, since it enables the doctor to inform parents of defects and advise them generally about their children's health, and provides an opportunity also for parents to raise matters on which they want advice. There has been a generally continuous rise in the percentage of parents who attend at school medical inspections, which is clear proof of growing interest. It is unfortunate, however, that as the age-groups rise the percentage declines, many parents apparently thinking that older children can be trusted to retail at home what the doctor may have said about them. Parents who fail to submit their children to medical inspection, and pupils at county colleges or other educational establishments who do not submit themselves, are liable on summary conviction to a fine not exceeding five pounds. Times of inspection are spaced out so as to permit of an average of seven children being inspected every half-hour.

It is customary for the health visitor or school nurse, as the case may be, to visit the school beforehand for the purpose of taking the heights and weights of the children and ascertaining their degree of vision. At the inspection particulars of the child's physical condition and a note of any defects found are recorded on a chart or card, so designed as to supply the information which has to be sent annually to the Ministry of Education and which forms part of the Annual Report of the School Medical Officer. It is desirable for the head teacher to be present during the inspection, so that he can be aware of children who need treatment, or over whom special care should be exercised (e.g. a child with a weak heart might not be

capable of doing physical training). The attention of parents is drawn to any defect which in the doctor's opinion requires medical advice or treatment: in the absence of a parent written notification is given to the child to take home. Hitherto the doctor, in theory at any rate, has not been supposed to do more than this, it being for the parent to take what steps he thought desirable to have the defect remedied. Only in the event of his saying that he was not in a position to do this was information about publicly-provided facilities given. Under the arrangements to be made under the new Act for securing the provision of free medical treatment, it will presumably be for the doctor to suggest the way in which it may be obtained.

A parent is entitled to refuse to allow his child to avail himself of any medical treatment provided under the Act. This does not necessarily mean that a parent is in a position to neglect his child's health, since if as a result of neglect the child is caused unnecessary suffering proceedings may be taken by the Local Education Authority under the Children and Young Persons Act 1933. Though legal action should only be employed if all means of persuasion fail, it should be resorted to if really necessary in the child's interests. An occasional prosecution tends to have a salutary effect upon other indifferent parents.

After an inspection the medical cards are taken to the office in order that the relevant information can be recorded for statistical and other purposes. A slip is then made out for each child suffering from a defect which requires treatment and passed over to the health visitor or school nurse whose task it is to "follow-up"; that is, to visit the child's home after a reasonable interval to inquire whether medical treatment has been secured and if not to urge the need for this to be done. Repeated visits may have to be made. A further slip is made out for the



doctor's use when he carries out a re-inspection of defective children in the school. Notes of any treatment obtained and its results are entered on these slips, since this information also is required for statistical purposes.

It is the general practice to keep the child's medical record in school, together with any other papers relating to him, so that they can readily be transferred when the child goes to another school. The same form of record is used throughout the child's school life, so that doctors at succeeding inspections are able to be aware of physical conditions found at earlier ones.

Special inspections may be carried out. At a routine inspection a head teacher may submit some children on whom he wishes to have the doctor's opinion, or the parent of a child being inspected may ask for another one to be seen. In the event of a number of children in a class having diphtheria an examination may be made of the others and throat swabs be taken so that unsuspected sufferers may be dealt with and a possible "carrier" be detected. In the last few years before the war School Medical Officers were directed by the Board of Education to carry out periodical surveys of the nutritional condition of school children. These did not in fact prove to be of any real value because of the difficulty of applying any satisfactory standard—a difficulty which also occurs in regard to the assessment of other conditions.

Modern schools are usually equipped with a special inspection room containing a sight-testing card and weighing and measuring machine, an undressing room and a waiting-room for parents. In older schools facilities are frequently very poor. The 1944 Act empowers Local Education Authorities to direct managers of voluntary schools to provide reasonable facilities, though they must not be required to incur expense in so doing.

Since the greater number of defects from which school

children suffer are fortunately comparatively slight, the greater part of the work of treatment is carried out in minor ailment clinics. Medical record cards need to be kept here, not only for use by the doctor, but also because account has to be kept of treatment which has been given for the annual statistical statement. Cases attending minor ailment clinics are not only those who have been referred from medical inspections in schools. Children may be referred by teachers, health visitors, voluntary bodies or brought by parents on their own initiative. Nor are they all found to have only minor defects. Some may be found on examination to be suffering from more serious conditions, in which case they may be referred to their own doctors or arrangements made to deal with them in other ways (e.g. in hospital), as the case may be. A more suitable title than minor ailments clinic is general school clinic, which some Local Education Authorities have adopted.

Treatment given at the clinic is that which does not require specialized knowledge or the use of any but simple equipment. Running ears, sore eyes, skin diseases like impetigo and the many cuts, grazes and bruises sustained by school children are the usual defects which are dealt with. It is not infrequently complained that parents are or should be perfectly competent to deal with many of these conditions and that the clinic relieves them of too much responsibility. On the other hand, some conditions may readily grow more serious if treatment is delayed or if the wrong treatment is given; otorrhœa (discharging ears) is a case in point.

If a child is absent from school on account of attendance at a clinic his attendance mark at school is recorded provided that he is not away from school for longer than an hour and a half in the case of an infant and two hours in the case of an older child, and that proof of the time he

spent at the clinic is available. So that the school mark may not be lost it is usual for the child to be issued with a card on which the times of his arrival at and departure from the clinic are entered.

Other forms of treatment which are provided are for defective sight, enlarged tonsils and adenoids, and ortho-pædic defects. The medical officer of an eye clinic may be a full-time member of the staff with special training in ophthalmology or a part-time specialist who may also act in this capacity at a municipal hospital and may be the certifying officer under the Blind Persons Act. Attendance at these clinics is by appointment. Arrangements may be made for children with diseases of the eye as well as those with visual defects to be examined. Spectacles are usually supplied by contract with a local optician, who is responsible for the fitting of frames and for repairs. Some Local Authorities have instituted special remedial classes for children suffering from squint, which if neglected generally results in severe impairment or loss of sight in the affected eye. Since its onset is frequently in the pre-school age, when the prospect of cure is good, it is important that facilities for treatment should be given at this time. As it is, many children come under the notice of the school doctor when little can be done except by operation to straighten the defective eye and even less to improve the sight.

Children suffering from enlarged tonsils and adenoids are generally referred to the ear, nose and throat department of a municipal or (by arrangement) a voluntary hospital. In the case of areas with a large number of school children, special sessions may be set apart for this purpose. Treatment may be medical or surgical. Where removal of tonsils or adenoids is necessary arrangements are made for admission to hospital and for the patient to be kept in bed for the night following the operation, or for a

longer period if necessary (e.g. in the event of continued hæmorrhage).

Crippling conditions and maladjustments of bones and joints are dealt with at the orthopædic clinic, which may be held on other clinic premises or in a hospital. The orthopædic surgeon is a part-time specialist, either in private practice or on the staff of a hospital (e.g. an open-air hospital for children). Arrangements have to be made to supply surgical boots, leg irons and other appliances: these are very often obtained through a voluntary agency such as an Invalid Children's Welfare Association. Provision must also be made for in-patient accommodation in cases where surgical treatment and prolonged medical care is necessary. Close co-operation with the Local Authority's supervisor of physical training in schools and with head teachers is important, as some forms of faulty posture and gait can be corrected by remedial exercises which can be carried out in school or at special classes. In other cases, participation in football and other games may be harmful.

There has been a considerable reduction in the incidence of crippling in recent years, due in large part to the measures undertaken by maternity and child welfare schemes. In regard to rickets, especially, the distribution of milk, cod liver oil and orange juice has had a marked effect. A great deal of physical inefficiency and impairment of productive capacity has been prevented for the expenditure of a very modest amount of public money.

Periodical examinations of the cleanliness of children attending school are carried out by the health visitors or school nurses: parents need not be notified of such examinations. Persons conducting these examinations must carry the written authority of the School Medical Officer. In most cases it is sufficient to inform the child or, in the case of a young child, the parent verbally and to

re-examine the child after a short interval. Where the child's condition is very bad, or when informal action is ineffective, a notice may be served upon the parent, or in the case of a pupil attending a county college upon the pupil himself, requiring his person and clothing to be cleaned. The notice gives warning that if the cleansing has not been carried out satisfactorily within twenty-four hours, it will be carried out under arrangements made by the Local Authority. Instructions as to the most effective method of cleansing accompany the notice. Cleansing centres equipped with bath and apparatus for disinfecting clothing are provided for this purpose. County district councils which own such premises must make them available to Local Education Authorities by agreement as to payment. If, after having been compulsorily cleansed, a child is again found to be in a verminous or foul condition the parent or, in the case of a pupil at a county college, the pupil is liable on summary conviction to a fine not exceeding twenty shillings. A girl may only be examined or cleansed by a doctor or a woman officer. A dirty or verminous child may be excluded from school until action can be taken. Such an exclusion is a defence to any proceedings for failure to attend school, unless the exclusion was necessitated because of wilful default.

Standards of cleanliness have steadily gone up since the school medical service was instituted. This has been the result of better housing conditions and the more enlightened outlook of parents as well as of the close supervision exercised by the school nursing staff. The improvement of cloakroom and washing accommodation in schools has also made its contribution. It is helpful to parents to lend them or to arrange for them to buy at low cost specially designed combs for ridding girls' hair of nits and vermin.

Dental inspection and treatment constitutes a very important part of the school medical service, which was expanding

considerably before the war. Local Education Authorities are required to appoint Senior Dental Officers and such other dental officers and nurses as may be necessary to secure an efficient dental service. Children must be dentally inspected as soon as possible after admission to maintained schools, and thereafter, and in county colleges, on such other occasions as the Minister may from time to time direct. The shortage of dentists will no doubt during the near future prevent these occasions from being as frequent as is desirable. The Board of Education estimated in 1936 that to provide an adequate school dental service there should be one dentist for every 5,000 children in an urban area and for every 4,000 in a rural area, this standard being insufficient when acceptances of treatment were high. At that time only about three-quarters of school children were being inspected.

Intimations are sent to parents, as in the case of medical inspection, inviting them to be present when dental inspection is carried out. Notification is afterwards sent to parents whose children's teeth have been found to be defective, informing them of this and asking them to let the Dental Officer know whether they intend to secure treatment privately or whether they wish to utilize the clinic facilities. In the latter case, appointments for the children to attend are duly made. Dental treatment, like medical treatment, is now provided free. A "follow-up" is made of parents who say they are going to make private arrangements or who do not reply.

Apart from children who attend a clinic for treatment by appointment others may be referred by school doctors or be brought by parents on their own initiative. Many of these latter cases cause difficulty as they are very often children whose parents have neglected to secure treatment when it was offered and who now suffer from toothache, perhaps severely. It is difficult, on humanitarian grounds,

to refuse to carry out immediate treatment. On the other hand, dealing with such children throws the time-table out of gear and adds to the waiting time of other patients. More seriously, if it becomes accepted by parents that they need not bother to get treatment when first advised that it is necessary, but can have their children dealt with as soon as it can no longer be deferred, the Dental Officer's attempts to have the importance of preventive treatment realized are very largely frustrated. Shortage of dental staff has greatly restricted the extremely important educational work which requires to be done among both parents and children about dental hygiene. It is a depressing fact that after over a quarter of a century of school dental services the proportion of children with defective teeth is nearly as high as it ever was.

In sparse rural areas it may be necessary for the dental staff to undertake treatment as well as carry out inspection in school. For this purpose a suitably-equipped motor-van is provided.

Special educational provision has to be made for what are termed handicapped pupils in the Handicapped Pupils and Medical Services Regulations issued by the Minister in 1945. These are children for whom ordinary methods of teaching are not suitable, or who need institutional care. Such pupils are those who are blind or partially sighted, deaf or partially deaf, delicate, diabetic, educationally sub-normal, epileptic, maladjusted, physically handicapped (e.g. cripples) or who suffer from speech defects.

The Local Education Authority is required to ascertain what children require special educational treatment. When it appears that such a child has been found, the parent (provided the child is at least two years old) may be directed in writing to submit him for examination by a medical officer. Failure to comply with such a direction renders a parent liable on summary conviction to a fine not exceed-

ing five pounds. A parent may himself ask for his child to be examined. An intimation to attend the examination must be given to a parent. If, following the report of the Medical Officer, the Authority is satisfied that special educational treatment is required, it must provide such treatment, and inform the parent of his obligation to see that his child secures it. At the request of either, the Medical Officer is required to issue to the Authority or the parent a certificate stating that in his opinion the child suffers from a disability and indicating the extent of it. The Authority need not ask for this certificate unless it is felt to be necessary for securing the child's attendance at a special school, i.e. in case the parent disputes the decision and legal proceedings have to be taken. If the certificate is cancelled (either by the Minister or by a medical officer of the Local Education Authority) the child need no longer receive special education.

Blind, deaf, physically handicapped, epileptic and aphasic children have to be educated in special schools; in the case of blind and epileptic children, these must be boarding schools. Others may be educated in ordinary schools so long as their presence is not detrimental to the interests of other children and certain provision is made for them, e.g. partially sighted children must use specially-printed books and be prohibited from doing some kinds of work. Hostel accommodation under medical and nursing supervision must be provided for diabetics.

Children attending special schools or who are receiving special educational treatment are subject to medical and dental inspection and treatment.

While it must inevitably be some time before Local Education Authorities are in a position to make the arrangements necessary to secure that all handicapped children are educated in a manner appropriate to their disabilities, the Regulations mark an important forward



step. Except for blind and deaf children, they have suffered great neglect in the past. The Minister of Education will be able to exercise considerable control, since he has laid down conditions which must be satisfied for the purpose of grant, e.g. the number of pupils in a class must not exceed a certain figure.

Where there is heavy unemployment among juveniles, the Local Education Authority is required by the Unemployment Act 1934 to set up Junior Instruction Centres, attendance at which is compulsory. Juveniles attending these centres are or are supposed to be kept under medical supervision, and the facilities for treatment provided for school children are equally available for them.

The Children and Young Persons Act 1933 prescribes the conditions under which children attending school are allowed to work. A child may not work if he is under twelve, not during school hours, not more than two hours on a school day and not before 6 a.m. or after 8 p.m. Local Education Authorities may make by-laws imposing other restrictions. These usually require that before a child is given an employment certificate he must submit to medical examination, so that in the event of the proposed work being considered prejudicial to his health the certificate may be withheld.

Before 1937, a gap occurred in the medical supervision and care of young people between the time of leaving school and the attainment of the age of sixteen, which qualified for entry into the National Health Insurance Scheme. The gap was closed by the National Health Insurance (Juvenile Contributors and Young Persons) Act of that year, which brought children into the scheme as soon as they became employed. The Act also entitled the insurance practitioner to obtain from the Local Education Authority the school medical records of applicants for inclusion on his panel. In general little advantage appears to have

been taken of this provision of the Act, although it is clearly in the interests of both that knowledge of an applicant's medical history shall be in the possession of his doctor.

The London County Council is the Local Education Authority for the whole of the administrative county (including the City of London) and therefore exercises all powers and duties in regard to the school medical service.

## CHAPTER IV

### *Tuberculosis and its Treatment*

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ALL forms of tuberculosis became compulsorily notifiable in 1912. A medical practitioner (whether in private or public practice) on first becoming aware of a case of tuberculosis must send a prescribed form of notification within forty-eight hours to the Medical Officer of Health of the district in which the patient resides, unless he has reason to believe that such notice has already been sent.

The Medical Officer of Health is required to keep a register of notified cases, including notified cases who have come to live in his area, and of deaths of persons who have not been notified to him. Not less than once a quarter the register must be revised by the withdrawal of entries in respect of persons (1) who have been incorrectly diagnosed; (2) who have recovered; (3) who have died, have removed or have been lost sight of. A person is not deemed to have recovered until there has been no evidence of the disease for five years in the case of pulmonary and three years in the case of non-pulmonary tuberculosis. The Medical Officer of Health must notify the Medical Officer concerned of the permanent removal of a patient into another area, sending all relevant particulars in the register.

In the case of the Medical Officer of a county district (i.e. a non-county borough, urban or rural district) he must send weekly to the County Medical Officer a statement of each notification received. The County Medical Officer must also be furnished quarterly with a statement giving the number of cases on the register at the beginning of the quarter, the number of cases notified for the first time during

the quarter, the number of cases removed from the register and other relevant information. By means of these quarterly statements the County Medical Officer is enabled to form a picture of the position in regard to tuberculosis over the whole of his area, and relate the county scheme of institutional treatment to possibly changing needs.

While the councils of county and county boroughs only are responsible for the provision of institutional treatment of various forms the councils of districts "may also make such arrangements as they think desirable for the treatment of tuberculosis" (Public Health Act 1936; Section 173). Such arrangements generally include a service of tuberculosis visitors, for the purpose of "following-up" domiciliary patients; the disinfection of premises and bedding; bacteriological examinations in connection with diagnosis; and the supply to patients of sputum flasks. They may lend bedsteads and bedding to patients so that they may sleep alone, and lend or hire garden shelters. They are authorized to publish or distribute information about tuberculosis and precautions to be taken against the spread of infection. These powers in some respects are those which can be exercised by the County Council, and it is therefore necessary that there should be a clear understanding between the different types of Local Authority to avoid overlapping and confusion.

In certain circumstances a tuberculous person may be removed against his will to an institution or hospital (Public Health Act 1936). Application must be made by the county or county borough council or other Local Authority to a court of summary jurisdiction, which must be satisfied that the person suffers from respiratory tuberculosis of an infectious nature, and that because proper precautions cannot or are not being taken serious risk is being caused to other persons. If the court so directs, the Local Authority must pay the whole or part of the cost of

the patient's removal to and maintenance in the hospital, and make a contribution towards the maintenance of his dependants. In the absence of any direction, the Local Authority may pay the whole or part of the cost and contribute as they think fit towards the maintenance of dependants.

The Public Health (Prevention of Tuberculosis) Regulations 1925, prohibit any person who knows that he suffers from respiratory tuberculosis from being employed in connection with milk. The Local Authority may require such a person to discontinue his employment. He is entitled to compensation for damage caused by such discontinuation, and to appeal against a notice to discontinue to a summary court.

Tuberculin tested milk (either certified or pasteurized) and "accredited" milk is derived from cows which are subject to regular veterinary examination, and must satisfy certain bacteriological tests. Production of these graded milks is under licence from the Local Authority. Cows producing ungraded milk are (or should be) also kept under veterinary inspection. The owner of a cow suffering from tuberculosis to any degree may be ordered to destroy it; in mild cases of infection he may be prohibited from selling its milk. Samples of milk sold retail may be taken by a Local Sanitary Authority and submitted to bacteriological examination for the detection of tubercle.

County and county borough councils are charged with the duty of making adequate arrangements for the treatment of tuberculous persons in their areas at or in dispensaries, sanatoria and other institutions approved by the Minister. They may exercise their functions through joint committees, and may be joint owners of sanatoria. Their schemes may be worked in association with voluntary organizations. In Wales, most of the work of treatment is undertaken on behalf of the county and county borough

councils by the King Edward VII Welsh National Memorial Association, to whom they pay grant. They may make such arrangements as they wish for the after-care of persons who have suffered from tuberculosis.

There are two main elements in a tuberculosis scheme. The first is the tuberculosis clinic or dispensary. This serves as a centre for diagnosis, for the detection of new cases and for the examination of contacts of infected persons. Certain forms of treatment may be undertaken. General supervision is exercised over the non-institutional patient, in conjunction when this is required with the patient's own doctor. Information about tuberculosis and advice as to the mode of life to be followed is given. Arrangements are made from the dispensary for the admission to hospital or sanatorium of patients who need institutional care, and for after-care of patients on their discharge from such institutions.

Dispensaries should be available at times which meet the needs of the public. Evening sessions are particularly important in the case of wage-earners, for two reasons. They may not be able to afford or may be reluctant to lose wages if they have to have time off from work to attend a dispensary. To ask for time off may involve disclosing that one suffers from tuberculosis, which (even though the disease be non-infectious) may prejudice continuance of one's job. More difficult barriers against securing full and early medical care exist than the provision of clinics at inconvenient hours; but this one, at least, is easily removable.

Definitely diagnosed cases of tuberculosis should be referred to their own doctors for domiciliary treatment unless this is of a kind which can be better provided at the dispensary or unless institutional treatment is necessary. Friendly co-operation between dispensary and general practitioner is obviously important. At the request of a

practitioner the tuberculosis officer may supervise the course of treatment in the patient's home, although it is no part of his work to carry it out. A National Health Insurance practitioner is under obligation to confer with the tuberculosis officer about a tuberculous patient and to render certain reports to him. In the case of the non-insured patient who cannot afford private treatment, the necessary medical attention is given at the dispensary.

Through the agency of tuberculosis visitors, the tuberculosis officer is kept in touch with the home environment of patients. He is thus in a position to make representations to the appropriate authorities where this is unsatisfactory, or to approach voluntary bodies who may be able to give help in regard to sleeping accommodation.

Early detection of tuberculosis is of great importance. Every endeavour should therefore be made to persuade the home contacts of a patient to submit to medical examination and to keep themselves under observation for as long as may be necessary. Tuberculosis visitors perform valuable work in following-up both patients and contacts who have become negligent in their attendance at the dispensary.

Close relations should exist between the tuberculosis officer and the municipal or poor law hospital, so that he can examine patients at the request of the resident staff, and supervise patients admitted on his recommendation. In some areas he is formally appointed as honorary consultant.

Provision is made for pathological examinations and X-ray examinations; a number of modern dispensaries are equipped with their own X-ray apparatus. It is important that dental treatment, the services of home nurses and extra nourishment should be available; but this is by no means always the case. Of recent years some Local Authorities, when the opportunity has arisen to erect new

premises, have included a tuberculosis dispensary with other clinics in the same building. In this way it has been possible to achieve improved co-ordination between the Authority's medical services. The development of mass miniature radiography, which enables tuberculosis to be detected in its early stages, will prove an increasingly important adjunct to preventive medicine.

It will be seen that the dispensary is much less a place for the treatment of patients than a centre for diagnosis, for education, for observation and for dispersal to sources of appropriate treatment elsewhere.

Many tuberculous patients require treatment in residential institutions, either because their condition demands such treatment or because home circumstances make effective treatment difficult or impossible.

Residential treatment is provided in a variety of institutions, according to the severity and type of the disease. The sanatorium caters for the fairly lengthy treatment of early cases of pulmonary tuberculosis and of cases where the prospects of arrest of the condition appear to be good. Nearly a third of the bed accommodation in sanatoria in England is provided by voluntary organizations; some of this is occupied by private patients but the remainder is available to Local Authorities. In Wales, the greater part of the bed accommodation in both sanatoria and hospitals is provided by the King Edward VII Welsh National Memorial Association, which also rents a certain number of beds in poor law hospitals.

The hospital deals with four types of patient: (a) doubtful cases for observation or for decision as to whether sanatorium treatment is advisable; (b) acute cases; (c) chronic cases requiring short periods of treatment and of instruction; and (d) dangerously infective and advanced cases. It is generally considered that the best type of residential institution is that which combines sanatorium



and hospital accommodation. The Ministry of Health encourages the provision of such institutions.

In place of hospital, patients in an advanced stage may be looked after in a home for such cases. This may be a specially erected building or an adapted house. This method of dealing with persons in the final state of the disease has many advantages, not only for the patients: it releases what may be much-needed accommodation in hospital for cases of acute illnesses of various kinds.

Surgical tuberculosis may be treated at residential institutions dealing solely with this form of the disease, or at an orthopædic hospital for the treatment of all kinds of crippling diseases. Other forms of tuberculosis (e.g. lupus) are usually treated at special or general hospitals. About half the accommodation for cases of non-pulmonary tuberculosis in England is provided by voluntary organizations.

The various classes of residential institutions are approved by the Ministry of Health. In addition, a relatively small number of beds are used in municipal general hospitals and poor law institutions which have not been so approved.

An extension of the sanatorium is the village settlement, in which, after completion of their treatment and occupational training, patients may take up permanent residence, in some cases with their families. Regular employment at work of various kinds is provided for them in the settlement's workshops at trade union rates of pay, and they thus become self-supporting members of the community. They enjoy working and living conditions conducive to keeping them in good health, and can be kept under continuous medical supervision.

While the value of the village settlement is considerable, it is necessarily limited. The difficult economic problems involved in tuberculosis can be reduced to manageable

proportions only by a full-scale endeavour to improve the unsatisfactory nutritional and environmental conditions of great numbers of the population.

Local Authorities may apply to the Minister of Health for permission to board-out the children living in contact with tuberculous parents. Such a procedure not only removes children from the danger of infection; it may persuade a parent, especially a mother, to undergo institutional treatment in the knowledge that proper care is being taken of the children. It is, therefore, important as a measure of prevention.

The councils of counties and county boroughs are empowered by Section 173 (2) of the Public Health Act 1936 to "make such arrangements as they think desirable for the after-care of persons who have suffered from tuberculosis." They are permitted to spend on after-care not more than £5 per 1,000 of the total population. Because of the close association of tuberculosis with economic factors, the after-care of the patient discharged from a sanatorium may be of great importance. If he returns to bad housing conditions, or to unsuitable work, or to an inadequate diet, he may speedily relapse and the benefit of his treatment be lost. The village settlement provides proper environment, suitable employment, and a wage which enables essential food to be secured. But many more settlements than for various reasons are practicable would have to be established to deal with all discharged patients. Much can be done in other directions (and a good deal more should in fact be done) to provide after-care.

A patient should not have to live in an insanitary or overcrowded house, either because he cannot secure or cannot afford to pay the rent of a decent one. Some Local Authorities set aside a number of their houses for ex-sanatorium patients, others give special consideration to

an application for a house which is supported by the tuberculosis officer. In one or two cases Local Authorities have built houses in which one bedroom is of the open-air veranda type, so that the living conditions of the sanatorium are partly reproduced. Rents may be lowered to meet the needs of patients who otherwise could not occupy a municipal house even if it were offered, or who could only pay the rent at the cost of reducing expenditure on food. Bed and bedding may be lent, or sold on easy repayment terms, to enable the patient to sleep alone, if this is desirable. Outdoor sleeping shelters also may be lent, when (as frequently is not the case) there is sufficient garden space to accommodate them.

Another important feature of after-care is the supplementation of diet by those items of food which are most important and least able to be procured out of a small income. Local Authorities may supply milk, eggs, butter, cod liver oil and malt extract free of charge or at a reduced cost to necessitous cases.

Effective after-care frequently involves the provision of suitable employment—suitable, that is, to the patient's physical condition. It may require, for instance, to be light in character and performed as much as possible out of doors. Many persons on discharge from sanatoria are out of work, having lost it as a result of physical incapacity through the disease or of going into sanatoria. Others have work to which it would be prejudicial to their health to return. In both cases, finding employment often presents very great difficulties, even when economic conditions are good, and only meagre attempts are made to overcome them. In consequence many discharged patients are driven to accept jobs which are wholly unsuitable and which result in a breakdown in health, or remain permanently unemployed and a charge on public funds. It would be economical to provide different forms of employ-

ment (on a non-residential basis) of the kind provided in village settlements even though wages had to be subsidized, as well as preserving in the employees the sense of being useful members of society. A few Local Authorities have taken steps in this direction which have proved successful, some ex-sanatorium patients at least having been enabled to maintain, or partly maintain, themselves without prejudice to their health. In some areas, posts as corporation car park attendants are reserved for suitable cases.

Arrangements in connection with after-care may be the responsibility of a committee of the Local Authority or of a voluntary committee, an alternative which is preferred by the Ministry of Health. The administrative expenses of such a voluntary committee may be defrayed by the Local Authority. Membership of a committee customarily comprises representatives of the Local Authority, the tuberculosis officer, representatives of voluntary social organizations and of business and commercial organizations, and hospital almoners. The Care Committee can be very helpful to patients and their families, putting them into touch with various sources of assistance, advising in difficulties, and trying to find employment suited to the patient's capacity. A trained social worker acts as the link between the Committee, the patient and the tuberculosis dispensary. Propaganda work, in the form of lectures and exhibitions, may also be undertaken by the committee, which provides an example of the valuable association of public and private effort.

During the war a very important step has been taken in the direction of securing treatment in the early and so more tractable stages of pulmonary tuberculosis while working capacity is unaffected. In many cases, especially where the family breadwinner is concerned, a patient is reluctant or unable to give up work, and so lose wages, for the purpose of undergoing treatment, National Health

Insurance benefit being inadequate to meet even essential needs.

Since 1943 persons who give up remunerative work to undergo treatment for pulmonary tuberculosis, whether domiciliary or institutional, may receive maintenance allowances. Cases of chronic tuberculosis, for whom treatment can do no more than alleviate the condition, are not, however, eligible. The determination of the amount to be paid (within the general limits laid down by the Ministry of Health) rests with the Tuberculosis Authority, whose expenditure is repaid by the Minister. Financial assistance is of three categories. The first is the standard rate of maintenance, designed to meet the needs of the ordinary case, to which is added actual rent (or mortgage repayments) and rates up to a maximum of 15s. per week and a fuel allowance during the cold months of 3s. 6d. per week. From the standard allowance is deducted any payment received from an employer or income from self-employment; any National Health Insurance sickness or disablement benefit; any amount over £1 per week as a disability pension; and 10s. a week in the case of a patient treated in an institution. The principal rates are: Man and wife (joint), 39s.; dependants, 12s. down to 5s. in accordance with age; single adult, 27s. Discretionary allowances may be paid where there are standing charges that cannot reasonably be met out of the standard allowance: exceptionally high rent or mortgage charges, insurances, educational charges and hire purchase charges. Such allowances should not normally exceed 10s. a week. Special payments may be made to poor near relatives to visit patients in institutions; to patients without dependants in institutions (these receive no standard allowance) who have no National Health Insurance benefit or other resources for pocket-money and (if necessary) to meet commitments for rent, insurances and other continuing charges; and (not more

than 10s. a week) for necessary domestic help if the patient is a housewife.

The powers of Local Authorities to give assistance in other ways (e.g. supply of extra nourishment) are not affected by the payment of the various forms of maintenance allowance.

The Minister has made it clear (Memo 266/T) that financial assistance should be regarded as an integral part of the tuberculosis scheme, and that the arrangements should accordingly be associated as closely as possible with the tuberculosis dispensary and the Care Committee, even though the actual payment should be under the jurisdiction of the Finance Officer.

Allowances can be made to persons who after or during treatment are capable only of undertaking part-time employment, one-third of such earnings being ignored when calculating the amount of allowance to be paid. When employment is full-time the payment of an allowance ceases.

Though the main purpose of the scheme of allowances was to secure the fullest utilization of labour-power for the war effort, it will no doubt be continued unless or until it is replaced by the provisions of a scheme of social security.

In London the Metropolitan Boroughs and the City Corporation are responsible for providing dispensaries, but the County Council is the authority for residential treatment. By arrangement tuberculosis officers are appointed as honorary consultants on the staff of hospitals which treat tuberculosis, and are given facilities for visiting patients in general hospitals. The County Council may make arrangements for after-care.

## CHAPTER V

### *The Control of Communicable Diseases*

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#### *Infectious Diseases*

POWERS and duties in connection with infectious diseases are exercised primarily by the councils of boroughs and districts and port health authorities. A county council, however, may with its own consent become an authority by regulation of the Ministry of Health. A non-county borough or district council may transfer its powers and duties by agreement to a county council, or they may be transferred in default.

Certain cases of infectious disease must be notified by the medical practitioner in attendance to the local Medical Officer of Health. Forms of certificate for this purpose are supplied free, and the medical practitioner is paid two shillings and sixpence for each notification (one shilling if the case occurs in his practice as the medical officer of any institution). Notifiable diseases are those set out in Section 343 of the Public Health Act 1936; those included in regulations made by the Minister of Health; and those that may have been declared by a Local Authority to be notifiable in their district. An Order made by the Local Authority to add to the list must have the approval of the Minister, except in the case of emergency, where it is in force for a month only. For various reasons it may be valuable for a local Order to be made: during an outbreak of smallpox, for example, it is important that cases of chicken-pox should be notified, since the diseases in their earlier stages appear similar.

The purpose of notification is to enable the public health authority to take steps to control the spread of the infection. Responsibility rests upon the patient, or, in the case of a child, its parents, to limit this danger. Thus it is an offence for a person knowingly to expose others to the risk of infection in the street or in places such as theatres or to sell articles which have been exposed to infection; or for a parent to send to school a child who is suffering from a notifiable disease or who has been in contact with such a child. Clothing exposed to infection must not be sent to laundries. Provision is made against the risk of spread of infection through the medium of library books, or travel in public conveyances.

If satisfied that disinfection of a house, or part of a house, is necessary as a preventive measure a Local Authority must give notice to the occupier that they will carry out disinfection at his cost, unless within twenty-four hours of receipt of the notice he informs them of his intention to undertake the disinfection. If the Local Authority is of opinion that the occupier is unable to do this effectively, they may do it at their own cost. The usual practice is for the Local Authority to have the work done by contractors, frequently without recovering the cost, which may be little if any more than the expense of collection. A certain number of Local Authorities have been persuaded by their Medical Officers of Health that disinfection of premises is of little if any value and consequently do not serve notices. The Local Authority may provide a disinfecting station and disinfect articles taken there free of charge. It is usual to collect and disinfect a patient's bedding and clothing and any books which have been borrowed from a library.

On application by the Local Authority a magistrate may make an order for the compulsory removal to hospital of a person suffering from an infectious disease in whose case



proper precautions against the spread of the disease cannot be or are not being taken. The cost of maintenance in hospital falls upon the Local Authority.

A Local Authority has no general statutory authority to require a person who has been in contact with a patient suffering from a notifiable disease to abstain from work, and in most cases the Medical Officer of Health does not suggest that this should be done. A teacher in whose home there is a case of infectious disease may, however, be instructed not to attend school during the period of the illness unless he can find living accommodation elsewhere, when after the appropriate quarantine period he may resume attendance. Any person who is an inmate of an infected house may, if circumstances make this course necessary, be removed temporarily with or without his consent (in the latter case a judicial order is needed) to accommodation provided by the Local Authority at their expense. Special provisions are made with regard to enteric fever and dysentery (Public Health (Infectious Diseases) Regulations 1927). On the occurrence of a case of these diseases the Local Authority may issue an order in writing forbidding the person named in the notice to continue during the time of the notice any occupation concerned with the preparation of food or drink intended for human consumption. Payment of compensation may be made. The Regulations also deal with any person in such occupation suspected of being a carrier of either of the diseases. The Local Authority may require him to undergo medical examination and if as a result he is found to be a carrier he must discontinue his employment for a specified period. The Milk and Dairies Orders make it unlawful for a person suffering from an infectious disease or who has been in contact with such a person to take any part in the production or distribution of milk. A Medical Officer of Health may prohibit the sale of milk from dairies

if in his opinion infectious disease could be caused by its consumption.

It is the duty of the Medical Officer of Health to send weekly to the Registrar General a statement of the number of cases which have been notified to him. A summary of these is included in the "Weekly Return" published by the Registrar General and forwarded to Medical Officers of Health. This summary enables the Ministry of Health to keep a watchful eye on the incidence of infectious diseases throughout the country. Should there be evidence of unusually high incidence in any area the local Medical Officer of Health may be required to make a special report, which may be followed by a visit from one of the Ministry's Medical Officers to give any help that may be required to investigate the circumstances and to institute such steps as may be considered necessary to limit the spread of the infection. The weekly summary is of value also to the Medical Officer of Health, since he is informed of any extensive prevalence of infectious diseases in neighbouring areas and so can be on the watch for their spread to his own district.

In the case of smallpox every care must be taken not only to isolate the patient but to trace all persons with whom he may have been in contact, even though they may reside in other areas, whose Medical Officers of Health should be informed of them. Contacts should be pressed to undergo vaccination and those who have been in close communication with the patient should either be put in quarantine for fourteen days or kept under daily supervision so that they may be isolated should symptoms disclose themselves.

On receipt of a notification of infectious disease, the home is usually visited by a sanitary inspector (who may be appointed specially for this work). He reports to the Medical Officer of Health on the home conditions, and

arranges where necessary (if the doctor in attendance has not already requested that this shall be done) for the patient (usually a child) to be taken by ambulance to the isolation hospital. It is considered important that cases of certain infectious diseases (e.g. smallpox and diphtheria) should be dealt with in hospital, because of the special nursing and treatment that is needed. Practice varies in regard to scarlet fever; but removal to hospital is felt to be very desirable if effective isolation of the patient at home cannot be effected. For practical reasons it is not possible to admit as a routine procedure cases of such prevalent diseases as measles, chickenpox and whooping cough, even in areas where they are notifiable; but particular circumstances may make admission necessary. Parents are instructed to keep other children in the family away from school for the appropriate period of quarantine.

The Public Health Act 1936 empowers all Local Authorities except parishes to provide hospital accommodation for cases of infectious diseases. In a number of cases two or more have combined for this purpose, either on their own initiative or as a result of a scheme made by the County Council. More is said about Joint Hospital Boards in a later chapter.

Owners of infectious diseases hospitals may recover the cost of a patient's maintenance (this is not compulsory as in the case of a general hospital). It is unusual for a charge to be made, since this might deter patients from obtaining hospital treatment and so add to the danger of infection spreading. The right of Local Authorities to decide as they choose whether or not to charge for treatment applies in the case of non-residents (e.g. visitors on holiday).

Sanitary authorities (i.e. councils of boroughs, urban districts and rural districts) may provide ambulances for the conveyance to hospital of persons suffering from infectious

diseases. No charge may be made to the patient. An isolation hospital district constituted by a county council must have an ambulance. In the case of a pauper patient, the cost of conveyance is chargeable upon the council of the county or county borough from which he is sent; in other cases upon the council of the borough or district in which he resides.

Vaccination is the only form of immunization against infectious disease which has been made compulsory. The Vaccination Acts require that every child shall be vaccinated before it reaches the age of six months, unless the parent makes a statutory declaration of conscientious objection before a justice of the peace or commissioner of oaths. A child may be vaccinated by any medical practitioner or by the Public Vaccinator, who is under contract with the Local Authority to carry out vaccination free of charge to the parent.

Local Authorities may, however, apply to the Minister of Health for powers to make arrangements to carry out immunization against other infectious diseases, and the great majority of them now provide facilities for immunization against diphtheria for children up to school leaving age. Arrangements vary: it is usual to immunize infants at welfare clinics, school children either at school or at clinics. The work may be carried out by the full-time medical staff, or by the part-time assistance of private practitioners, who may in addition be supplied free of cost with immunizing material for use in their surgeries. Except in the case of the last arrangement, no charge is made for immunization. Considerable educational work has to be carried out if a high proportion of children are to be treated.

Isolation hospital accommodation in London is provided by the County Council. Notifications of cases of infectious diseases are sent to the Medical Officers of Health of the

Metropolitan Boroughs, which exercise powers in regard to disinfection and other preventive measures.

Responsibility for measures to prevent the introduction of infectious diseases into the country rests with the Port Health Authority, constituted by the Minister of Health under the Public Health Act 1936 in districts which include or abut upon a port. Regulations made by the Minister provide for the treatment of persons on ships or aircraft who are suffering from infectious disease and for the prevention of the spread of infection. The Port Medical Officer is empowered to board any ship and examine any person who is suffering from or has been exposed to infection.

The City Corporation is the Port Health Authority for the Port of London.

#### *Venereal Diseases*

There are only two Acts of Parliament dealing with venereal diseases. One is the Venereal Diseases Act 1917 which makes it an offence for any person except a doctor to give treatment and to advertise publicly any preparation purporting to cure or prevent the diseases. The other is the Matrimonial Causes Act 1937, which empowers a court to grant a decree of nullity to either partner to a marriage when one of them at the time of marriage was (unknown to the other) suffering from venereal disease in a communicable form.

Public provision for the control of venereal disease constitutes the only branch of the public health service introduced by and still maintained under regulations. The Public Health (Venereal Diseases) Regulations 1916 required county and county borough councils to provide centres for treatment and diagnosis; and to supply medical practitioners on request and free of charge with approved drugs to treat private patients. They are required

also to examine and report upon any specimen from a suspected patient which may be submitted by a private practitioner. It empowered them to undertake propaganda and to give information to the public about their arrangements for treatment and diagnosis.

Unlike many other infectious diseases, venereal diseases are not notifiable, i.e. a doctor is not required to inform the Medical Officer of Health of a case coming within his notice. The Local Authority provides facilities for treatment and diagnosis, makes (or should make) them known to the public, and leaves the sufferer free to take whatever action (if any) he chooses to secure medical attendance. He may be in a condition gravely dangerous to himself and to the community, but no legal power exists (except in certain limited circumstances, described later), as it does in the case of other communicable diseases, to compel him to undergo treatment and to provide safeguards for others. Nor, having begun treatment, can he be prevented from abandoning it before cure is effected. In the case of a child a parent can be proceeded against for causing injury to health or unnecessary suffering by neglecting to secure medical treatment.

There has been considerable controversy for a long time about the question of notification. The argument against it is that a sufferer might be deterred from going for treatment by the knowledge that his name and address would be sent to the Medical Officer of Health and thus the fact that he was being treated for venereal disease perhaps become widely known. It is said, on the other hand, that without notification it is not possible to take effective steps to control venereal diseases by the compulsory treatment of infected persons and the sources of infection, and the compulsory examination and, if necessary, treatment of contacts. Several Local Authorities have, from time to time, sought powers to make venereal diseases notifiable, but Parliament has not granted them.

During the war, because of the increased prevalence of the disease, by a Defence Regulation (33B) certain limited powers to compel treatment were introduced. The Regulation provides that when two patients name the same person as being the source of their infection, such person can be required by the Medical Officer of Health of the county or county borough in which he or she lives to attend for examination and if necessary for treatment and to continue such treatment until certified not to be suffering from the disease in a communicable form.

Facilities for the diagnosis and treatment of venereal disease must be made available under conditions of secrecy and generally without charge. These facilities must be available to all persons, irrespective of place of residence. A considerable number of patients attend for treatment at centres in neighbouring towns rather than in their own, even though clinics must not be designated as such. Reasonable travelling expenses of patients may be repaid. Centres are customarily held in the premises of a municipal or (by arrangement) a voluntary general hospital, and must be open at times which make it possible for patients to attend without having to obtain leave from their work. Sessions are separate for each sex, except in the case of infants, who may be dealt with at women's clinics, and young children, for whom special sessions may be held in school clinic premises. Where bed accommodation is required for certain forms of treatment this must be provided. Names and addresses of patients are kept separate from the records, which are identified only by numbers, thus maintaining the greatest degree of secrecy.

There should be close co-ordination between the venereal diseases scheme and the maternity and child welfare and school medical services, so that suspected cases may be referred for diagnosis and any necessary treatment with as little delay as possible.

By international agreement (Brussels Agreement 1924) free facilities for seamen are provided at most ports throughout the world, patients being supplied with a card giving particulars of the types of treatment which have been received, which they submit at each centre at which they attend. A similar arrangement is in operation in this country for long-distance haulage drivers.

One of the problems in connection with the treatment of venereal diseases is the defaulter—the patient who stops attendance for treatment before cure is effected. Local Authorities are empowered to employ suitable trained persons to visit defaulters in their homes and urge upon them the need for continued attendance, and to trace contacts.

The Venereal Diseases Regulations authorize Local Authorities not only to give information to the public about their arrangements for diagnosis and treatment, but to carry out educational work by way of lectures, film shows, exhibition of posters and the like. Most Local Authorities entrust the greater part of this propaganda to the Central Council for Health Education, which took over responsibility for this work from the British Social Hygiene Council in 1941.

For the purpose of providing for the diagnosis and treatment of venereal diseases, the London County Council has entered into a scheme with the Councils of the Home Counties and of Croydon, East Ham and West Ham, each Local Authority contributing to the cost. All but one of the treatment centres are established in voluntary hospitals: the exception is administered by the London County Council.



## CHAPTER VI

### *The Care of the Mentally Afflicted*

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MENTALLY afflicted persons fall into two groups, each of which (broadly speaking) is the subject of distinct legislation and of different methods of care.

The first comprises persons of unsound mind (Mental Treatment Act 1930). These are persons who have attained normal mental development, but who through illness, accident or other cause (which may be unknown) depart materially from common standards of behaviour, intelligence or judgment. It follows that the condition of such persons may be remediable, and indeed in recent years much has been done by way of treatment to restore patients to normality.

The second group consists of mentally defective persons who (Mental Deficiency Act 1927) suffer from "arrested or incomplete development of mind existing before the age of eighteen years whether arising from inherent causes or induced by disease or injury." Little can be done for many mentally defective persons except the provision of care and protection, both in their own interests and that of the community.

The principal central authority dealing with persons of unsound mind and mental defectives is the Board of Control, which consists of five Commissioners and which has a general responsibility to the Minister of Health. It has wide powers of supervision over the administration of legislation: it approves institutions, and visits and inspects them, and maintains institutions (known as State Institutions) for mental defectives of dangerous and violent

proclivities. The Ministry of Health is charged with the superintendence of the relief of mental defectives where they are still dealt with by Public Assistance Committees. Many Local Authorities have not yet put into operation Section 5 of the Local Government Act 1929, which provides that "as soon as circumstances permit" all assistance which can lawfully be provided other than by way of poor relief shall be provided exclusively under the Mental Deficiency Act 1913. The Home Secretary exercises jurisdiction over criminal lunatics. The Ministry of Education is responsible for the general supervision of Local Authorities in respect of the ascertainment of mentally defective children between the ages of 2 and 16 and of the education of educationally sub-normal children in special schools or classes.

#### *Persons of unsound mind*

Local Authorities under the Lunacy and Mental Treatment Acts 1890 to 1930 are the councils of counties, county boroughs and certain specified boroughs, although the cost of the treatment and maintenance of rate-aided patients falls only upon the two former as Public Assistance Authorities. The Local Authority is under obligation to provide and maintain a mental hospital or hospitals for rate-aided patients. The mental hospital may be provided outside the Local Authority's area. In such a case the council and justices of the area have full power to act in the county or borough in which the hospital is situated. Local Authorities may be joint owners of mental hospitals. The Local Authority is also required to investigate the needs of its area and to provide accommodation for the reception of temporary patients. It may provide accommodation for private patients and for voluntary patients. Subject to the approval of the Board of Control, it may contract for the reception of temporary or voluntary

patients in institutions not maintained out of public funds.

Apart from the case of temporary patients, there is no statutory requirement on the part of the Local Authority (as there is in regard to mental deficiency) for the ascertainment of mental disorder. For a person of unsound mind to be dealt with a petition, supported by two separate medical certificates (one signed by the patient's customary doctor) must be presented by the nearest relative to a Judicial Authority, who may make an order for the reception of the patient into a mental institution. In the case of the rate-aided patient, i.e. one who is not financially able to secure treatment as a private patient, a relieving officer must notify a Justice of the Peace, who is required to visit the patient and who may appoint a medical practitioner to examine and report upon him. If, on consideration of the report, the Justice is satisfied that the patient is of unsound mind he may make an order for admission to a mental hospital. If a relieving officer feels that it is necessary for the public safety or for the welfare of the patient that the patient should be removed to a place of safety pending certification, he may have him detained in a Poor Law institution or public health hospital. The Justice must then visit the patient and the proceedings described above be carried out in the institution or hospital. In the case of a person of unsound mind who is not under proper care or control, or who is neglected or cruelly treated, a constable or relieving officer must report to a Justice, and a similar procedure ensues. The great majority of mental patients (about 90%) are rate-aided cases. A senile or harmless rate-aided patient may be removed from a mental hospital and received in a public assistance institution or a general public health hospital when it is possible for him to be accommodated apart from the other inmates, or when his condition is such that separation is not necessary.

The Mental Treatment Act 1930 created two new classes of mental patient—the temporary and the voluntary patient. The former, on written application to the Local Authority by the nearest relative or person in charge, accompanied by the recommendation of two doctors, one of whom must be approved by the Board of Control, may be received in an institution for temporary patients. There is no need in such case for a judicial order. A temporary patient cannot be detained as such for longer than six months, except with the consent of the Board of Control, who may extend the period for another three but not more than six months. If he becomes capable of expressing himself as being willing or unwilling to continue treatment he may not be detained for more than a further twenty-eight days, unless in that time he becomes again incapable of so expressing himself.

A voluntary patient may make personal application for admission for treatment: in the case of a person under sixteen, the application may be made by the parent or guardian, but must be accompanied by a medical recommendation of the family doctor or one approved by the Board. No judicial order is required. He may leave the institution on giving seventy-two hours' notice (in the case of the patient under sixteen this is given by the parent or guardian).

The 1930 Act empowers a Local Authority to make arrangements for the treatment as out-patients of persons suffering from mental illness: such treatment may be given gratuitously. It may provide for the after-care of patients, either directly or by contribution to the funds of after-care associations. Similarly it may give financial assistance to voluntary bodies for the prevention and treatment of mental illness and (with the consent of the Board of Control) to bodies engaged in mental research.

In London the institutional treatment of mental patients

is the responsibility of the County Council and of the City Corporation. The procedure in regard to certification and judicial orders is, however, undertaken by the County Council throughout the whole of London. The Council has delegated its powers both in regard to mental disorder and mental deficiency to the Mental Hospitals Committee.

### *Mental defectives*

Mentally defective persons are defined by the Mental Deficiency Act 1927 as follows:

- (a) Idiots, who cannot guard themselves against common physical dangers.
- (b) Imbeciles, who cannot manage themselves or their affairs; or, in the case of children, be taught to do so.
- (c) Feeble-minded persons, who require care and supervision for their own sake and for that of others.
- (d) Moral defectives, in whose case mental defectiveness is linked with vicious or criminal tendencies and for whom control is necessary for the protection of the community.

It is the duty of the Local Education Authority to ascertain mentally defective children between the ages of 2 and 16. Many authorities have instituted a system of routine intelligence tests applied by teachers in what until 1945 were known as elementary schools. When a child's mental age appears as a result of a test to be below its actual age, the School Medical Officer is informed and the child's mental ability is examined by a specially qualified member of the medical staff. No action can be taken in respect of a child unless a form of medical certificate (appropriate

forms are supplied by the Ministry of Education) has been completed and signed. If a child is found to be educationally sub-normal, but not ineducable, there must be provided "some specialized form of education wholly or partly in substitution for the education normally given in ordinary schools." This may be tuition given individually or in small groups or classes in such a school, or in a special school. A special school may be a day or residential school; the latter is required where home circumstances are very bad or to serve sparsely populated areas. Since the number of children in a town may not justify more than one day special school, many of the children may have considerable distances to travel from their homes. In such case, the authority may employ guides to take groups to school; it may collect children in motor conveyances; it may board out children near to the school. A parent is obliged to see that his child is appropriately educated, but he has a right to dispute certification of mental deficiency.

Special schools are staffed by specially qualified teachers. The children are educated within the limits of their capacities, a number of higher grade cases becoming capable of earning their living and leading independent lives. An informal after-care committee, of which the head teacher should be a member, can be very helpful to this type of young person in the first year or two after leaving school, since it may not be necessary to refer them to the control of the Mental Deficiency Committee.

Facilities (such as the provision of medical inspection and treatment and of meals) which are available for normal children are likewise available for sub-normal children receiving education.

The following classes of children between the ages of 2 and 16 must be referred by the Education Committee to the Mental Deficiency Committee to be dealt with :

- (a) Children who are incapable of deriving benefit or further benefit from education in special schools or classes.
- (b) Children whose presence in such schools or classes is detrimental to themselves or to other children.
- (c) Children in whose case special circumstances make it desirable that they should be dealt with by the Mental Deficiency Committee.
- (d) Children who are about to leave a special school or class, and to whose benefit it would be to be placed under the supervision of the Mental Deficiency Committee.

The case records of children who leave special schools or classes without being notified to the Mental Deficiency Committee should be destroyed.

The Mental Deficiency Authority must ascertain what persons in their area over 16 are defectives "subject to be dealt with" under the Mental Deficiency Acts. The circumstances which make a person subject to be dealt with (apart from those already mentioned) are as follows:

- (a) That he is neglected, abandoned, cruelly treated, or without visible means of support, or that his parent or guardian has intimated that the necessary care or training cannot be provided at home.
- (b) That he has been found guilty of a criminal offence, or is in an approved school, prison, or mental institution; or, being a woman in receipt of poor relief, is pregnant of or has given birth to an illegitimate child.

It will be seen that a mentally defective person does not come under the control of the law except when certain other conditions also exist.

Duties in connection with ascertainment must be undertaken by qualified officers of the Local Authority (who need

not be doctors) or by officers of approved voluntary bodies. The efficiency of ascertainment depends very largely upon co-operation between the officer and other departments of the Local Authority, mental welfare associations and other voluntary societies in the area.

The Mental Deficiency Committee must deal with each case referred to it in one or other of three ways, according to which is appropriate.

If home circumstances are favourable, the defective may be supervised at home. Such cases are generally those referred by the Education Committee. Supervision is carried out by specially appointed officers, by health visitors or through local mental welfare associations, to whom grants are paid. The frequency of visits depends upon the type of case and the home conditions. The function of the visitor is to report to the Medical Officer of Health, to advise parents on possible home training, and to be generally helpful (e.g. in trying to find employment where this is possible). If it is found that home supervision does not give sufficient protection to the defective, other methods of dealing with him must be employed. The local deficiency authority has no power to give financial assistance to the relatives of a defective under home supervision.

Training and occupation may be provided for defectives under supervision, either by the authority or through the agency of a voluntary organization. Occupation centres cater for low grade defectives notified by the Education Committee. They do not give vocational training, but attempt instruction in simple handwork and domestic work and teach the elements of personal hygiene and obedience. The teacher should have had some training for her task : this may be provided by the Central Association for Mental Welfare.

Local Authorities may also maintain industrial centres for supervised defectives over 16. At these, the higher



grade cases engage in productive work of various kinds, the less competent in simple occupations. Both types of centre are not only of benefit to the defectives, but relieve the members of the family, especially the mother, of the responsibility for care and supervision for several hours of each day.

Where the method of home supervision is inappropriate, a defective person must, according to circumstances, be placed under guardianship or committed to a residential institution. In both cases the order of a judicial authority is required.

A petition for an order may be presented by a relative of the defective or by an authorized officer of the Local Authority. The petition must be accompanied by two medical certificates, one signed by a medical practitioner, approved for the purpose by the Authority or the Board of Control, and by a statutory declaration made by the petitioner and at least one other person (who may be one of the two doctors who signed the medical certificates). The declaration must state (*inter alia*) that the person named is a mentally defective person of a certain class, and that he is a person subject to be dealt with under the Acts, giving the reasons therefor. If the defective is between the ages of 5 and 16 he must have been notified by the Education Committee to the Mental Deficiency Committee before the petition is presented.

When a petition has not been presented by a relative an order may not be made without the consent in writing of the relative, unless this is withheld without proper reason or the relative cannot be found.

If the judicial authority is not satisfied that the person to whom the petition relates is a defective, he may dismiss the petition, or may adjourn the case for not more than two weeks for further information, and may order the person to have a further medical examination.

The object of guardianship is to secure proper care and supervision of the defective, the guardian being required to provide for the education, training and general interests of the defective both mentally and physically. Regulations require that he shall keep certain records, notify change of address, and so forth. The deficiency authority must arrange for the defective to be visited at least quarterly. The home may be visited at any time without notice by the Commissioners or Inspectors of the Board of Control. By means of a varying Order a defective under guardianship may be sent to an institution or vice versa.

The deficiency authority are empowered to pay for the maintenance of a defective under guardianship. The guardian may be a parent or near relative, who for economic reasons would otherwise find it difficult to provide proper care for the defective. Cases suitable for guardianship are amenable, medium-grade adult defectives and imbecile children, whose parents (where they are guardians) are able, with financial help, to provide a good home. Difficulties are often experienced in finding suitable guardians other than parents or relatives.

Apart from the State institutions (Rampton and Moss Side) for violent mental defectives which are managed by the Board of Control, accommodation is provided in certified institutions, public assistance institutions, public health general hospitals, certified houses and approved homes. Certified institutions are provided by deficiency authorities and voluntary bodies; deficiency authorities in many cases co-operate in the provision of a certified institution. On the application of a Local Authority, and with the consent of the Ministry of Health, the Board of Control may approve the use of a public assistance institution or public health general hospital for the accommodation of defectives. Approval is not given unless the defectives are separated completely from the other inmates. Persons

received into public assistance institutions as defectives are not considered to be in receipt of poor relief. Certified houses are run for private profit. In approved homes the inmates are maintained wholly or partly by voluntary contributions. Beds in the two latter types of institution comprise only about 2% of the total bed accommodation provided for mental defectives.

All institutions for mental defectives are subject to regular inspection by the Board of Control, and must be visited by members of the Local Authority or committee of management.

On the application of the deficiency authority, a judicial authority may make an order requiring a defective person, or any person liable to maintain him, to pay such contribution to the cost of his maintenance under guardianship or in an institution as seems reasonable.

Defectives dealt with in institutions are those for whom closer care and supervision are required than can be given at home or under guardianship, in the interests of defectives and community alike.

The superintendent of an institution under certain conditions may grant to an inmate a licence to be absent. The defective must (generally) reside with the person named in the licence, who must enter into any necessary undertaking with regard to due care and supervision. Types of defectives released on licence are high grade cases for whom work (e.g. domestic service) is available and lower grade harmless cases likely to be amenable at home. If the defective causes difficulties, or if the conditions attaching to the licence are not observed, the licence may be revoked and the defective sent back to the institution without the need for further certification or judicial order.

The deficiency authority must make annual reports of a nature laid down by regulations to the Board of Control and furnish such other reports as the Board may require.

The London County Council is the deficiency authority for the whole of London, including the City. As already noted, the Council has delegated its powers under the Mental Deficiency Acts and the Lunacy and Mental Treatment Acts to the Mental Hospitals Committee.

## CHAPTER VII

### *General Hospitals*

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ALTHOUGH the Sanitary Act 1866 gave power to Local Authorities to provide hospitals "for the reception of the sick," it was used in practice almost exclusively to provide hospitals for infectious diseases. The only hospitals maintained out of public funds were the poor law infirmaries, since Boards of Guardians were compelled to make provision for the destitute sick, either in general hospitals or in other institutions. For a good many years before 1930, when the Boards of Guardians were abolished, these infirmaries had been increasingly used by the general public, although all patients were admitted technically as paupers. This development was due to the inability of voluntary hospitals to meet the growing demand for treatment in hospital, which arose partly because of the introduction of new techniques which could not be applied in a patient's home, and partly because of a breaking-down of public dread of hospital treatment. The quality of poor law infirmaries had been immensely improved during the present century in regard to staff, equipment and facilities. When the Local Government Act 1929 abolished the Boards of Guardians and handed over their powers, duties and property to the councils of counties and county boroughs, these authorities found themselves the owners of general hospital accommodation on a large scale. In a good many cases poor law unions did not coincide with county or county borough areas, and transferred hospitals, therefore, served the needs of more than one Local Authority. The Local Government Act 1929 accordingly

provided that ownership of such a hospital should be vested in one of the Local Authorities concerned or in two or more jointly or in a joint body representing two or more. In the event of the first alternative being adopted, an agreement had to be made for the reservation of accommodation for patients living in the areas of the other Local Authorities.

Section 5 of the Act empowered Local Authorities to declare that hospital treatment should be provided by virtue of the Public Health Act 1875 (which had repeated with some modification the power given by the Sanitary Act 1866 to provide hospitals) instead of by way of poor relief. Section 14 conferred upon county councils (including the London County Council) similar powers to provide hospitals as were conferred upon urban and rural sanitary authorities by the Public Health Act 1875. The same section also extended to county and county borough councils the power given in the latter Act to include the power to provide hospital accommodation for pregnant women, who are not necessarily sick persons.

The Local Government Act, therefore, afforded the opportunities to the new owners of poor law infirmaries to transform them by a process of "appropriation" into public hospitals, without prejudice to their powers to build such hospitals, including maternity hospitals.

For various reasons a considerable number of hospitals are still administered as poor law hospitals—that is, they have not been "appropriated." In some cases the buildings are old and so out-of-date as to be incapable of adaptation to modern requirements. In others they form an integral part of poor law institutions, impossible of separation. The need to spend considerable sums of money to improve the quality of hospital services if hospitals are to cater effectively for the general public has deterred some Local Authorities from utilizing the powers given to them

by Section 5. Local Authorities must recover the whole of the cost of maintenance in a public health hospital (with the exception of an infectious diseases hospital) from a patient or from any person legally liable to maintain him, except when they are satisfied that because of financial circumstances only a part or no part of the cost can be paid. There has been a belief on the part of many Local Authorities that these powers of recovery are not as wide as those given by the Poor Law Act, and that accordingly the cost of administration would be higher in an appropriated hospital. The Minister has stated, however, that he has been legally advised that the range of relatives covered by the Local Government Act is in fact as wide as that laid down in the Poor Law Act. Local Authorities which have appropriated hospitals in any case are able to protect themselves against possible financial loss either by admitting all patients formally as poor law cases (i.e. on a relieving officer's order) or by declaring patients who after admission are found to be destitute to be in fact admitted under the poor law. It is not, however, possible under the Public Health Acts to recover the cost of treatment from a patient's place of settlement or in respect of a patient admitted from the area of another Local Authority from that Authority unless an agreement exists to that effect.

For the purpose of assessing ability to pay Local Authorities formulate an income scale, which takes into account earnings, contribution to household income by members of the family, dependants and outgoings such as rent. The income scale may be applied by a financial officer of the Local Authority, who is made responsible for the collection of payments; or by a member of the hospital staff, who may be given limited discretionary powers in regard to assessment.

Notwithstanding the above provisions, the Local Authority may enter into an arrangement with an associa-

tion providing hospital benefits for its members for the payment by the association of an agreed sum for the maintenance of a member in lieu of recovering from the patient or his relatives. The agreed sum is usually materially less than the cost of maintenance, but it is fixed at a figure which, taking into account that many patients otherwise would pay less than cost or nothing at all, provides an annual amount approximately the same as would have been received had payment been secured from patients or their relatives. The arrangement is of considerable advantage to the Local Authority since the work of assessing and collecting payments of many patients is eliminated. It is probable that at least a quarter of the population is now included in Hospital Savings Associations of one kind or another.

The cost of maintenance is the average daily cost per patient of the whole cost of the hospital: that is, a flat rate of charge irrespective of how expensive a particular patient's cost of treatment may be. Higher charges may be made for private ward accommodation. Poor Law hospitals are required to submit returns showing institutional costs in a prescribed manner to the Ministry of Health.

Local Authorities may charge for out-patient treatment, and in some cases Hospital Savings Associations make a payment for this; but Local Authorities have no power to sue for recovery of payment.

The proportion of the cost of maintenance in Public Health general hospitals which is paid by patients or their relatives or from contributory schemes is so small (about 10%) as to suggest that much work involved in assessment and collection and a certain amount of hardship to patients might be eliminated without any appreciable burden being placed upon the rates if treatment were provided free of charge.



Local Authorities have no general powers to provide hospital accommodation for persons not resident in their area. As a result there may be a waiting list of patients for a hospital belonging to one Local Authority and vacant beds in a hospital in an adjacent town. Further, a patient may be found to be in need of certain specialized treatment which is not provided in the hospital of which he is an inmate; but he cannot be admitted into a neighbouring hospital where the treatment is available in the absence of any agreement between the Local Authorities. Specific exceptions, however, have been made in regard to the hospital treatment of venereal diseases and of infectious diseases: in the former case any persons, in the latter case temporary residents (e.g. people on holiday) may be admitted.

The power to provide hospitals not only enables a Local Authority to build and maintain its own hospital but to contract for the use of a hospital (or part of it) which is not their property or to pay the managers of a hospital to receive the Local Authority's patients. Payment may be on an annual or a *per capita* basis. In the case of a small or financially weak Local Authority it may not be practicable to provide a hospital of sufficient size to be efficient and economical. There appears to be no legal reason why such an Authority should not contract with an adjoining Local Authority owning a hospital for the reception of all their cases, and for the hospital to be planned by its owners to accommodate such cases. The joint use of a hospital under such an arrangement avoids the difficulties which may arise from joint ownership, and which are discussed elsewhere. The Local Government Act 1933 enables a Local Authority owning a hospital to include on the hospital committee persons who are not members of the Authority. By this means the contracting Authority may be represented and exercise some say in the management of the hospital.

The joint ownership of hospitals is authorized by the Public Health Act 1875. Such ownership is commonest in regard to infectious diseases hospitals and tuberculosis sanatoria.

The Local Authority may give subscriptions to voluntary hospitals serving the inhabitants of their area of an amount in any one year not greater than the product of a rate of  $1\frac{1}{3}$ d. in the £.

Local Authorities are required by the Public Health Act 1936 when making provision for hospital accommodation (except in respect of infectious diseases) to consult the governing bodies and medical staff of voluntary hospitals serving their area. If the best results are to be secured from the hospital resources of an area there should be close and continuous co-operation between the municipal and voluntary authorities. Public and voluntary hospitals should be complementary to and not in competition with each other. Without co-operation it is possible, for example, for both hospitals in the same area to install expensive equipment when one or other could have met all the local need for the particular form of treatment thereby made available. At the same time another equally important form of treatment may be provided by neither. One hospital can be used to relieve another in times of especial pressure upon accommodation. Particular services (e.g. maternity) may by agreement be concentrated at one hospital. Interchange of patients may be arranged.

Differences in outlook and perhaps a certain amount of mutual suspicion may prevent co-operation from being as close as it might be, and ought to be, in the interests of the public. The natural unwillingness of voluntary hospitals to admit either destitute or chronic cases is sometimes a ground for resentment on the part of Local Authorities. Greater barriers to uniformity of administration and practice are firstly that voluntary hospitals are not restricted,

as are municipal hospitals, to the admission of patients living in a particular area; and secondly, that voluntary hospitals make such charges for treatment as they wish, while Local Authorities must recover the whole or part of the cost of maintenance. Arrangements for the transfer of patients from one type of hospital to another, therefore, present practical difficulties. Co-operation can best be effected by the appointment of a joint committee of the Local Authority and the governing body of the voluntary hospital, which can meet at regular intervals or at the request of either side. It can be secured by less specific means by the co-option of voluntary hospital representatives on to the appropriate committee of the Local Authority and the appointment of members of the Local Authority and of their Medical Officer of Health on to the hospital committee.

The power to provide hospitals includes the power to afford out-patient facilities. There has been a considerable extension of these facilities in recent years. An efficient out-patient system enables the period of in-patient treatment to be reduced in many cases. The institution of arrangements for attendance by appointment lessens materially the length of time patients have to wait for consultation or treatment and the discomfort endured by patients and staff alike which results from overcrowded waiting-rooms.

It is the duty of every Local Authority providing a hospital to appoint such officers and servants as they think necessary, the rate of remuneration (which must be 'reasonable') and the term of office being decided by the Council. In the case of a Joint Hospital Board the responsibility in these respects is laid down in the provisional order setting up the Board. Certain officers must be employed in a poor law hospital and in a mixed institution (i.e. an establishment for the reception of the poor other

than a hospital). Such officers are in the former case a Medical Superintendent, a Matron, a Steward and a Chaplain; and in the latter a Medical Officer, a Master, a Matron and a Chaplain, and if there are a hundred beds or over for sick inmates, a Superintendent Nurse. The Public Assistance Order prescribes in detail the qualifications, duties and conditions of service of these officers.

The size of the medical and nursing staff naturally depends on the size of the hospital. In most cases, in addition to the resident Medical Staff (the senior of whom may be Deputy Medical Superintendent) there will be part-time consultants (e.g. gynæcologist, ophthalmologist). These may be paid at a rate per visit or at an annual salary for so many regular sessions per week.

The duties of the steward, in either a public health or a poor law hospital, have altered and extended materially in recent years. The tendency has been for him to become more and more a lay administrator, somewhat akin to the Secretary-Superintendent of a voluntary hospital, responsible for the compilation of statistics and returns, the preparation of estimates and committee business and the general management of the clerical and non-professional staff. Though it may not be easy to define the boundary between his responsibilities and those of the Medical Superintendent, it should be so devised as to allow the latter to be as free as possible to undertake the purely medical administration of the hospital. A number of hospital stewards have obtained the Institution and Hospital Officers' Certificate of the Poor Law Examination Board. More recently the examinations of the Institute of Hospital Administration have been open to them. Through their Association (the National Association of Administrators of Local Government Establishments) they are pressing, however, for the institution of a qualification of higher status specifically for the administrative staffs of public hospitals,

possession of which they hope will in time become a requirement for appointment.

Local Authorities have been much behind the governors of voluntary hospitals in the appointment of almoners. Voluntary hospitals have always had the need for staff to undertake the assessment of patients' payments, since no fixed charge (except a maximum) is made and the amount of payment depends upon individual circumstances. In the case of the poor law hospital patients were either destitute or had the assessment made by the relieving officer who gave the order for admission. Where a poor law hospital has been appropriated the rate of charge is determined by the application of an income scale. It is being increasingly recognized, however, that an almoner has functions to perform of more importance than the assessment of capacity to pay. Not only the voluntary hospitals but a growing number of municipal hospitals realize this, and are therefore appointing trained persons possessing the certificate of the Institute of Hospital Almoners. This certificate is issued to candidates who have either Degrees in Social Science or Certificates or Diplomas awarded by University Departments of Social Science, who have successfully undergone some months of practical training and experience arranged by the Institute. The almoner's work consists in putting patients or their dependants in touch with public or voluntary agencies that may be of help to them, informing them of their position in regard to contributory and other insurance schemes, arranging for the supply of surgical appliances, and generally being of as much assistance in a variety of ways as possible.

As well as having power to provide and maintain ambulances for the conveyance to hospital of persons suffering from infectious disease, Local Authorities may use such ambulances for sick persons discharged from hospital so long as precautions against infection are taken.

A reasonable charge may be made. Sanitary authorities (i.e. councils of boroughs, urban districts and rural districts) may provide ambulances for cases of accident or sudden or urgent disability; or may allow them to be used by other Local Authorities or persons on agreed terms.

Persons carrying on nursing homes must be registered by the county or county borough council (Public Health Act 1936). A nursing home means premises used for the nursing of persons suffering from sickness, injury or infirmity, but does not include (a) a hospital owned by a Local Authority or by any body constituted by Act of Parliament or incorporated by Royal Charter: or (b) institutions for persons of unsound mind or for mentally defective persons. Registration may be refused if the applicant or any person employed by him is not a fit person; or if the premises, in respect of situation, state of repair, accommodation, staffing or equipment are considered to be unsuitable; or if (except in the case of a maternity home, which is dealt with in an earlier chapter) the home is not under the charge of a resident doctor or qualified nurse, or if there is not a sufficient number of qualified nurses. Registration may be cancelled if the requirements for registration are not being observed. Appeal against refusal or cancellation of registration may be made to a Court of Summary Jurisdiction. The Local Authority may make by-laws about records to be kept, and may inspect the premises and records (except medical records) at any reasonable time. Hospitals and institutions not carried on for profit may be exempted from the provisions of the Act. A county district may apply to the county council to exercise the functions of the county council in respect of any nursing home in its area.

The provision of hospital accommodation in the metropolitan area is made by the London County Council, to which were transferred by the Local Government Act 1929

all the functions of the Metropolitan Asylums Board. Section 18 of the Act provides in particular that the County Council shall have power to admit into its hospitals children from schools outside London. In addition to these transferred powers, the County Councils were given power to provide places for the reception of the sick and of pregnant women. The City Corporation and the metropolitan borough councils, being sanitary authorities under the Public Health (London) Act 1891, also have power to provide hospital accommodation either by building hospitals or entering into agreements with hospital authorities to provide it. They do not, in fact, use these powers, except in regard to maternity homes.

The general division of responsibility for the County Councils' institutions as between the Hospitals and Medical Services' Committee and the Public Assistance Committee is that the former should be concerned with persons who are primarily in need of medical care, and the latter with destitute persons in need of assistance and who may need medical care. Persons suffering from acute diseases, the chronic sick requiring continuous medical attention, mental patients and sick children are, therefore, all the responsibility of the public health department. The County Medical Officer of Health is responsible for the medical care and treatment of all sick persons, whether they be in public health or public assistance institutions.

Special units for certain branches of medical or surgical work which are highly specialized have been established at some of the general hospitals. The purpose of these units is to economize on equipment; to have medical and other staff who can best gain experience if patients suffering from particular conditions are concentrated in one hospital instead of being dispersed over many; and to meet the convenience of specialists and consultants who may be associated with the work (including research) which is being undertaken.

Out-patient treatment is provided at a number of general hospitals. The following categories of out-patients are included among those for whom treatment is available : casualties, accidents and emergencies referred by their doctors or attending on their own initiative for initial treatment, subsequent treatment being dependant upon inability to obtain it otherwise ; patients referred by their own doctors if they cannot obtain the service themselves ; former in-patients requiring continuation or after-care treatment ; and patients referred by a medical officer of the council. Certain special out-patient facilities are also provided, e.g. for diabetic cases. There is a uniform scale of charges for out-patients except for first attendances, unless these are made by former in-patients or for X-ray examination.

Co-ordination with voluntary hospitals is achieved through the Voluntary Hospitals Committee, which consists of representatives of the council, the voluntary hospitals and the Ministry of Health. Certain of the public general hospitals are associated with the medical schools of the voluntary hospitals so that students may obtain some of their training in the public hospitals.

The London County Council has extensively developed the laboratory service of the Metropolitan Asylums Board.

Ambulances are provided free of cost within the Council's area (except in the City of London, which maintains its own service) for accident cases, cases dangerously ill at home, urgent confinement cases, cases suffering from infectious disease, and non-infectious cases on the application of the public assistance department or of the Councils' hospitals.



## CHAPTER VIII

### *Poor Law and other Services*

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#### *Poor Law medical services*

THE long association of public health with the poor law still continues, since it is generally accepted that domiciliary medical care of the destitute cannot be provided under any other legislation and much other provision may be made either by way of poor relief or under various public health acts. The Poor Law Act 1930 places upon Public Assistance Authorities the duty of providing "such relief as may be necessary for the lame, impotent, old, blind and such other persons as are poor and not able to work." This means in effect that all necessary medical attention which cannot be obtained out of a person's own resources or from any other source must be given by the Public Assistance Authority.

The Local Government Act 1929 (Section 5) enables Local Authorities to undertake to provide medical care where it can be provided either by way of poor relief or by virtue of Public Health Acts exclusively under the latter. The intention of the Section was to allow for the poor law medical services to be absorbed into the general public health service and thus to secure unification in place of division and overlapping. Many Local Authorities have made declarations that certain forms of medical care (e.g. for mothers and young children) shall be provided other than by way of poor relief. For various reasons, such declarations have not been made nearly so extensively about other forms of care, especially in regard to institu-

tional treatment. The movement for the unification of health services has thus gone farther in the areas of some Local Authorities than in others; but it is nowhere complete, since domiciliary care (except for persons who can make their own arrangements and persons covered by the National Health Insurance Acts) is still everywhere provided under the poor law, and in most cases is the responsibility of the public assistance and not the public health committee. Very often indeed it is a function which is administered almost wholly in dissociation from the rest of the health services. Yet the Public Health Act 1875 is one of the statutes specified in Section 5 of the Local Government Act by virtue of which assistance can be exclusively given instead of by way of the poor law. Section 133 of the Act states that "any Local Authority may . . . themselves provide or contract with any person . . . to provide . . . medical assistance for the poorer inhabitants of the district." The section has been employed to give domiciliary medical care during epidemics of typhus and has been repeated in the Public Health Act 1936 (Section 177). Since there appears to be no reason to conclude that it relates only to epidemics, it would seem competent for a Local Authority (with the sanction of the Minister of Health) to declare that the domiciliary care of the sick poor should be provided under the Public Health Act instead of the Poor Law Act. The Ministry of Health has, however, expressed the opinion that it is not competent for a Local Authority to make such a declaration; and it may be noted that both in regard to maternity and child welfare and the medical care of school children domiciliary treatment is specifically prohibited.

In all cases, in fact, medical relief in the home is administered under the poor law; and in many cases, where no declarations or only partial declarations have been made under Section 5 of the Local Government Act,

other forms of medical service also (e.g. hospital accommodation for tuberculosis patients).

The general practice is for the Public Assistance Authority to appoint a general practitioner as district medical officer responsible for the medical care of destitute persons in each relief district. He is required to reside in his district except in special circumstances. As a senior poor law officer he cannot be dismissed without the consent of the Minister of Health. Appointment may be on a temporary basis: this allows the Local Authority to introduce a different method of dealing with the sick poor without having to compensate a dispossessed officer. The amount of salary naturally varies in accordance with the amount of work involved, and ranges from £100 to £350. In a few cases full-time doctors are appointed; but it has not always been found easy to get applicants for a rather depressing job. This method is regarded with disfavour by the British Medical Association as a further encroachment on private practice.

The engagement of general practitioners on a part-time basis has or may have unsatisfactory features. The district medical officer will probably have both private and national health insurance patients, and through pressure of work may be unable to give sufficient time to his poor law patients. The sick person has no choice of doctor: he may only be attended by the medical officer of the district in which he lives. He has therefore little or no remedy against insufficient attention or want of consideration. Furthermore, since the district medical officer is usually well known in his area, his visit to a house is an indication that the inmate is receiving relief, which may cause a feeling of humiliation to a man who may be temporarily in unfortunate circumstances.

For these reasons some Public Assistant Authorities have instituted a panel or open choice system, which is similar

to the method employed in the national health insurance scheme. Any private practitioner may elect to serve on the panel, his remuneration not being on a salary basis, regardless of how much time he may have to devote to his patients, but at an agreed rate per patient or per visit, or a combination of both methods of payment. This system is of advantage both to doctor and patient. For the doctor there is a much closer relation between the work he does and the pay he gets for doing it. For the patient there is the strong probability that the doctor who customarily attends him (whether as a fee-paying or a National Health Insurance patient) will continue to do so, which from a medical point of view is desirable. In addition, he has the right to change his doctor, and thus has a remedy against unsatisfactory attention. Experience has shown that the open choice method of providing for the medically destitute is more costly than the original and still usual method, since the rate of remuneration has to be sufficiently high to attract the large number of doctors upon which the scheme depends. There can be no doubt of its considerable benefits. The consent of the Minister of Health is required for its introduction, since it requires departures from the Public Assistance Order.

It is the duty of a district medical officer to attend all poor persons in his district in need of medical attendance, but only (except in exceptional circumstances or in the case of persons on permanent medical relief) on a written order of the council or of a relieving officer. Should he have attended without an order he must inform the relieving officer immediately. He must supply any necessary medicines to his patients unless the conditions of his appointment provide for these to be supplied by chemists. A record of his attendances must be kept and submitted to the appropriate committee at every meeting, and he must give to the council, when required, any reasonable

information about any of his patients. He must supply the medical officer of a hospital or an institution to which one of his patients has been admitted with a statement on the medical history, and furnish to the Medical Officer of Health such information as may be required about cases of illness and death among his patients.

A relieving officer in a case of sickness or accident where it is not possible for medical attendance to be procured otherwise must issue an order on a district medical officer (or on a "panel" doctor where this method is employed) or an admission order to hospital in the event of urgency. Such an order must be given even where a man is earning wages if at the moment of applying he is destitute, in the sense that he is unable to pay for medical attendance. Visits must be paid to the home of a poor person receiving medical relief by the relieving officer, who is required to give any other form of relief (except money) as he thinks fit or on the written recommendation of the medical officer until the next meeting of the Relief Sub-Committee.

Admission to hospital is usually on the order of a relieving officer accompanied by the certificate of a district medical officer or other qualified medical practitioner. It may, however, be on an order signed by the clerk or medical officer of the council as a result of a particular direction of the council or of a general direction to cover cases in which the patient or other person is willing and able to pay the full costs of maintenance and treatment. This is a useful provision when the hospital is still maintained under the Poor Law Act, since it enables the hospital to be used by persons who are not medically destitute. A medical superintendent is authorized to admit without an order in urgent cases, but he must report such cases in writing to the committee.

The medical officer of a public assistance institution (who may be the medical superintendent of the hospital) has

to undertake certain duties specified in the Public Assistance Order. Among the more important of these are the regular visitation of all the inmates, the frequent examination of infants and children, and the examination of the bodily condition of lunatics or alleged lunatics on admission and immediately before removal. Provision must be made in the institution for the treatment and nursing of sick inmates.

The family of a destitute person has the legal duty (Poor Law Act 1930) of maintaining him, those liable being father, grandfather, grandmother, mother, husband or child. The cost of medical relief can be recovered from any or all of such members of the family. The Local Authority can also recover from the Local Authority of a destitute person's place of settlement.

#### *The welfare of the blind*

Before 1920 Local Authorities had no powers to undertake schemes for the general welfare of blind persons; although Local Education Authorities had the duty of educating blind children and the Boards of Guardians of relieving destitute blind persons. Voluntary agencies which were almost entirely dependant for funds upon private charity were responsible for such care as was given.

The Blind Persons Act 1920 required county and county borough councils to make arrangements, to the satisfaction of the Minister, for the promotion of the welfare of blind persons ordinarily resident in their area; and to make provision for the technical education of blind persons capable of deriving benefit from it.

Most Local Authorities included in their welfare schemes the grant of financial assistance to blind persons, but in nearly all cases dependants of blind persons had to resort to public assistance if they were in need; while some Local Authorities made no specific financial provision. The Blind

Persons Act 1938 remedied this unsatisfactory position. Assistance to blind persons, except in institutions or in the form of medical care, must be given by virtue of the Act and not by way of the poor law. Further, in determining the extent to which financial assistance is to be given, regard has to be paid to the needs of dependants. In deciding the amount of assistance, certain items of income are disregarded: the first 5s. sick pay from a Friendly Society, the first 10s. 6d. of National Health Insurance sickness benefit; the whole of maternity benefit; the first pound of war pension; and half any sum received in workman's compensation. In regard to savings, the first £25 is ignored; each £25 thereafter up to £300 is counted as equivalent to a weekly income of a shilling. The 1938 Act thus made obligatory (to a large extent) the power conferred by Section 5 of the Local Government Act 1929 to remove the blind from the care of Public Assistance Authorities. Blind persons who are otherwise qualified are entitled to non-contributory old age pensions at the age of forty. By this means part of the cost of financial assistance is borne by the Exchequer. Local Authorities may pay or contribute towards the funeral expenses of blind persons and their dependants. The cost of financial assistance may be recovered by the Local Authority which gives it from the Local Authority in whose area a blind person was previously ordinarily resident. Where there are a large number of cases on the register it may be necessary to appoint a special investigating officer, since financial circumstances may change and adjustments in the amount of assistance may have to be made.

To be included in the register and thus to be eligible for the benefits of the welfare scheme a person must be certified by a qualified and experienced medical practitioner to be "so blind as to be unable to perform any work for which eyesight is essential" (Blind Persons Act 1920). This

definition may cause difficulty, since an office worker, for instance, may be unable to continue in his occupation and yet be capable of doing unskilled labouring work. The Minister has, therefore, suggested that persons below a certain degree of visual acuity should generally be considered to be blind, and that certifying officers should be permitted to take other relevant factors into account. In the great majority of cases applicants are too old to be capable of work. It may be necessary to re-examine some of the persons on the register from time to time, as change in their vision may occur and they may have to be certified as no longer blind within the meaning of the Act.

Since a return of blind persons has to be made to the Ministry of Health it is advisable for the register to be compiled in such a way as to make the information easily obtainable. It should give particulars of age, cause of blindness, date of occurrence, eligibility for training and form of employment (if any).

A welfare scheme, in addition to providing financial help, includes (a) training for employment; (b) employment and (c) arrangements for promoting the social interests of the blind.

Training is usually provided in schools for the blind, that is, after ordinary education has ended at the age of sixteen, or in institutions maintained by voluntary organizations. The cost of training may be borne, or partly borne, by the Local Authority. The position in regard to training of persons who become blind during their adult life is not satisfactory, largely because of the want of any comprehensive scheme to find employment. The provision made by the Disabled Persons (Employment) Act 1944 for the training of physically handicapped persons and for requiring employers to engage them will materially improve the position.

Blind persons are commonly employed at present in



workshops for the blind, usually run by voluntary agencies, in which chair caning and mat, basket and brush making are the principal occupations. Since the blind, highly skilled though some of them are, can rarely compete on economic terms with sighted workers, their wages are seldom high enough for maintenance. It is therefore generally necessary for the Local Authority to augment their earnings in some way so as to bring them up to an agreed minimum. From every point of view it is beneficial to do this. The blind prefer to feel that they are partly responsible for maintaining themselves; while it is more economical to subsidize their earnings than to have to provide wholly for their support. Where blind people can work in their own homes (for example at machine knitting) the Local Authority can help by supplying material at wholesale rates and by advertising and in other ways assisting in the sale of the product.

In this connection a home teacher can be of great service, as she can in many other directions. While the profession is open to both sexes, almost all home teachers, in fact, are women, doubtless because the salary is insufficient to attract men. Most home teachers have taken the course of training for the certificate of the College of Teachers of the Blind, but possession of the certificate is not a requirement for appointment. The home teacher is not greatly concerned with employed blind persons; her main work lies among those (the great majority) who are too old to work. Her duties are manifold. She visits them in their homes, helps to find lodgings for those who need them, teaches them to read and write Braille or Moon script, teaches handicrafts and pastime occupations, advises them about their personal affairs (for example about health insurance), and arranges outings and concerts. Some Local Authorities provide social centres, where blind people can gossip and play games: these are a great boon, especially to those

who live in rooms and are often very lonely. A good home teacher needs to possess great tact, sympathy and understanding, and a strong sense of the extent to which her own efforts (since what she does cannot, except very broadly, be prescribed by a committee) can be of service to those among whom she works. To enable the work to be done effectively, there should be one home teacher to approximately every hundred blind persons; but this ratio is unfortunately very rarely attained. Home teachers may be appointed by Local Authorities; or they may be servants of voluntary organizations which undertake the work in return for payment.

Local Authorities may exercise their powers under the Act through a committee. In some areas the Education Committee is responsible; in others the Health Committee; in others a special committee. Co-opted members may serve: these usually include representatives of the National League of the Blind and of voluntary organizations.

Under the Public Health Act 1936 Local Authorities (including the councils of non-county boroughs and districts) outside London may make arrangements for assisting in the prevention of blindness, in particular for the treatment of persons suffering from injury to or disease of the eyes. Some provide free spectacles and free hospital treatment. A great deal of blindness is avoided by the routine treatment of the eyes of new-born infants by midwives, and as a result of the notification of cases of ophthalmia neonatorum. The institution of "sight-saving" classes for children suffering from certain forms of defective vision (e.g. high myopia) also assists in the prevention of blindness.

Blind welfare authorities are associated regionally in County Associations for the Blind, which hold conferences, compile information and statistics and provide for the inspection of workshops for the blind.

*Diagnosis and treatment of cancer*

It was stated in the Ministry of Health's Annual Report 1937-38 that investigation had shown that only about 20% of all cancer cases came under the care of Local Authorities, many of them in such an advanced stage of the disease that little effective treatment could be given. In the absence of any specific obligations on the part of Local Authorities there was no possibility of a comprehensive treatment service being provided, since this was beyond the capabilities of the relatively small number (eighteen) of voluntary hospitals in which radium centres had been set up, and which were irregularly dispersed through the country.

The Cancer Act 1939 was designed to ensure that all cancer patients shall receive appropriate treatment. County and county borough councils had the duty placed upon them of securing that facilities for diagnosis and treatment were adequate to meet the needs of their areas. They were empowered to pay all or any of the reasonable travelling expenses (including those of a companion) incurred by persons making use of the services provided. They were required to consult with representatives of local voluntary hospitals and of medical practitioners, and to submit their schemes to the Minister for his approval by March 1940.

Schemes had to include arrangements for providing adequate surgical treatment and for specialized treatment in special centres, and for full co-operation between all the hospitals in the area covered by a scheme, since patients may need to be transferred from one hospital to another during the course of treatment. Local consultative and diagnostic centres had to be established, preferably on general hospital premises, staffed by visiting experts from the treatment centres. Patients could attend these for observation after treatment.

Since to be effective a high degree of co-ordination is

required, schemes would be operated by joint boards of all the Local Authorities concerned, upon which representatives of voluntary hospitals and general practitioners would be appointed.

The Act provided that over a period of ten years the Minister might lend to the National Radium Trust a sum not exceeding in total half a million pounds for the purchase of radium and apparatus. Financial assistance was to be given to Local Authorities on the basis of half their additional expenditure, scaled up or down by the application of the block grant formula. From 1947 this grant would be merged in the block grant.

The Act conferred upon the London County Council the same powers as it has in regard to tuberculosis.

Shortly after the passage of the Act the Minister of Health issued a circular to Local Authorities stressing the need for the fullest publicity to be given to their arrangements.

The growing efficacy of treatment in regard to curing cancer and in alleviating suffering where cure is not possible makes it imperative that treatment shall be available to all patients. The National Cancer Service lays the basis for the achievement of this purpose; but the shortage of skilled staff, hospitals and equipment unfortunately prohibits the possibility of any considerable results for some time to come. In the meantime Local Authorities under interim schemes have combined to provide a joint cancer service, contributing to the costs of administration on a population basis. These temporary arrangements will be merged in the comprehensive provision of hospital facilities which will form an essential part of any reorganized and expanded national health service.

The Act makes it illegal to advertise treatment for cancer, or the prescription of any remedy, or the offer of advice. The penalty for a first offence is a fine of £50,

for a subsequent offence a fine of £100 or three months' imprisonment or both.

### *Health Education*

Continuous education in health and hygiene necessarily arises out of the day-to-day carrying out of the public health services. The health visitor going about her district is a valuable educational agency; the school doctor not only examines children but advises their parents about their food, their hours of sleep and their mode of life; mothers take their babies to clinics to find out how to keep them well; the dentist not only extracts a faulty tooth but explains how to keep the other teeth sound. This constant educational work has probably played no less valuable a part in securing improved national health than the provision of treatment, and constitutes an important element in the preventive nature of the public services.

Local Authorities, however, may engage in more specific form of health education, power to do so having been given first by the Venereal Diseases Regulations 1916 and later on a comprehensive scale by the Public Health Act 1925. Increasing use has been made by Local Authorities of these powers, but few have taken as much advantage of them as the importance of public education warrants. There is still not only widespread ignorance about health but ignorance also about the health services. The Ministry of Health, indeed, collaborated with Local Authorities in 1937 in a "Use Your Health Services" campaign, which by means of posters, lectures and films exhorted the public to make more extensive use of facilities provided out of their own pockets and administered by their own elected representatives.

Much of the work of health publicity is undertaken on behalf of Local Authorities by the Central Council for Health Education, whose activities have grown steadily

since its inception in 1927, and which obtained a Charter of Incorporation in 1935. The Council consists among others of representatives of the Ministries of Health and Education, the Society of Medical Officers of Health, the British Medical Association, the Dental Board and the Local Authorities' Associations. Activities carried on by the Council include the organization of Health Weeks on behalf of Local Authorities, the preparation and distribution of posters for display, the distribution of films and articles for the Press, and the publication of the journal "Better Health," available to Local Authorities for circulation through clinics, health offices and in other ways. Some of these activities had to be abandoned or curtailed during the War. Certain voluntary organizations also issue publicity material and undertake various forms of educational work. The display boards handed over to Local Authorities by the Empire Marketing Board make particularly useful sites for the exhibition of posters, since they are always shown in the same place and passers-by form the practice of looking out for new ones to be displayed.

A most valuable recognition of the need for sustained rather than spasmodic propaganda was accorded some years ago by four adjacent county boroughs, which combined in the appointment of a full-time public health lecturer and organizer (who was medically qualified). In addition to arranging large-scale events such as Health Weeks, he got into touch with such organizations as trade unions, townswomen's guilds, church societies and youth clubs with offers of lectures and film displays, and found a most gratifying response. Despite this, the work was sacrificed to the economy campaign of the 1930s and was not re-started.

The great success of the Ministry of Health's propaganda for diphtheria immunization is proof of the results

which attend efficient and sustained publicity. Large Local Authorities, and groups of smaller ones, would find it well worth their while, even in terms of saving of public expenditure on the treatment of much avoidable disease and disability, to take their powers to engage in health education more seriously than they have been inclined to do in the past.

**PART TWO**  
**THE ADMINISTRATIVE MACHINERY**



## CHAPTER IX

### *The Distribution of Powers and Duties*

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ALL types of Local Authority, with the exception of the parish council and the parish meeting, exercise powers in connection with the personal health services, the county council and county borough council having the widest responsibilities. The tendency since the early years of the present century has been to give new powers to the latter types of Local Authority only, and in certain cases to take powers from the others. Thus the Mental Deficiency Act 1913, the Venereal Diseases Regulations 1916, and the Public Health (Tuberculosis) Act 1921 made county and county borough councils the responsible Local Authorities; while the Education Act 1944 took from those borough and urban district councils which formerly exercised them their powers and duties in regard to the health of children attending elementary schools. The Local Government Act 1929 transferred all the functions of the abolished Boards of Guardians (which included medical services for the destitute sick) to county and county borough councils.

This approach to concentration of powers in the hands of the two major Local Authorities has been due to two reasons. The first is that a residential institution needing expert staff and expensive equipment can be provided economically only on a large scale, so that the cost per bed is as low as possible. This requires that the institution shall serve a large population, preferably under the jurisdiction of one Local Authority.

The second reason is that medical services should be integrated. This is difficult to achieve in practice, however efficient administrative co-operation may be, if a

certain form of medical care is provided by one Local Authority which is dependent upon arrangements with another Authority should further methods of treatment be required for one of its citizens. Satisfactory integration can only be attained if all necessary services are provided by a single Authority, with adequate financial resources and with a population sufficiently large to make their provision economical.

The selection of counties and county boroughs for the responsibility of administering the major part of public health legislation does not in fact mean that in all cases a self-contained and integrated service is secured. Powers and duties are apportioned to Local Authorities according to their status, and not in accordance with their achievement of a certain standard in regard to size, population and rateable value. There are not only great differences in these respects between Authorities of the same status: many Authorities of a lower status have greater populations and financial resources than others of higher rank, and are in a position to exercise powers wider than they possess.

As a result of these variations many counties and county boroughs are not able of themselves to provide comprehensive services and may be driven to such expedients on the joint ownership of institutions, the sharing of the services of specialists and the use by agreement of equipment belonging to other authorities. Further reference to such arrangements is made later in this chapter. On the other hand, many counties and a smaller number of county boroughs are in a position in all respects to provide all necessary services (except perhaps certain highly specialized forms of treatment) and thus to secure integration.

It may be convenient to set out here the various types of Local Authority which are or may be responsible for the personal health services which have been described in previous chapters.

The county borough council provides all these services within its area.

The county council is the only Authority within the area of the administrative county for the medical inspection and treatment of school children, the institutional treatment of tuberculosis, the provision of accommodation and care for mental defectives, the welfare of the blind, the diagnosis and treatment of venereal diseases, the treatment of persons suffering from cancer and the provision of medical care for the destitute sick.

District (i.e. non-county borough, urban district and rural district) councils are Local Authorities for the notification of tuberculosis and infectious disease. In certain cases they are Local Authorities for the notification of births and for the supervision of midwives: where these powers are not exercised, they are functions of the county council. They may make provision for maternity and child welfare; so also may the county council, if district councils do not choose to use their powers. They may provide general hospitals, but none in fact does so. They may provide infectious diseases hospitals. If they do not make such provision, they may be required to do so by the county council as constituents of a Joint Hospitals Board. A few borough councils provide and maintain mental hospitals; otherwise it is the duty of the county council to do so.

In regard to certain services, it will be noted, it is only possible to ascertain whether they are the responsibility of the county council or of a district council by specific inquiry in the locality. In the area of one urban district, for example, maternity and child welfare services may be provided by the county council, in the area of another by the district council itself. The Education Act 1944 did a good deal to reduce the extent of divided responsibility when it transferred to the county council the duty of administering the school medical service from those district

councils upon whom it had been imposed by the Act of 1907. The Local Government Act 1929 also made it possible to effect a similar reduction by giving the Minister of Health power, on application by a county council, to transfer to that council maternity and child welfare services which were being provided by a council which was not a Local Education Authority. There were, however, before 1945 a number of county districts whose councils were responsible for the welfare of mothers and young children but where school medical inspection and treatment was undertaken by the county council. Now that district councils are no longer Local Education Authorities there will be still more places where this is the case, unless the county council applies to the Minister or unless (which is improbable) the district councils concerned relinquish their powers to the county council with its consent (as provided in Section 57 of the Local Government Act 1929).

### *Joint Boards and Committees*

Certain Acts of Parliament enable Local Authorities to enter into arrangements for the joint exercise of public health functions. Such arrangements involve (a) the constitution of joint bodies with executive powers and with independent financial powers, which are usually called Joint Boards; and (b) the constitution of joint bodies with executive powers but without independent financial powers, which are usually called Joint Committees.

Any two or more councils of boroughs, urban districts and rural districts may apply (Public Health Act 1936) to the Minister of Health to be formed into a united district under a Joint Board for the purpose of the Public Health Acts. The Minister may then form a district by Order which has to be confirmed by Parliament if it is opposed. Similar powers in the Public Health Act 1875 had resulted in the creation of a number of Joint Boards for the provision of isolation hospitals.

The Isolation Hospitals Acts 1893 and 1901 empowered county councils to set up Hospital Districts, and required them to form Hospital Committees to administer these districts and to issue precepts to the constituent Local Authorities as in the case of Joint Boards. The Public Health Act 1936 required the Minister to dissolve by Order every Hospital Committee constituted under these Acts. In most cases they have been replaced by Joint Hospital Boards. Although a number of Joint Boards and Hospital Committees had been set up, provision for the treatment of infectious diseases was not adequate. The Local Government Act 1929 and the Public Health Act 1936 both therefore required county councils to consider the arrangements in their areas and to prepare schemes for providing adequate isolation hospital accommodation. As a result there has been a considerable extension of combined action in this respect. Shortly before the War 812 county districts were grouped into 181 hospital areas under schemes approved by the Minister.

Joint Boards for the exercise of functions under the Mental Deficiency Acts may be created on application by the Local Authorities concerned by Order made by the Minister. Local Authorities under the Lunacy Act 1890 are empowered to unite with others to provide and maintain mental hospitals.

The Public Health (Tuberculosis) Act 1921 empowered the Minister, with the consent of the county and county borough councils concerned, to make an Order constituting a Joint Tuberculosis Committee. The Public Health Act 1936 changed the name of such committees to Joint Boards. The Minister has greater powers under the Cancer Act, since he may require two or more councils of counties or county boroughs to combine to such an extent and on such terms as he may direct. The Minister of Education was given similar powers in the Education Act 1944.

The Minister has power under the Public Health Act 1936 to constitute by Order as a Port Health Authority any two or more Local Authorities whose districts include or abut upon a port or part of a port.

Since many Local Authorities are too small to be able to exercise certain of their functions efficiently, the device of the Joint Board and the Joint Committee, which enable two or more Local Authorities to join in the provision of a service, serves a very useful purpose. If heavy capital expenditure is required it is always more costly to provide a number of smaller undertakings than a single much larger one. Where a wide area is covered there is sustained demand and use of full capacity and consequently saving on overhead charges. It is possible to make use of specialists and expensive equipment if cost is spread over a large population.

On the other hand there is much to be said against Joint Boards. Being statutory bodies, they have virtually perpetual existence, since the constituent Authorities cannot withdraw. As they have independent financial powers the constituents have very little control over them. The members are elected by the constituents and thus have no direct responsibility to the ratepayers. There may be a great deal of friction between the members, who may be primarily concerned with the interests of their own areas.

The Joint Committee has considerably less power than the Joint Board, and objections to it in some directions are also less. It cannot precept to its constituent bodies, which confer upon it certain of the powers, with or without restrictions, which they may exercise themselves. Its expenses are defrayed in such proportions as the constituents may determine: it must ask them for whatever money it requires. Whereas the Joint Board, therefore, merely sends in a demand, the Joint Committee submits a request. Herein exists its weakness, since a refusal of one

constituent to pay its share, for example, of a new hospital wing would cause the project to be abandoned. In many cases the agreement to form a Joint Committee can be terminated if one of the constituents wishes to withdraw.

Dislike on the part of Local Authorities of joint action is reflected in the relatively small use which has been made of their powers in connection with the medical services. So long as the initiative rested with them, inertia and considerations of local prestige, as well as reluctance to be committed to expenditure over which they had little control, combined to make them eschew the benefits of co-operative effort. As a result many isolation hospitals, for example, were small, ill-equipped and badly staffed. It is noteworthy that although the Local Government Act 1929 laid an obligation upon county councils to prepare schemes "for the provision of adequate hospital accommodation for the treatment of infectious disease," the Public Health Act 1936 had to re-impose this duty.

Despite the drawbacks of Joint Boards they nevertheless do enable more efficient services to be provided than would otherwise be the case: indeed, they have come into being as an expedient to try to overcome the inherent defects of the local government structure. The fact that there are nearly twelve hundred joint bodies for various purposes (including public health purposes) is a demonstration of the need for a considerable diminution in the number of Local Authorities whose resources in all respects are inadequate properly to meet essential needs.

#### *The county council and minor authorities*

The county council has general powers of control over the health services provided by the councils of non-county boroughs, urban districts and rural districts, which are exercised in a number of ways. The Medical Officers of Health of county districts are required to transmit to the

county Medical Officer copies of their annual reports and weekly statements of the number of notified cases of tuberculosis and of infectious disease, and inform him immediately of the notification or discovery of cases of certain other diseases (e.g. smallpox and plague).

Both the Local Government Act 1929 and the Public Health Act 1936 laid an obligation upon the county council to prepare schemes for the provision of adequate isolation hospital accommodation, which has led to many groupings of district councils into Hospital Districts under the administration of Joint Boards.

If the county council is of opinion that a district council is failing in the efficient discharge of a public health duty it may take steps to try to persuade the negligent council to improve its ways. Should it be unsuccessful in its efforts, it may make representations to the Minister of Health, who may then institute the procedure described in the chapter dealing with the Ministry of Health.

It is the duty of the county council to secure that on the resignation of a Medical Officer of a district council who has engaged in private practice the conditions of appointment of a successor shall preclude private practice.

The county council may make by-laws for the good rule and government of the whole or part of the county, which may be enforced by the council of the area to which they apply. A copy of every by-law made by a district council must be sent to the county council.

Bills promoted by district councils may be opposed by the county council.

Parish councils and rural district councils may apply to the county council to be created urban district councils. If the county council is satisfied that a *prima facie* case has been made out, it may hold an inquiry and make an order in accordance with Section 141 of the Local Government Act 1933.



Alterations in status, however, do not depend only upon application being made in this manner. The county council was obliged by the Local Government Act 1929, after consultation with district councils, not only to consider the desirability of changing the status of districts and of forming new districts but of altering the boundaries of districts. Any proposals to make such changes, which had the object of securing more effective administrative units, had to be submitted to the Minister of Health, who might make an order giving effect to the proposals, or to some of them, with or without modifications. Subsequent reviews might be made by the county council or the Minister might give instructions for them to be made; but the interval between reviews might not be less than ten years. The provisions of the Act were embodied in the Local Government Act 1933. Further adjustments of areas and status were prohibited by the Local Elections and Register of Electors Act 1939. As a result of these reviews the number of rural districts were reduced from 779 to 476 and of urban districts from 827 to 572. The newly-created Local Government Boundary Commission will in future exercise the powers of the county council and Minister of Health in connection with these matters.

The county council's supervising and co-ordinating powers are considerable, even though they are no longer directly concerned with alterations in the status and areas of minor authorities. Default procedure in particular enables them to bring pressure to bear upon indifferent or recalcitrant councils; although willing and friendly co-operation is the most satisfactory method of securing acceptable standards of service.

## CHAPTER X

### *Local Administration*

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#### *Committees of the Local Authority*

As in the case of other branches of its services, the Local Authority appoints committees to transact its business in connection with public health. Certain committees must be appointed by statute; such others may be appointed (Local Government Act 1933) as the Local Authority wishes. In the case of a statutory committee, all matters competent to be dealt with under the Act or Section of the Act which requires the appointment of the committee stand referred to it and the Council, before exercising its functions under the Act, must receive and consider the report of the committee unless a matter is urgent. In all cases the Council may delegate any of its powers to a committee, with or without restrictions, except the power of borrowing or levying or issuing a precept for a rate. It is more usual for county councils than for other Local Authorities to delegate such powers as they customarily meet only quarterly.

The Local Government Act 1933 empowers Local Authorities to co-opt on to committees non-members of the council to the extent of not more than one-third of the membership. In certain cases co-optation may be compulsory, since members of the council may not have the qualifications required by a specific Act of Parliament, e.g. the Public Health Act 1936 provides that two members of the maternity and child welfare committee shall be women. Co-opted members, some of whom must be women, must

be appointed on to a committee for the care of the mentally defective.

The arguments for and against co-option have been discussed so frequently that there is little occasion to refer to them here. In the sphere of public health there are considerable advantages to be derived from the presence on committees of persons of professional skill and specialized knowledge. Perhaps even more valuable is the association which can be established between the Local Authority and professional bodies (such as the local division of the British Medical Association) and voluntary institutions (such as voluntary hospitals).

Legislation which requires Committees to be appointed includes the Lunacy Act 1890, the Mental Deficiency Act 1913, the Local Government Act 1929, the Public Health Act 1936 and the Education Act 1944.

Under the Lunacy Act 1890, the Local Authority must appoint a Visiting Committee of not less than seven persons to exercise the council's powers in regard to mental hospitals. At least two members of the Visiting Committee must together, at intervals of not less than two months, visit the council's mental hospital and see every patient.

Where patients are received under contract in a county hospital, they must be visited by members of the borough's Visiting Committee at least once every six months. The Committee must make an annual report in writing to the Local Authority owning a hospital on its conditions, accommodation and management.

A Local Authority under the Mental Deficiency Acts must appoint a Committee for the Care of the Mentally Defective. The Committee must consist either of the members of the Visiting Committee appointed under the Lunacy Acts (with the addition of at least two women); or the members of the Visiting Committee must be the members of the Council appointed to the Mental Deficiency Committee.

The Local Government Act 1929 provided that the councils of counties and county boroughs should constitute a Public Assistance Committee or arrange for an existing committee to act as such. Its function (*inter alia*) is to administer medical relief to the destitute sick.

Welfare authorities (i.e. those exercising powers in connection with maternity and child welfare) are required to appoint a Maternity and Child Welfare Committee, which may, at the discretion of the Local Authority, be a committee appointed for other purposes or a sub-committee of such a committee.

Local Education Authorities (i.e. county and county borough councils) must appoint, with the approval of the Minister, such Committees as they consider necessary for the proper discharge of their functions. Some of the members must be persons of experience in education. Among other duties the Education Authority is responsible for the physical well-being of school children.

Councils distribute responsibility for the administration of their health services broadly speaking on one or other of two principles. They may appoint a committee charged with general responsibility, which is divided into sub-committees dealing with particular services. Thus there may be a Health Committee, with Maternity and Child Welfare, Hospitals, Mental Welfare, Tuberculosis and Child Health Sub-Committees. In this way administration may be integrated, and a general policy for public health formulated. The proposal of a sub-committee can be considered in relation to its effects upon the services with which other sub-committees are more especially concerned, and provision made for any necessary readjustments should the proposal be accepted. The members of the Health Committee are enabled to have a clear grasp of all (or most) of the council's health services and can see them as a unified whole.

It is improbable that any Local Authority has appointed a committee to be responsible for the whole of its medical services. It is almost universally the practice for the domiciliary relief of the sick poor to be a function of the Public Assistance Committee acting as an independent committee, and for the administration of the arrangements for the health of school children to be the exclusive or almost exclusive concern of the Education Committee. Where this is the case, these two important branches of the public health service tend to be administered in isolation from the others; or, at any rate, integration is made more difficult.

The Local Government Act provided (as noted above) that an existing committee might act as a Public Assistance Committee, and there is nothing therefore to prevent a Health Committee (for instance) from so acting, and appointing a sub-committee to be responsible for poor law medical services, which could thus be fitted into the general health service of the Local Authority more effectively than is usually the case. Indeed, in a few cases such an arrangement has been made; in one county borough at least powers and duties under public health acts are the concern first of a sub-committee of the Public Assistance Committee.

In regard to the health of school children, there is no legal barrier to prevent an Education Committee from arranging for this part of its functions to be carried out on its behalf and subject to its general approval by a Health Committee or sub-committee of a Health Committee. Since a child may contract a disease (e.g. tuberculosis) which may bring him under the care of a specialist medical officer of another committee, which may have to provide institutional treatment, such an arrangement has much to commend it.

The second principle upon which administrative respon-

sibility for the exercise of public health powers and duties rests is the appointment of a number of committees each of which is concerned with some of them, e.g. Maternity and Child Welfare Committee, Mental Deficiency Committee. These may have sub-committees: a Maternity and Child Welfare Committee, for instance, may have a Maternity Home Sub-Committee. This principle fails to recognize the conception of the public health service as a unity, and not an aggregation of unrelated services. By dividing responsibility it makes integration difficult or at any rate cumbersome to achieve. It is not easy for a councillor who is a member of a committee concerned with only one branch of the health service to have a clear understanding of the service as a whole, and to appreciate how the various parts dovetail one into the others. Many matters which concern one committee may concern others. The provision of bed accommodation for sick babies, as an example, involves the maternity and child welfare committee and the hospitals committee. Much time and work may be wasted in references going backwards and forwards from one committee to the other. To avoid this, a temporary joint committee may be set up to deal with a specific question; but the recommendations of the joint committee have to be referred back to the appointing committees for approval, and disagreement on the part of either means delay and possibly deadlock. The device of the joint committee is in fact an admission that there has been an unnatural division of functions. Apart from specific matters, there are many issues affecting one section of the service which affect others, and the expedient of the joint committee cannot be used to deal with all these unless a number are appointed and required to meet frequently. An attempt may be made to co-ordinate the work of committees by securing that on every committee there are one or two members of each of the others, so

that all of them thus have some knowledge of what each is doing. The clerk of the Local Authority also acts as a co-ordinating agency, since he is represented on all committees and is thus informed of what goes on in all of them. But in neither case are the merits of organization of administration on the first-described principle obtained. Control of the administration of the whole of the health services by one committee enables fully-considered and integrated plans to be put before the council, and the council to have a clear comprehension of the various branches of the medical provision for which it is responsible.

In the case of a few Local Authorities all the members of one committee are members of all the other committees. Where this practice is adopted there is no doubt that they are all fully conversant with the whole field of public health provision; but it makes unnecessary demands upon the members' time and is no more effective in results than the method of the single responsible committee with specialized sub-committees.

#### *Officers of the Local Authority*

A Medical Officer of Health must be appointed (Local Government Act 1933) by the council of every county, borough and district. The Minister of Health, on representation being made to him, may unite districts (including county boroughs) for the purpose of appointing a Medical Officer, being empowered in the Order to lay down conditions about such matters as the method of appointment and the salary to be paid.

A person appointed as a Medical Officer of Health must be a properly qualified medical practitioner and the holder of a diploma in sanitary science, public health or state medicine. In the case of boroughs or districts with a population of under 50,000 possession of the latter require-

ment has only been necessary in the case of appointments since 1935, subject to the right of the Minister of Health to waive the requirement when he thinks fit.

Medical Officers of counties and county boroughs are forbidden by the Local Government Act 1933 to engage in private practice; nor can other public appointments be held without the consent of the Minister of Health. The Act requires a county council, on the resignation of a district Medical Officer who has undertaken private practice, to prepare a scheme for a combination of areas so that a Medical Officer of Health subsequently appointed shall be restricted from doing so. The Minister may dispense with the requirement prohibiting private practice.

Except in the case of a Medical Officer of Health who is not required to give the whole of his time to public health duties, a Medical Officer of Health cannot be appointed for a limited period. The sanction of the Minister of Health is required to the dismissal of (a) a County Medical Officer; (b) a Medical Officer of a county borough whose council before it was created a county borough was paid by the Minister of Health or the county council part of his salary; and (c) a Medical Officer of a county district whose council is paid part of his salary by the county council.

When a county district complies with the regulations made by the Minister of Health as to the qualifications, duties and salary of its Medical Officer of Health, the county council is required to pay one-half of his salary. If the district Medical Officer fails to supply to the Minister or to the County Medical Officer such information as he is required to give under Section 113 of the Local Government Act 1933, this payment is paid to the Exchequer and not to the district council.

Except in the case of a County Medical Officer of Health, vacancies in the office must be filled within six months.



The duty of a Medical Officer of Health in general terms is to take all such steps as are necessary to safeguard the health of the people living in his area. Some duties are imposed by statute, others are prescribed by regulations or directions of the Minister of Health, others may be assigned to him by the employing authority. He advises his council both as to matters on which they have asked for his views and as to action which he considers desirable in the interests of efficiency and for the benefit of the community.

In counties and county boroughs the Medical Officer of Health is usually School Medical Officer, and the Administrative Tuberculosis Officer. One of the conditions with which Local Education Authorities had to comply for the purpose of receiving grant was that they should appoint a School Medical Officer. Some Authorities (and these among the largest) appointed as such an officer one who was not the Medical Officer of Health, and thus created a divided responsibility for the health services as a whole. Regulations made under the Education Act 1944 also require the appointment of a School Medical Officer. The Public Assistance Order 1930 requires the Medical Officer of Health to advise the council in connection with the discharge of its poor law functions.

Medical Officers of Health of all Local Authorities are required to make an annual report to the council, and every five years a survey report, in accordance with a memorandum issued by the Minister of Health. The report includes information about vital statistics, hospitals, housing conditions, infectious diseases and (where appropriate) about arrangements for maternity and child welfare and for the diagnosis and treatment of tuberculosis and venereal diseases. The Medical Officer may include such other subjects for report as he thinks desirable. A survey report takes note of such matters as developments in services

and changes in the incidence of mortality and disease in the preceding five years. Certain weekly reports (e.g. except for counties, on cases of infectious disease) have to be submitted; and such special reports (e.g. on maternal deaths) as the Minister may require.

A County Medical Officer of Health is not only concerned with the administration of services which the county provides; he has the responsibility of being informed on all matters affecting public health in his county, even in those areas in which another Local Authority (except a county borough) exercises powers and duties. He visits these areas and in connection with housing and sanitation (with which the county council is not directly concerned) maintains a general supervision. He may make special visits if requested by a council or its Medical Officer, or following upon complaints about conditions in an area alleged to be injurious to health. In other matters he acts as a co-ordinating agency. The Medical Officers of district councils are required to send to him a weekly return of notifiable infectious diseases, and he is thus enabled to inform them of the prevalence of such diseases in the county. Annual reports of Medical Officers of county districts must similarly be sent to him; he is consequently in a position to compare conditions between one area and another, and to draw attention when necessary to deficiencies in services or laxity in carrying out legal requirements. When the Minister of Health is holding a local inquiry (e.g. into a housing or sewage disposal scheme) the County Medical Officer may be asked by the inspector or by the Local Authority concerned to give evidence or to supply information.

In smaller areas the Medical Officer of Health may engage in practical medical duties, e.g. in connection with maternity and child welfare clinics or an infectious diseases hospital.

The Medical Officer of Health is, therefore, responsible for the efficient administration of all branches of the services provided by his council, for advising on the formulation of policy, and for co-ordinating as far as possible all the forms of medical provision in his area.

In a public health department there is much work of a non-clinical nature, and there is the danger that this may absorb too much of the time of the Medical Officer of Health to the detriment of his purely medical responsibilities. Preoccupation with daily office routine, handling of correspondence, preparation of financial estimates and of committee business may make it difficult for him to consider broad aspects of policy, to supervise the work of his medical staff and to acquaint himself with the developments of preventive medicine. His administrative training and experience are likely to have been small. A medical training in the nature of things is not a good preparation for the development of the qualities required by an administrator; and early years as an assistant medical officer are devoted almost exclusively to purely technical work. In consequence the Medical Officer of Health has to undertake a great deal of administrative work of a nature which he may dislike and for which he may not be fitted.

Because of these considerations the practice is growing (albeit slowly) of appointing lay administrative officers, who are responsible for the general management of clerical staff and for those aspects of the work of the department which are not wholly of a medical nature. The Medical Officer of Health is thus left far more free to exercise the functions for which his training and professional knowledge qualify him.

While the Medical Officer of Health is usually the Administrative Tuberculosis Officer, the clinical control of tuberculosis is in the hands of the Tuberculosis Officer: by definition he is the Medical Officer in charge of the

tuberculosis dispensary provided by the Local Authority. His duties may occupy the whole or part of his time, according to the size of the employing authority. He must be a registered medical practitioner, and if not appointed before 1930 must have been qualified for three years, have had at least eighteen months' experience in general clinical work, of which not less than six must have been occupied as resident hospital officer, and at least six months' special training in the diagnosis and treatment of tuberculosis. For special reasons the Minister of Health may dispense with any of these requirements. The Medical Superintendent of a tuberculosis sanatorium must either have been a tuberculosis officer or a medical superintendent approved as such by the Minister of Health before 1930: if appointed since then he must possess the same qualifications as a tuberculosis officer.

The Medical Superintendent of a poor law hospital, in addition to being a qualified medical practitioner for at least five years, must have held appointment as a house physician or house surgeon in a public general hospital and have had administrative experience in such a hospital or a poor law hospital. In a large hospital the Medical Superintendent's work tends to be wholly or almost wholly administrative, and there may be, in addition to the usual resident staff, whole-time or part-time medical officers in charge of medical, surgical, obstetrical and gynæcology cases. In smaller hospitals the Medical Superintendent may undertake some clinical work. There are no specific qualifications required in the case of district medical officers, medical officers of poor law institutions, medical superintendents of general hospitals or medical officers of infectious diseases hospitals.

The Venereal Diseases Officer must have been a qualified medical practitioner for at least three years and have been certified by a Venereal Diseases Officer in charge of a centre

where at least 500 new cases have been dealt with in the previous year, to have attended at the centre for three months and to have had 130 hours' experience in treatment and diagnosis.

The size of the staff of assistant medical officers does not depend wholly upon the size of the population served by the Local Authority; it depends also upon the extent of the services, and the extent to which part-time staff is employed. In very large districts work may be specialized, certain of the assistant staff working in connection with the school medical service, others on maternity and child welfare work, others in local tuberculosis dispensaries. This method has the advantages which pertain to specialization of any kind; but it narrows the interest of the staff, and isolates them from the other parts of the service. It also deprives them of wider administrative experience, and thus tends to act as a barrier to their prospects of securing posts as Medical Officers of Health. There is certainly a good deal to be said, whatever the general merits of either system, for doctors doing both maternity and child welfare and school medical work. The same doctor can have a child under supervision (or there is a possibility that this may be the case) from infancy until it leaves school; which is much better from all points of view than seeing the last of it when it reaches five years of age, upon which it becomes the care of another doctor who sets eyes upon it for the first time. It is true that the second doctor may know something of the child's medical history if case-records are transferred; but this is by no means always done.

The school medical service, because it comes under the jurisdiction of the Education Committee, may be organized in almost complete independence of the other health services, even though the Medical Officer of Health is also School Medical Officer. Where this detachment exists, unnecessary trouble is caused and delay incurred in dealing,

for instance, with a child of school age requiring hospital treatment, for whose care another committee is responsible. If the staff is housed in and its activities directed from another building, such co-ordination as may exist can only be secured at the cost of much correspondence, duplication of records and overlapping of work (as, for example, in home visiting). Even though the education committee may retain its right to decide policy and to exercise general supervision, it is by far the better practice to arrange for the direction of the school medical service, as part of the health service as a whole, to be entrusted to the Medical Officer of Health, and for the professional and administrative officers concerned to be members of his staff and responsible to him. Where this is done, it is necessary for each committee concerned to pay its proportion of expenditure on salaries in accordance with the amount of work performed on its behalf.

Regulations made by the Minister of Education this year (1945) require Local Education Authorities to appoint a Senior Dental Officer and such other staff as may be necessary. Since probably in every case the Education Committee is responsible for the administration of the school medical services, dentists are not available for other sections of the health services except by arrangement with other committees. In most instances, however, they are fully occupied with their work among school children, and dental care for mothers, infants and others has to be provided by other means (if at all). The school dental staff usually come under the general direction of the Medical Officer of Health in his capacity (in most cases) of School Medical Officer. The risk that a dental inspection of a school may be fixed at the same time as a medical inspection is thus obviated.

Health visitors, if appointed since 1928, must hold the Health Visitors' Certificate of the Royal Sanitary Institute.

Until recently school nurses did not need to have any specific qualification, some Local Authorities not even stipulating that they should be on the State register. Regulations made under the Education Act 1944, however, require that school nurses shall possess the same qualifications as those of health visitors. This requirement may be dispensed with in the case of existing appointments; where a nurse is employed wholly in a school clinic or on special work; or where there is an unavoidable lack of qualified nurses.

Local Authorities have different methods of organizing the work of their health visiting staff. In some cases certain of them are allocated to particular sections of the service (e.g. maternity and child welfare, tuberculosis). In others all the staff (with perhaps one or two exceptions) are employed over the whole field. The advantages of the former method are that health visitors tend to become specialists, with an intimate knowledge of the people among whom they work. They tend, however, to become detached from and thus out of touch with the branches of the service with which they are not concerned. Moreover, specialization means that one home may be visited by a number of the staff for different purposes (one about a baby, another about a school child and so on), which causes unnecessary trouble to mothers. Where each health visitor is responsible in her district for visitation in connection with all or most of the sections of the service her experience is naturally broadened and she becomes more generally useful to the department. She can, for example, take over part of a colleague's work at holiday times or during other times of absence. She can, also, establish closer relations with the home if she is concerned with the health of more than one member of the family. On the other hand, her knowledge of any one branch of the service is necessarily less detailed.

There is ample scope for co-operation between the Health Committee and the Housing Committee. Agreement may be reached whereby the latter makes special provision for tuberculosis patients in ways indicated in an earlier chapter. Where this is not the case (and such arrangements are unfortunately rare) the Tuberculosis Officer can urge the claims of a patient to be considered as a tenant of a corporation house if he is living in a very unsuitable environment. Health nurses, again, can report to the Medical Officer instances of living conditions which may have a particularly bad effect upon health and he in turn can forward such reports to the Housing Committee, or to the officer in charge of letting, if the duty has been delegated to him. Rent collectors, on their part, can where necessary inform tenants about the public health services, or pass on word to the health visiting staff to make a call for the purpose of giving advice. In those cases where house property managers have been appointed, more specific forms of co-operation are possible, since they are concerned with the general well-being of corporation tenants.

While the Medical Officer of Health is required by the Public Assistance Order 1930 to advise his council on the medical care of the sick poor, it is unfortunately very often the case that he has little opportunity of discharging this duty in any but a nominal way. As in regard to the school medical service, the poor law medical service is apt to be administered as a separate unit. This is regrettable even in places where as far as possible the sick poor are provided for under the Public Health Acts instead of the Poor Law Acts, since it means that there can be no effective supervision if district medical officers are not directly responsible to the Medical Officer of Health. Services which might be available to the destitute may in fact not be utilized if district medical officers, because of this detachment, are not



aware of provisions made for the general public to which their patients are entitled. There is no check upon their efficiency or upon the manner in which they discharge their duties. Furthermore, the existence of a more or less separate branch of the public medical services perpetuates the invidious division of the community into two classes dealt with in different ways, which it was the purpose of the Local Government Act 1929 to abolish.

Nevertheless, even in these circumstances, as much co-operation as possible between the public health department and the public assistance department should be achieved. As in the case of sanitary inspectors and investigating officers of the Assistance Board, relieving officers can give advice to their clients about clinics and other facilities, and can report to the health visitors cases which need attention and help. Arrangements can also be made for applications for free services for which normally a charge is imposed to be checked by the public assistance department.

The functions of the Assistance Board include "assistance to persons who are in need of work . . . and the promotion of their welfare." Its officers can exercise these functions more effectively if they are well acquainted with the various medical services which are provided by Local Authorities, and so are in a position to refer applicants to them when necessary. For this reason, there should be co-operation between the Board's Area Offices and public health departments. Both can be saved a great deal of time in asking and answering inquiries if Area Officers are supplied with a list of clinics and other facilities and information about the kind of cases dealt with and the charges, if any, which are made. The Board's investigating officers have many opportunities for seeing where a call from a health visitor or a consultation with a doctor at a baby clinic would be of much benefit, and thus can assist

applicants in more extensive ways than the mere grant of money allowances.

The health department, in its turn, can obtain valuable help from the Area Officer. The Board is precluded from giving medical assistance (i.e. it cannot, except for a short period, give an allowance to an applicant who is ill and thus unfit for work, nor can it pay for medical care). It can, however, give special allowances to applicants or their dependants for extra nourishment, where this is necessary for health reasons and where it cannot be procured from any other source. If a good understanding between Area Office and health department exists, arrangements can be made whereby additional allowances will be given, for example, to buy special food for a diabetic child or for an applicant with latent tuberculosis, who is not unfit for work. Such arrangements would necessarily include the submission, in each case, of a note signed by a member of the medical staff.

Where certain medical services of the Local Authority are provided free in cases of need, it is customary to require applicants to fill in a form giving particulars of family income. Where the applicant states that he is in receipt of an allowance from the Assistance Board it is as well to get the statement verified at the Area Office, since it is not always the case that the information given is accurate.

## CHAPTER XI

### *The Ministries of Health and Education*

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CENTRAL responsibility for public health—a very limited responsibility at first—was transferred in 1858 from the general Board of Health to the Privy Council and in 1871 to the newly-created Local Government Board, which took over also the functions of the Poor Law Board. The Permanent Secretary was responsible for both public health and poor law affairs, an unhappy association which meant in practice the continuation of the old poor law traditions and the subordination of the medical staff to the lay secretariat, which was declared by Sir John Simon, the Board's medical adviser, to have been made "administrative in an unconditional a sense as if no technical officers existed, or as if mere clerkship was meant to be the Office's sanitary strength." Notwithstanding the restrictive effects of its poor law duties, the administration of the Board's public health functions steadily improved, and this was reflected in an improvement in the standard of local administration.

Growing feeling that the care of the nation's health was of such importance as to be the responsibility of one department instead of being distributed among a number of agencies culminated in the creation of the Ministry of Health in 1919. A Minister of Health was appointed "for the purpose of promoting the health of the people throughout England and Wales." His powers and duties, *inter alia*, were to take all desirable steps "to secure the preparation, effective carrying out, and co-ordination of measures conducive to the health of the people, including measures for the prevention and cure of diseases, the treatment of

physical and mental defects, the initiation and direction of research, the collection, preparation, publication and dissemination of information and statistics relating thereto, and the training of persons for health services." To the Minister were transferred all the powers and duties of the Local Government Board and of the Insurance Commissioners and the Welsh Insurance Commissioners; the powers of the Board of Education in regard to mothers and young children, and in regard to the medical inspection and treatment of school children; the powers of the Privy Council under the Midwives Acts; and the powers of the Home Secretary in regard to the infant life protection provisions of the Children Act 1908. With respect to the medical inspection and treatment of school children the Minister was authorized to allow this function to be exercised by the Board of Education on his behalf. He was required to appoint officers to constitute a Board of Health for Wales. Most of the powers of the Home Secretary in regard to lunacy and mental deficiency were transferred by Order in 1920.

The establishment of the Ministry of Health resulted therefore in a very considerable unification of central responsibility for the care of the public health; but important branches are still under the control of other Departments (e.g. industrial health comes under the Ministry of Labour and the health of seamen under the Board of Trade). Where (to quote the Committee on the Machinery of Government) "the promotion of physical well-being is a subordinate, although an indispensable, element in a service primarily devoted to other ends," there is justification for this being the function of another Department, so long as there is consultation between the Department and the Ministry. In regard to industrial health, however, there is a strong case to be made out for the responsibility for this to be transferred from the

Ministry of Labour. In addition to its health functions the Ministry has other important duties. It is responsible for the administration of housing and planning Acts; it is the principal loan-sanctioning Department; the accounts (though not all) of Local Authorities are audited by its staff of district auditors; it is concerned with local taxation and valuation and Private Bill legislation, and administers the Contributory Pensions Acts.

Parliament places the responsibility for the actual provision of most of the public health services upon the Local Authorities. The function of the Ministry is to supervise this work and to use efforts to co-ordinate the activities of the Local Authorities so as to secure the highest possible level of efficiency. The degree of responsibility for the adequacy and efficiency of local services which the Ministry accepts is limited. Thus, it would not expect to incur blame for an outbreak of typhus fever in a county borough as a result of local negligence or the incompetence of the Medical Officer of Health. On the other hand, the Ministry could not avoid censure had it not used certain powers of coercion which it possesses to repair a patent deficiency in essential services; for example, inadequacy of isolation hospital accommodation.

Supervision is exercised in a number of ways. Medical Officers of Health are required to submit an annual report on the health conditions of their area, the setting out of which is indicated in a circular from the Ministry. Certain information must be included, such as vital statistics, arrangements made for the welfare of mothers and young children, and action taken under the Housing Acts. Reference may be made to any new developments introduced during the year, and to any matters worthy of note; for example, the use of a new form of treatment or the steps taken to deal with cases of food-poisoning. Every five years a report surveying developments carried out during

the previous period and comparing mortality and morbidity rates must be compiled. Through the medium of these reports the Ministry is enabled to obtain a general picture of the state of the national health and of the extent and efficiency of the medical services. The Ministry is thus in a position to draw attention in its own annual report to trends in the incidence of disease, extensions in hospital accommodation, to the results of new technical procedures that have been tried and the like. The Chief Medical Officer to the Ministry can deal more comprehensively with these matters in his annual Report on the State of the Public Health. Both these reports are of material value and help to Local Authorities and to their staffs, enabling them to compare the position in their own areas with that prevailing elsewhere, and to estimate the extent to which their arrangements might be considered adequate in the light of those provided by other Local Authorities.

The principal means of supervision, however, is inspection by the Ministry's technical officers, the primary object of which is to enable the Minister to be assured that Local Authorities are maintaining proper standards in the discharge of their public health responsibilities. An incidental but very valuable consequence of inspection is the personal contact which is achieved between the Ministry's officers and local Medical Officers of Health. This contact is of advantage to both. "It enables the Department's officers to gain first-hand information and impressions of local conditions, and it enables the local officers to benefit from the pooled experience of other districts with which the Department becomes familiar in the course of its work throughout the country. Problems and difficulties tend to occur in more than one area; practical solutions found workable in one case are of interest in another, and the power to draw on the wider experience of many districts is a helpful one" (Ministry's Annual Report 1938-39).

The Ministry's medical staff was until shortly before the War arranged in specialist divisions (e.g. tuberculosis) which dealt with the country as a whole. The re-arranged scheme divides the country into five regions, each with its headquarters, and each with a group of Medical Officers under the directors of a Principal Regional Medical Officer. This scheme enables the officers to become more closely acquainted with the conditions and problems of their regions, and makes them more accessible to Medical Officers of Health. There are in addition a headquarters service and specialist divisions concerned with the general aspect of particular health services.

Inspections may be made of branches of the services or full-scale surveys of all the services. In either case, they are followed by reports from the Minister, drawing the attention of the Council to any weaknesses or inadequacies and suggesting the steps to be taken to remedy these. The Ministry's Medical Officers are also available to Medical Officers of Health for consultation and advice.

The relation between the Ministry and the Local Authority should be the relation which exists between partners, each of whom undertakes functions which serve a common end. The task of the Local Authority is to apply its legislative powers in a manner best fitted to satisfy local needs, and for this reason, and because it bears a large part of the cost, it should have a considerable degree of freedom from detailed control. The Ministry's business is to lay down national standards, and to try to secure adherence to these standards everywhere. It is in a position to do this because of its greater knowledge of the public health services as a whole, which enables it to urge upon indifferent, because possibly ill-informed, Local Authorities the need to raise the level of the services for which they are responsible. The issue of memoranda on the steps to be taken in the event of the occurrence of rare

diseases (e.g. psittacosis, which made an appearance some years ago), and giving information about new methods of treatment that have proved to be effective, constitutes a valuable service rendered to Local Authorities by the Ministry. The success which it achieves in undertaking its share in the partnership is measured by the extent to which it is regarded as a source of help and stimulus rather than as a mere directing and controlling agency, seeking to impose its wishes by regulation and order.

This is not to say that the Ministry does not exercise powers of control. It does this indeed, or can do it, in several ways. Its permission must be obtained before money may be borrowed for capital undertakings. A statement must be submitted to the Ministry giving certain particulars: these include the amount of the proposed loan, the proposed period of repayment, the amount of existing debt, the product of *id.* rate, the rate levied in preceding years, rateable value, population and area. If the execution of works is necessary (e.g. building a hospital) plans and estimates have to be furnished. It is usual for a local inquiry to be held by an inspector of the Ministry, who needs to be satisfied that the project for which the money is to be borrowed is necessary, and that it conforms to the Ministry's view of what is desirable. In the case of a new hospital, for example, his considerable knowledge of hospital developments and experience of hospitals built elsewhere add weight to his views and may result in valuable modifications being made in the original plans. At the conclusion of the inquiry (at which the opinions of opponents of the scheme may have been heard) he makes a confidential report to the Minister, as a result of which the Minister's decision on the application is made and transmitted to the Local Authority.

The position in regard to the Metropolis is different. Various Acts give powers to borrow to the London County



Council, notably the London County Council (Finance Consolidation) Act 1912. The Council promotes each year a Money Bill, which does not seek Parliamentary sanction to borrow but limits the various heads of capital expenditure. With certain exceptions, therefore, the Council does not have to obtain the permission of a Government Department to borrow. Metropolitan Borough Councils have power to borrow with the consent in some cases of the London County Council (e.g. for hospitals) and in others of the Ministry of Health (e.g. for maternity and child welfare purposes). The County Council in its Annual Money Act obtains powers to lend money to Metropolitan Borough Councils, at a rate of interest fixed by itself. The greater part of the loans of the Borough Councils have been advanced by the County Council, although they are not restricted in regard to their source of borrowing.

A second method of control is by means of the audit of the Local Authority's accounts. This is carried out by the District Auditor appointed (with the consent of the Treasury) by the Ministry of Health. All the accounts of Local Authorities with the exception of county borough and borough councils are subject to audit (though the Local Government Act 1933 enables these to provide for their accounts to be audited likewise). In the case of county borough and borough councils, only certain of their accounts are audited by the District Auditor: included in these are the education and public assistance accounts. Among other duties the District Auditor is required to determine whether expenditure has been made in accordance with the law, to disallow expenditure contrary to law, and to surcharge any such expenditure upon the person or persons responsible for it. Local Authorities are therefore careful to ensure that no public money is spent on purposes which have not had legislative sanction. Difficulties may however arise in the interpretation of the

legal powers. In a particular case a District Auditor was inclined to disallow expenditure on cod liver oil emulsion which had been given free of charge to children attending a school clinic, on the grounds that the Local Education Authority had no power to supply medicine. It was with some reluctance that he accepted the opinion of the School Medical Officer that cod liver oil emulsion is a form of nourishment and could therefore be given under the provision of meals section of the Education Act. Appeal against the Auditor's decision may be made to the High Court or the Minister of Health (where the amount exceeds £500 to the former only). A person may apply for relief to the Court or the Minister on the ground that he acted reasonably or in the belief that his action was authorized by law.

Legislation may require Local Authorities to submit schemes which must have the approval of the Minister to become operative. County and county borough councils, for example, had to formulate schemes of their administrative arrangements for discharging the functions transferred to them by Boards of Guardians under the Local Government Act 1929. Failure to submit a scheme within the stipulated time may result in the making of a scheme by the Minister. Schemes for putting into operation certain provisions of the Midwives Act 1936 did not however require the Minister's approval. Similarly by-laws (e.g. in connection with the registration of nursing homes) have to be sanctioned by the Minister. Model by-laws are often framed by the Minister and adopted by Local Authorities. For most by-laws the Local Government Act 1933 has laid down a procedure which secures that before they come into force their requirements shall be brought to notice in the local Press and the deposit of the by-laws for inspection. Local Authorities have no general power to make by-laws: legislation confers the right for specific purposes.

Many Acts of Parliament empower the Minister to make regulations which have the full force of law. Thus the Public Health Act 1936 gives power to the Minister to make regulations for the prevention and treatment of infectious disease and in regard to the qualifications and duties of Medical Officers of Health of port health districts.

The Minister can exercise great influence in connection with Bills promoted by Local Authorities. A copy of a Bill must be delivered to the Minister by the promoter. Parliament may direct him to submit a report on a Bill. In any case, he is always at liberty to submit such a report, which in accordance with Standing Orders on Private Bills must be referred to the Private Bill Committee. The Committee are required to note in their report to the House the recommendations of the Minister, and to state reasons for their dissent where these have not been followed. The Bill may therefore be modified to meet the views of the Minister. Strong opposition on his part would in most cases result in the Bill being killed. The intervention of the Minister may be for the purpose of bringing pressure to bear upon the promoting Local Authority to improve its health services. Thus in a case which occurred a few years ago, a Bill to extend a county borough's boundaries was rejected because in the opinion of the Minister its sewage system was inadequate.

Since many of the services provided by Local Authorities are of importance to the community as a whole, part of their cost is borne by the Exchequer. The device of the grant-in-aid involves a very important control over local health services by the Ministry. Before dealing with this something must be said about the various forms of grant which are given.

Before 1930 most of the grants in aid of the health services were on a percentage basis—that is, a certain proportion of the approved net expenditure of Local

Authorities was paid by the Exchequer. For the school medical, tuberculosis, mental deficiency and maternity and child welfare services the grants were 50%, for the venereal diseases service the grant was 75%. Except in respect of the school medical service, these grants were abolished by the Local Government Act 1929 and grant on an entirely new basis was substituted. This change in the method of paying grant was part of a large-scale financial reorganization which followed upon the substantial derating of agricultural and industrial properties. For the health and certain other grants which had been discontinued and to recoup for loss of rates, the Act substituted a block grant in general aid of Local Authorities' undertakings and not specifically in respect of any one of them.

The defects of the percentage grant system were two. The first was that as the grant was only paid on approved expenditure, very close supervision of the work of Local Authorities was necessitated and detailed statements of proposed expenditure had to be submitted to the Ministry of Health. The other was that this method of grant was not related to the needs of Local Authorities, so that those which were least able to maintain adequate services received the least assistance from national funds.

The block grant remedies these defects. Recipients are free to spend the money as they like (within their legislative powers) since the amount is not determined in relation to their expenditure on particular services; and the size of the sum given to a Local Authority is so fixed as to take its needs into account. The grant can, however, be used to ensure a satisfactory standard of performance in the discharge of its functions by a Local Authority.

A brief account of the block grant must suffice, since it is dealt with more comprehensively in another volume in this series. To compensate Local Authorities for losses caused by the discontinuance of grants and by derating,

and to allow for expansion of grant-aided services, a national fund known as the General Exchequer Contribution has been created. Provision has been made to cover expenditure incurred by Local Authorities as a result of new duties being imposed upon them from time to time by Parliament. The additional expenditure which was involved by the Midwives Act 1936 has been met by a 50% grant, which will subsequently be merged in the block grant calculation. The grant is revised periodically, so that it can take into account rising expenditure consequent upon extensions of the Local Authority's services.

The General Exchequer Contribution is distributed according to a formula which takes into account certain factors which determine need. These are rateable value, unemployment, the number of young children and (in counties) density of population (this is because of the high cost of roads per head in rural as compared with urban areas). The actual population of the county and county borough is "weighted" as a result of the application of this formula; each receives as its share of the General Exchequer Contribution an amount equal to the proportion which its weighted population bears to the weighted population of the whole country. The county council is required to distribute to district councils their share of the grant, rural districts receiving one-fifth of the amount received by boroughs and urban districts.

Apart from criticisms of the factors employed in the formula (which has in some respects been amended by the Local Government Act 1937) Local Authorities complain that in the years before a periodical revision of the General Exchequer Contribution extra expenditure on health services has to be borne wholly by themselves. A more serious criticism is that their income from rates might in many cases be substantially higher than it is because of the considerable increase in industrial property, which as a result

of derating pays only a quarter of the normal rate. It has unfortunately been the case that for many Local Authorities in the years before the War the block grant was swallowed up by the mounting cost of poor relief, causing a steady rise in their rates.

Though the block grant avoids the meticulous supervision required in a percentage grant, it carries with it large powers of control over Local Authorities. The Minister is empowered to reduce the grant "by such amount as he thinks just" if in his opinion Local Authorities have "failed to achieve or maintain a reasonable standard of efficiency and progress in the discharge of their functions relating to public health services." The grant may be reduced also if he is satisfied that the expenditure of a council has been excessive and unreasonable: such expenditure is not merely that incurred on the health services. When a reduction is made, the Minister must lay before Parliament a report stating the amount of the reduction and the reasons therefor.

The Minister is thus armed with a very powerful weapon against indifferent or recalcitrant Local Authorities which he can use not only when services are poorly managed but when, though in themselves they may be above criticism, they do not expand to keep pace with growing needs. A reduction in grant might mean curtailment of services or an increase in local expenditure to maintain them: in either case the council might expect to arouse the resentment of the ratepayers. The possession of this power tends to maintain closer adherence to the Minister's conception of a proper public health standard than otherwise might be the case. Nevertheless, having regard to the great variations in the services provided by Local Authorities, to which fuller reference is made in a later chapter, it would not appear to be regarded very seriously. Use has not in fact been made of the power (at any rate, it had not been up to

a date shortly before the War), since it was stated that the Minister had had no cause to use it. It is certain that a reduction of grant, especially in respect of "excessive and unreasonable expenditure," would arouse great resentment, and, in the case of a large Local Authority, a considerable political storm.

In the case of grant being reduced the Local Authority may bring a Petition of Right (with the sanction of the Attorney-General) against the Crown and seek to prove that the money was unlawfully withheld by the Minister.

The Local Government Act 1929 did not make any change in the method of paying grant in connection with the school medical service. This continued to be 50% of net approved expenditure, payable by the Board of Education, and in consequence it has involved Local Authorities in the need to present detailed estimates of expenditure and to submit to a considerable degree of supervision. It is difficult to understand why the advantages both to Government Department and Local Authority which Parliament found in the substitution of block grants for percentage grants in connection with health services should not have applied with equal force to education services, at any rate to the school medical services. By Section 100 of the new Education Act the Minister of Health is to make annual grants to Local Authorities in aid of their expenditure on their school medical functions, unless arrangements are made for this to be done by the Minister of Education. At the time of writing it would appear that such arrangements have been made or are to be made, since the regulations prescribing the conditions to be fulfilled for the receipt of grant have been made by the latter Minister (Handicapped Pupils and Medical Services Regulations 1945).

The Minister of Health has a final power of control, which in practice is very rarely required to be used. This is

the power which may be exercised when a Local Authority fails to carry out its obligatory functions. If a complaint is made to him that a Local Authority is in default he may cause a local inquiry to be held. If as a result he is satisfied of the Local Authority's failure he may make an order declaring it in default and instructing it to remedy the failure. Should the Local Authority not comply with the order the Minister may do one of two things. He may apply to the High Court for the issue of a writ of mandamus, requiring the defaulting council to fulfil its duty. Failure to obey would involve the council in contempt of court. He may, if the defaulting body is the council of a county district (i.e. a borough, urban district or rural district), make an order transferring the functions to the county council; or, in the case of a county or county borough council, transfer the functions to himself. The expenses incurred in discharging transferred functions are recoverable from the defaulting councils by the county council or the Minister, as the case may be. Orders relating to defaults may be subsequently varied or revoked.

In regard to the school medical services, the Minister of Education has power to make an order declaring a Local Education Authority to be in default and giving such directions for its duty to be carried out as he thinks fit. These directions are enforceable by mandamus. The Minister has no power to exercise functions himself.



**PART THREE**  
**A NATIONAL HEALTH SERVICE**

## CHAPTER XII

### *Medical Services provided by other Agencies*

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#### *National Health Insurance*

ALTHOUGH the National Health Insurance scheme provides certain forms of medical care for about twenty million people it exists in almost complete isolation from the other public medical services. Any registered medical practitioner may have his name entered on the medical list compiled by the clerk to the local insurance committee. The insured person is supplied with a medical card by the committee, which he can present to any doctor on the list and ask to be accepted as a patient on his panel. If he is accepted, the doctor returns the card to the committee, who send it back to the insured person and supply the doctor with a record card.

A panel doctor is required to provide all necessary medical services except those involving special experience or skill which a general practitioner could not reasonably be expected to possess. Attendance upon a patient is at the doctor's surgery or, if circumstances necessitate, in a patient's home. The surgery and waiting-room accommodation must be adequate.

Insured persons must be supplied with 'proper and sufficient medicines.' As a general rule these are dispensed by chemists, but in areas where a chemist may not be easily available a panel doctor may be required by the insurance committee to supply them himself. There is no precise definition of medicines which may be supplied, and insurance committees may have to decide whether a par-

particular preparation is a drug coming within medical benefit.

There is no organic connection between the National Health Insurance scheme and the public medical services, by means of which a patient requiring specialist or institutional treatment may obtain it. A panel patient is in the same position as a private patient in this respect: he must make what arrangements he can, with or without the assistance of the panel doctor.

The local administration of medical benefit is the responsibility of insurance committees, one of which must be set up in each county and county borough. The council appoints one-fifth of the membership. Three-fifths of the members are representatives of insured persons. Of the remaining members, one is a medical practitioner appointed by the council, two are appointed by the local medical committee (which represents the practitioners in the area, whether insurance or not) and the remainder are appointed by the Minister of Health. The committee may have sub-committees (e.g. Finance, Medical Services). Its functions include the administration of medical benefit, the provision of medicine and appliances, and the investigation of complaints. Such matters as the suitability of surgery accommodation come within its concern. It has power to inquire into excessive sickness among the employees of a particular firm or Local Authority and to take steps to sue employers if this is due to negligence or 'unsatisfactory conditions of work'. This power, however, has only rarely been exercised. It is authorized to undertake health propaganda, with a view to diminishing the amount of sickness and so reducing the amount paid out in sickness benefit. A material reduction might result either in a lowering of the rate of contribution or an increase in the surplus available for additional benefits (i.e. extra to the statutory sickness and maternity benefits). Little use has been made of this power, though in some

cases insurance committees have co-operated with Local Authorities in health educational work.

It is generally agreed that insurance committees are not very effective bodies, and that their functions might very well be transferred to county and county borough councils. The prospective changes in the public health services will probably see the end of them, in their present form at any rate.

### *Private practitioners*

During the past century the official powers and duties of the general practitioner have been steadily increased by legislation, and he is thus more and more associated with the public medical services. He is one of a number of persons who may be required to notify a birth to the local Medical Officer of Health. He must notify certain cases of infectious disease, including tuberculosis in all its forms. On application, the Local Authority must supply him with approved drugs for the treatment of venereal diseases. In some areas he may be provided with material for immunization against diphtheria. A midwife may send for him to attend one of her patients, in which case he is entitled to submit a claim for payment to the Local Authority. He may request that a patient be admitted into a hospital for infectious diseases, or into a general hospital, and refer a patient to a tuberculosis or venereal diseases clinic. He is represented on the local insurance committee. As a citizen he may offer himself for election and be elected to his Local Authority, and he may be co-opted on to a committee of the Local Authority. He may as a member of the medical committee of a voluntary hospital be their representative on a joint committee of the voluntary and public hospitals.

It is important, therefore, that good relations should exist between private practitioners and the public services.

It is to the advantage of the family doctor that he should have knowledge of the various facilities provided by his Local Authority, and thus be in a position to advise his patients about them. A great deal of time can be wasted in making *ad hoc* inquiries about a particular form of treatment required for a patient. Some Local Authorities have adopted the sensible practice of sending all the general practitioners in their area lists of their clinic and hospital out-patient arrangements and such other of their services as may concern doctors in private practice, revising them as and when necessary. The earlier feeling that the public services were growing at the expense of private practice, that the State was entering into unfair competition with the family doctor, has been giving way to a realization that public and private medicine are complementary and not competitive. A very large number of mothers and young children attend maternity and child welfare clinics; but few of them could afford to or would go otherwise to private doctors, even if doctors had the time to give to them. Furthermore, the object of these clinics is to afford supervision and advice, which requires specialized knowledge, and not to give treatment, for which the mother is referred to her own doctor unless it is obvious that she is unable to pay his fees. The tuberculosis dispensary, again, provides expert knowledge and diagnostic facilities which the general practitioner does not profess to have; but in the case of the patient who does not require institutional treatment the general practitioner can rightly claim to undertake any necessary medical supervision, when the patient can afford it, in association with the tuberculosis officer. The general division of responsibility between private and public medicine should be that the latter should deal with those persons who cannot afford to or do not wish to make their own arrangements with doctors in private practice, and with those for whom special training

and knowledge and the resources of large-scale organization are required.

General practitioners, however, may and do play a more active part in the public health services, since many of them are engaged in part-time duties with Local Authorities. The great majority of poor law district medical officers are general practitioners, undertaking to provide medical care for the sick poor for remuneration at rates which vary according to circumstances. Many Local Authorities employ them as medical officers in maternity and child welfare clinics, and less frequently for the work of school medical inspection. There may come a stage in the expansion of certain services (for example, an increase in the number of clinic sessions) when it is impossible for the existing full-time staff to cope with it but when the added work is not sufficient to justify another addition to the full-time staff. In such circumstances it is convenient to appoint a private practitioner on a sessional basis. It may be impracticable, in any case, where there are a number of centres holding clinic sessions on the same occasions to have sufficient full-time doctors to man them, since there may not be enough work of other kinds to occupy them fully.

The British Medical Association are in favour of the introduction of part-time practitioners into the public services on the ground that it is important to establish a link between the private and public practice of medicine. There is indeed much to be said for this view. The Ministry of Health suggested some years ago that because it is necessary for a doctor in charge of an antenatal centre to have special experience of practical midwifery and antenatal work, there are material advantages in appointing part-time practitioners with these qualifications. The Education Act 1918 required Local Authorities to consider the employment of part-time staff in their school medical

services. Since the transfer of the functions of Boards of Guardians to councils, the considerable extension of hospital services has led to a great increase in part-time specialist staffs, attached to ear, nose and throat, eye and other particular departments. They are being used to a growing extent as consultants in connection with cases referred by doctors in charge of maternity and child welfare and school clinics.

Nevertheless, there are some disadvantages in the employment of part-time staff. They tend to be out of touch with the work of the public health department as a whole, and so may not be fully acquainted with other services available to their patients. Because of the claims of their private practice they may not be very punctual in their attendance. They may find it difficult to appreciate the need for record-keeping and be indifferent to the various forms required for statistical purposes.

Despite the growing contact of private practitioners with the public service, it is, however, nevertheless the case that, in general, private and public medicine tend to run along parallel roads rather than along the same road, to the detriment of the community and contrary to their own interests.

### *Voluntary Organizations*

Voluntary organizations of various kinds have played and continue to play a considerable part in the country's general medical services. The term voluntary is of wide application, since a large hospital with numerous paid staff and a small child guidance clinic with unpaid workers are both so described. It may be said of them generally that part of their funds at any rate derive from private sources and that they have complete or partial freedom in the management of their affairs. So far as their functions are concerned, they fall more or less into four categories. First,

bodies organized and controlled by their members to promote some interest of their own—institutions for self-help, as they have been described. Of such are the various types of Hospital Savings Societies, whose association with municipal hospitals has been dealt with elsewhere. Next, organizations for research and experiment, of which an example is the British Empire Cancer Campaign, which rely upon subscriptions and donations from the general public. Local Authorities may derive great benefit from the work of such organizations, since they can make use of the result in the shape of new forms of treatment in their own services. Thirdly, bodies which conduct propaganda, either on subjects as to the importance of which there is general agreement (e.g. personal cleanliness) or on those about which opinion is divided (e.g. birth control, sterilization). Bodies of this type are in nearly all cases national organizations, and carry out their work by means of the distribution of leaflets and pamphlets and in some cases by the production of films which they rent to Local Authorities, by arranging conferences and exhibitions and by providing speakers. Their income is derived from the sale of their publications and the charges which they make for their services in other directions. In some cases, Local Authorities may make grants (e.g. to the British Social Hygiene Council). The work of most of these bodies is co-ordinated by the Central Council for Health Education, on which both Government Departments and Local Authorities are represented, and to which reference has been made.

The fourth type of voluntary organization is that with a charitable or philanthropic purpose, which it furthers by the collection of private subscriptions and donations, so that certain services may be provided free or at a price less than cost to those who cannot obtain them out of their own resources. The voluntary hospital is the best known



example of this type of organization : others are maternity and child welfare associations, invalid children associations and district nursing associations. These bodies are controlled, at any rate in theory, by a general meeting of subscribers. If they perform specific services on a fairly large scale on behalf of a Local Authority in return for payment, the Authority may be represented on the executive committee.

If complete reliance upon privately-raised funds determines their right to be described as voluntary organizations, many of them have lost or are in process of losing that right. The voluntary hospital, for example, depends more and more upon payments made by patients directly or on their behalf by some hospital savings association, upon payments for services provided by agreement with Local Authorities and upon grants made by them. A blind association may act as agent for the Local Authority in discharge of some of its duties under the Blind Persons Act, and draw the greater part of its income from public sources. Many voluntary bodies receive grants in general aid of their work. Indeed Local Authorities are required to submit periodically to the Minister schemes for the payment of annual contributions to voluntary associations providing services in respect of blind persons, mothers and young children, and mental defectives. On application the Minister himself will pay contributions to these and other bodies and deduct the amount from the block grant.

In some cases a voluntary organization may be the only body providing certain services, relying solely upon its own funds, or being aided financially by the Local Authority. In others both the voluntary organization and the Local Authority provide the same services and thus need to co-operate if there is not to be overlapping and confusion. This position occurs particularly in regard to hospitals, but it is not infrequent where maternity and child welfare

services are concerned. In other cases again the Local Authority is responsible for certain parts of a service (e.g. general supervision of infants and some forms of treatment) and a voluntary body for other parts (e.g. convalescent homes).

Voluntary associations may have to devote a large part of their energies to raising funds and they may be inadequately staffed and equipped. They claim that they have a personal touch which is absent in public bodies, although this need not be and indeed is by no means always the case. On the other hand, there may be a sense of patronage about them or a sentimental approach to their clients, both of which are undesirable. One unfortunate consequence of the existence of a voluntary body may be that the Local Authority is content to let it go on providing services (possibly efficiently) on a limited scale, with the aid of a grant, in preference to taking over the work itself and carrying it out adequately. Where a grant is made, it is not always easy to secure from the organization the forms of records and statistics which are required for official purposes, or to be able to be satisfied that the grant is economically administered.

There is every need for the voluntary participation of individuals in the conduct of public affairs. But there is very much to be said against essential medical services being provided out of financial resources deriving from the pockets of the kind-hearted or the proceeds of street collections, and therefore subject to little if any public control. The provision of such services by voluntary organizations means that the medical care of the community is of a fragmentary instead of a unified character, and that the highest degree of efficiency and adequacy cannot be attained. The fact that voluntary bodies have undertaken pioneer work is too often used as a justification to let them continue as solely responsible when the importance of the work is well

recognized and has grown beyond their capacity to perform it on a scale sufficient to meet the need for it. When this stage is reached it is time for a private service to be taken over, adequately financed and integrated with the other branches of the public service.

## CHAPTER XIII

### *The Need for an Integrated Service*

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IF one looks at the medical care available to the community as a whole, one is struck by the complexity of the pattern and the absence of any clear design. The public medical services have developed in piecemeal fashion, coming into being at different times to serve different purposes and under different enactments. In some cases they have been instituted to meet needs not met or not met adequately by voluntary agencies. In other cases they have been introduced to make certain forms of medical care available to persons who could not or did not wish to secure them out of their own resources. In yet other cases they have been provided exclusively for those without the means to obtain medical care from any other source. Side by side with the public services are the voluntary services, which may or may not (according to circumstances) charge for the help which they give, and the private practice of medicine by doctors whose income is derived from fees. With this distribution of responsibility, it is not inappropriate to compare the medical services as a whole to a number of imperfectly linked pieces of machinery rather than to a single machine.

Although the provision of medical care has increased greatly in recent years it is nevertheless still far from the case that all persons, wherever they may live and at all times, can obtain all the care which they may require. There are many reasons (to quote the late Government's White Paper on a National Health Service) for this lack of "a comprehensive cover for health provided for all people alike."

Every one needs a family doctor to whom he can turn for consultation about his state of health. The National Health Insurance Scheme provides the services of such a doctor to approximately twenty million insured people (broadly all employed manual workers and non-manual workers—with certain exceptions—earning up to £420 per annum), but not to their dependants. The poor law medical service makes similar provision for the destitute. The rest of the population (about half) has to make what private arrangements it can afford, which means in practice that many people, especially the wives of lower-paid workers, have to go without the services of a general practitioner or can secure them only with great difficulty.

The National Health Insurance Scheme does not provide for specialist advice or hospital treatment. Where either is necessary, doctor or patient has to do what he can to obtain it, which may mean the expenditure of much time and energy in getting into touch with the Local Authority or voluntary organization which seems the appropriate body to meet the case.

Neither the services of a consultant nor a hospital may in any case be available, not necessarily because the patient is not eligible but because of where he happens to live. In some parts of the country hospital accommodation is ample, in others it is very limited. Large towns are usually well provided; but while the voluntary hospital can serve a district greater than that of the town itself the Local Authority's hospital generally can cater only for its own populace. In smaller towns accommodation may be absent, or the hospital may be so small as to make it impossible for it to be properly equipped or staffed. Of approximately 700 voluntary general all-purpose hospitals over 500 have less than 100 beds, more than half of these having less than 30 beds. Consultants are distributed unevenly throughout the country, being concentrated in

the vicinity of the teaching hospitals, which themselves are situated in the large towns. For many people therefore it is extremely difficult to have the services of a consultant, since (apart from other considerations) it may mean travelling considerable distances and possibly having to stay away from home overnight. General practitioners also are not spread out evenly. Many industrial towns are relatively under-doctored, while more prosperous towns tend to be over-doctored. It has been estimated that before the war there was in Richmond (Surrey) one general practitioner to every 1,440 people and in South Shields one to every 4,105. A small practice where patients' fees are high is as lucrative as a large one where fees are low, but the interests of patients tend to be less well served in the latter case, since less time and attention can be given to them. Moreover, the doctor who is burdened with a large practice may find it difficult to keep himself abreast of medical developments or to refresh himself by engaging in activities outside his profession.

There are very great variations in the adequacy and efficiency of the services provided by Local Authorities. This is not surprising in view of the large number of them upon whom legislation confers powers and duties. Voluntary hospitals and private practice are outside public control and do not therefore conform to any established principle of uniformity. The public services, however, might be expected to fit into a planned framework designed to secure a reasonable similarity and to meet needs equally, whether at a high or a low level. An inquiring foreigner, from an examination of health legislation, might deduce that this was the case, except for relatively minor differences. He would observe that legislation imposes duties and confers powers upon Local Authorities according to their status, and would assume that all Local Authorities of the same status would broadly be comparable with each other and equally

able to undertake their responsibilities. It would be a matter for surprise for him to discover that this was in fact far from being so. He would find that one county borough has a population of over one million, while another has one of less than thirty thousand. It would appear to him probable that the first could with economy and efficiency provide itself with all the institutional accommodation that it required; and equally probable that the other could not possibly do so. Pursuing his inquiries, he would be puzzled to find that some rural districts, with no power to provide certain kinds of institutions at all, had populations many times larger than that of the small county borough. It would by now be with less surprise that he learned that a Local Authority with great need for health services had much less financial ability to provide them than another whose needs were very much smaller. In short, he would discover that powers and duties are distributed among a great number of local agents widely dissimilar in all important respects. Having reached this stage in his researches, he would accept as an inevitable consequence the remarkable variations in the range, adequacy and efficiency of the services which in fact result.

An inquiry carried out by the writer into the services provided by eighty county borough councils a few years before the War revealed something of the extent of these differences. Thus only half paid the fees of midwives for their attendance upon necessitous mothers; a quarter had a service of home helps; less than half paid the fees of consultants called in by general practitioners in confinement cases; less than a fifth had "toddlers" clinics. One council spent £3 3s. per birth per annum on free milk for mothers and babies; another (also an industrial area) spent 3s. 9d. Of the six major forms of medical treatment for school children, twenty-eight councils provided all, thirty-five provided five, two provided three and one provided

two. Less than half gave any after-care to tuberculosis patients; only thirteen took any steps to provide them with suitable housing. The same situation would doubtless have been found in connection with the services provided by other types of Local Authority.

It will be noted that in none of the services instanced above is the size of population a factor that has to be taken into consideration, as is the case in regard to institutional accommodation. The smallest county borough, in so far as population is concerned, can pay midwives' fees and supply extra food to tuberculous patients: it is merely a difference in the scale of provision required that distinguishes it from the largest. Some other circumstances must therefore account for these particular inadequacies. The more important of these are (a) financial inability, real or imagined; and (b) indifference on the part of the council. The latter arises out of a third circumstance: that a good deal of health legislation is of a permissive character. Thus Local Authorities may provide for the welfare of mothers and young children, though they must appoint a maternity and child welfare committee; they may make arrangements for assisting in the prevention of blindness; they may provide hospital accommodation for persons who are sick. Even when legislation imposes a duty, as in the case of adequate arrangements for the treatment of tuberculosis, there are many opportunities for the exercise of passive resistance. The Ministry of Health, so far as major services are concerned, has to deal with 145 Local Authorities, each with its own peculiarities and differences, and each resolutely determined to put its own interpretation upon the meaning of adequacy. The number of Local Authorities which have failed to make proper provision for educable mentally defective children, although they have an obligation to do so, is some evidence of the extent to which duties can be evaded. It provides evidence also of



the reluctance of Government Departments to exercise their powers of enforcement, and of the not unwarranted belief on the part of Local Authorities that this reluctance exists.

Permissive legislation in the nature of things leaves a considerable degree of discretion to Local Authorities in the use they make of their powers, and thus makes it inevitable that there will be considerable variations in the level of the services which are provided. In some cases services are poor because the Local Authority sees no need for better ones. It may not regard dental care for expectant mothers to be of sufficient importance to justify an increase in professional staff; or it may feel that a disused church hall with minor alterations is adequate for the purposes of a school clinic. Real conviction as to the need for any services beyond a bare minimum is not by any means as widespread as it might be. Appeal for votes is still to a considerable extent based upon claims to have kept the rates low or promises to reduce them. An indifferent council is the product of an indifferent electorate, and measures to arouse informed interest are possibly of more importance in relation to the health services than to others which are the responsibility of Local Authorities.

There appears to be no reason why much permissive legislation should not be converted into obligatory legislation; since there is no congruity between a Local Authority's being required to make "arrangements for securing the provision of free medical treatment for pupils" (Education Act 1944) and merely being allowed to make "arrangements for the care of expectant and nursing mothers and of children who have not attained the age of five years" (Public Health Act 1936). Even in regard to obligatory functions the Ministry has difficulty in securing the attainment of standards which it considers desirable, but it is at least armed with more effective powers of persuasion.

The chief difficulty lies in the determination of what in respect of a particular Local Authority constitutes adequate services. Certain criteria can be applied. Long waiting lists for hospitals clearly indicate a shortage of accommodation. A school dental staff which is only able to deal with certain age-groups of children or children attending certain schools is proof that the staff is too small. But in many cases such tests cannot be used. Maternity clinics, for example, may appear sufficient to meet need, but more mothers might attend if another centre more conveniently placed were opened. An evening session at a tuberculosis dispensary might make it possible for workers to come for examination who could not or would not leave their jobs to do so. Compulsory legislation obviously cannot prescribe precisely what forms of service should be provided in the areas of hundreds of Local Authorities, each with its different circumstances and needs. It can do no more than declare it to be the duty of Local Authorities to make adequate provision in their areas and arm the Minister with various powers designed to secure that Parliament's intentions are fulfilled. All the evidence shows either that these powers are not sufficient or that they are not fully exercised. Annual Reports of the Ministry and of its Chief Medical Officer continually draw attention to deficiencies or refer hopefully to improvements that are being made.

While many Local Authorities would find it hard to defend themselves from the charge that their services were poor largely because they lacked the desire to make them otherwise, many could with justification say that it was because they were not in a financial position to do better. Their ability to provide more adequately for the health of their citizens might be enhanced in one or other of several ways. An increase in the general exchequer contribution, accompanied by a heavier weighting of the factors in the formula which determine relative need, is one way. An

amendment of derating so as to make industrial undertakings pay full rates instead of only one-quarter is another. It has been pointed out elsewhere that the increase in the yield of rates which would be secured (bearing in mind the considerable amount of industrial development since 1929) if industry paid full rates would be materially more than the amount fixed (£22 million) as compensation for derating in the general exchequer contribution. A considerable number of Local Authorities have expressed themselves in favour of the abolition of derating. A third way, and for other reasons probably the best, would be to make public assistance a national instead of a local obligation.

Professor and Mrs. Hicks are two of many who have pointed out (in *Standards of Local Expenditure*, published in 1943) the heavy burden which the relief of destitution still imposes on poorer Local Authorities. "There is not the slightest doubt . . . that expenditure on domiciliary relief is one of the main causes of high rates." They propose the creation of a national body which would precept a rate at a uniform level upon all Local Authorities and thus spread the burden over the whole country. "We have put this proposal . . . first in our list of suggestions, not only because it is the largest single step which needs to be taken, but because it is also very much the most urgent." It is generally assumed that the introduction of a comprehensive scheme of social security will in due course automatically bring to an end the expenditure of Local Authorities upon poor relief. Professor and Mrs. Hicks have pointed out, however, that this may not be the case, since Local Authorities may be required to pay into the social security fund an annual amount equivalent to their previous expenditure on public assistance.

Indifference to the need for decent health services and financial inability to provide them are, then, two of the causes of the considerable disparities which exist in the

public provision of medical care. To these must be added a third, of equal if not greater consequence, which applies to several branches of the public health service but particularly to the provision of institutional accommodation and specialized treatment. This is insufficiency of population. Where population is small the advantages of large-scale organization cannot be secured and expenditure, if undertaken at all, is thus disproportionately high. It is uneconomical to install very costly apparatus in a hospital if the number of patients for whom it will be used is small, or to employ specialist staff to see only a handful of people. In consequence, perhaps naturally enough, Local Authorities in such circumstances tend not to provide certain facilities which are available to the residents in larger centres. Since the population of small Local Authorities in the aggregate is of considerable size, a fairly large proportion of the total population is thus denied advantages which are at the disposal of the others. If in addition to a small population there is a low rateable value, the difficulties of the Local Authority are correspondingly greater.

The various arrangements for the joint ownership of hospitals and the use by one Local Authority of another's hospital represent the attempt to overcome the obstacles which stand in the way of adequate services. The disadvantages which attach to them have been already discussed. Yet, although they serve to meet needs which otherwise would remain unsatisfied, such arrangements have not been made on a sufficiently large scale, mainly because they depend upon a local initiative which is often wanting. There is a shortage of general hospitals, of sanatoria for tuberculous patients, and of institutions for the mentally afflicted which could be met by the creation of more Joint Boards. There is a shortage, also, to an undiscoverable degree, of specialized forms of treatment and of treatment of particular diseases: the Cancer Act

is proof of deficiencies in the latter respect. No plans for material improvement in the country's medical services (if they are to remain in large part the responsibility of Local Authorities) will be of much value unless the need for the creation of larger administrative units is recognized. The present structure of local government has been incapable of meeting satisfactorily all of the more recent demands made upon it. In regard to the generation of electricity Local Authorities are now little more than agents of the Central Electricity Board; while responsibility for trunk roads has been taken from county councils and vested in the Ministry of Transport. If the test of a good public health service is that adequate provision (adequate, that is to say, to meet varying needs) is made in all parts of the country, then quite certainly the existing service does not pass the test. Nor can it do so, while responsibility rests upon a great number of local agencies possessing considerable discretionary powers, varying degrees of financial capacity, and in many cases (not through their own fault, but because of their low population figures) incapable of carrying out that responsibility effectively.

Even if a radical reform of local government were undertaken, so that there was effected a considerable diminution in the number of Local Authorities exercising important functions and the substitution for them of a much smaller number of Authorities each large enough to be able to provide adequate services, there would still be variations in standards unless by some means or other their financial resources were equal. Even then, variations would continue to persist so long as Local Authorities had a large measure of responsibility for their services: differences between the most progressive and the least progressive might be great, with many gradations in between. It would clearly be impossible to preserve anything but a semblance of local responsibility if there had to be conformity to a standard imposed from outside.

For this reason it is tempting to suggest that Local Authorities should lose all their health functions, except those of an impersonal nature, and that they should be exercised by the Ministry of Health through some form of regional administration. If this were done, two advantages would accrue. In the first place, the cost of the public health service would be spread equitably over the country, since it would fall wholly upon the taxpayer. In the second place, and still more important, the standard of service would be the same everywhere. Local jealousies, failures to co-operate, the limitations of local government boundaries, the size of populations and lack of financial resources would no longer be the factors which determined whether services were good, bad or indifferent. While it is true that the Assistance Board works within a much narrower field, it was created to meet the same situation as exists in regard to the public health services: heavy financial burdens upon those Local Authorities which could least afford to bear them and marked differences in the rates of allowances granted to the long-term able-bodied unemployed.

A nationally uniform health service would, however, be bought too dearly if the cost were the loss to the community of a measure of control larger and more effective than can be exercised through Parliament. Lenin once said that the health of the people is the concern of the people themselves. The nearer the approach to the conception that health services are not provided for people but are provided by them, the more efficient, extensive and developing those services will be. The endeavour should be not to take responsibility away because so many are too indifferent or ignorant to shoulder it, but rather, in the various ways which can be employed, to create an informed public opinion that will not be satisfied with any service but the best. It is therefore of prime importance that the

present partnership between centre and locality should continue: the centre acting in a supervisory, advisory and stimulative capacity, the locality adapting and adjusting a nationally-conceived service to suit its own circumstances and requirements.

An informed public opinion must, however, be given the conditions in which it can exert itself, it must be made practically possible for it to secure its purposes. The most important requirement is that each administrative area should be capable of providing all, or almost all, its health services efficiently and adequately, and that a single Local Authority should be responsible. The only exception should be in regard to very specialized forms of treatment for which collective arrangements should be made. There is now a considerable volume of opinion which is in favour of the division of the country into areas so designed as to have resources which make possible the most effective provision of large-scale services of various kinds. Views differ, however, as to such matters as the optimum size of these areas, the range of services which might be left in the hands of smaller Local Authorities within the larger areas, and the method of election of the larger Authorities. A difficulty which faces all advocates of reform along these lines is that an area which is well suited for one purpose (e.g. general hospital accommodation) may be ill suited for another (e.g. water supply), since different factors determine these issues. Nevertheless, these are only minor problems to be solved in the creation of suitable areas for the most effective provision of the social services, in connection with which geographical and technical considerations are relatively unimportant. Those services in which these considerations are of great importance, and where areas of administration may need to be very extensive, might more suitably be the concern of regional or provincial boards.

It would be going outside the scope of this book to

engage in further discussion of these matters. Suffice it to say that a public medical service can be of maximum value to the community only if each Local Authority commands such resources in population and finance as to be itself responsible for the whole of the service in its area. Only if this is the case can all forms of medical care be provided, can the various components of the service be integrated, and can responsibility be clearly affixed and accepted. In terms of size such a Local Authority would require a population of not less than four to five hundred thousand. What constitutes adequate financial resources is much more difficult to determine, and it can only be suggested here that the expedient proposed by Professor and Mrs. Hicks in regard to the cost of public assistance might be applied also to the medical services, once a general standard had been laid down.

The creation, where necessary, of administrative units of the kind described would remove one of the causes of the worst defects of the public health service—the great disparities which exist as between one area and another. There would be no structural difficulties standing in the way of uniformity, even though varying degrees of indifference on the part of the public and inertia on the part of Local Authorities resulted in the continuance of some discrepancies. Even so, however, the most effective medical care would still be wanting so long as responsibility were divided between public bodies under public control on the one hand and private practitioners and voluntary organizations, not directly answerable to the public, on the other. An integrated service for health is necessary if the individual member of the community is to be able to secure at all times, wherever he may live and whatever his circumstances, all the attention and skill required to cure disease and to preserve physical and mental efficiency.

Such a service must provide for everybody, as the essen-



tial basis, a personal or family doctor, the first agency for advice and help to which a patient applies. Secondly, it must make readily available all the aids to diagnosis which the family doctor may require. Thirdly, it must supply all the forms of treatment and after-care which are outside his capacity to give or which cannot appropriately be given in the patient's home. Fourthly, it must arrange for domiciliary nursing when this is necessary. And lastly, medical care must be free of charge to the recipient. The reduction of avoidable disease and the enhancement of the national health is a duty which the community owes to itself as well as to the individual. To provide a service of this nature it must be ensured that all available resources are fully utilized and co-ordinated, and that deficiencies of any kind are made good. For this to be done, control and direction must be in the hands of a single responsible body, carrying out locally a national plan but with wide discretionary powers in its application to local requirements. This controlling and directing body must be popularly elected, not as an *ad hoc* but as an all-purpose authority, and have associated with it an advisory body (or bodies) representative of health workers and voluntary organizations in the area.

The fitting of private practice and voluntary organizations into a comprehensive, free service for which public bodies are ultimately responsible presents certain problems which cannot be altogether satisfactorily solved. They need not, however, stand in the way of far-reaching improvements in the country's medical services. These have reached a stage of development which demands that they should now be brought together to constitute a planned and directed national health service, which while it has been shaped by past experience will be an instrument more capable of satisfying present and future needs.

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