THE HEALTH OF THE PEOPLE

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HEALTH IS ONE OF our most cherished possessions. Like most precious things in life, its true value is not appreciated until it is lost. Unfortunately, we are not then in the best position to obtain the best provisions for regaining it. The patient stricken down with tuberculosis, panting with asthma and bronchitis, or bedridden with heart trouble is not the best protagonist for an improved health service. If human suffering, agony and sickness are to be relieved, then the healthy must take an interest before sickness overtakes them.

This book is dedicated to those among the healthy who are striving to improve the conditions of the treatment of the sick.

Part One:

HISTORICAL SURVEY

CHAPTER I

AN INTRODUCTORY SURVEY

SOCIETY MUST FIGHT DISEASE. Society cannot progress or advance without conquering disease. Primitive communities riddled with malaria, smallpox, cholera and tuberculosis remain primitive. Disease saps their mental and physical energy and hinders progress. On the other hand, it is only by the progress of science and society that disease can be defeated. The society whose highest scientific attainment in the medical field is the witch-doctor will rarely produce anything better in other fields.

The problem, which is that science and society cannot advance until they have conquered disease but that disease cannot be defeated until science and society advance, is not insoluble. The advance of science can be more rapid than the restricting influences of disease. (An example of society's advance after defeating disease is the building of the Panama Canal after the conquest of malaria.) The application of science is, however, restricted by other influences.

There is no doubt that world suffering could be considerably reduced and world production considerably increased if our scientific medical knowledge were more universally applied. Millions of people who are to-day suffering from malaria, smallpox and other infections could be playing a useful role in the reconstruction of our war-stricken world. War, which in some degree acts as a stimulus in the advancement of science, also produces conditions which promote the advance of disease. If there is another war, disease rather than any nation may emerge as the victor, with the complete annihilation of modern society.

The World Health Organisation (W.H.O.) emphasised the difficulty of achieving recovery in a war-stricken world saddled with the burden of disease-ridden populations. In a special number of the *Chronicle* of W.H.O. (August–September, 1948) the following observation was made: "It must not be forgotten that malaria strikes at hundreds of millions of persons each year and causes hundreds of thousands of deaths. Its effects are most

marked among rural populations, and thus it directly aggravates the world food-shortage." W.H.O. decided to confine its main activities to fighting the diseases which can be efficiently controlled by present-day scientific medical knowledge. W.H.O. recognised the fact that there was a general failure to apply this knowledge to the countries which were suffering most from the preventable disease. The W.H.O. *Chronicle* referred to this subject in the following words:

"Although the methods of curing or preventing certain diseases may be universally known, they are not in practice accessible to every country. Those in which malaria is rife do not manufacture D.D.T., and have to import it. Countries in which tuberculosis is rife are without institutes for the preparation of B.C.G., and lack the qualified personnel required to apply present-day methods of diagnosis and treatment. Nations producing new drugs, such as antibiotics and sulfonamides, which need complex and expensive apparatus for their manufacture, are not always those with the most urgent needs; nations impoverished by the war cannot afford the considerable expenditure involved in large-scale imports of these drugs, quite apart from restrictions arising out of trade agreements. Numerous countries have no personnel conversant with modern techniques; and, finally, very often, the populations are ill-informed or may even be ignorant of the course of development of a disease and of its consequences, and of what modern science can offer for the relief of suffering and the safeguarding of health."

In this book we shall only be dealing with the efforts of England to conquer disease. We must, however, bear in mind that England is only part of a greater community, that of the British Empire. There are some people who view with pride the advance of our medical services. They would soon lose their complacency if they reviewed the services of the colonial populations, for which we are responsible. When we study the medical services in England, we shall find that medical science is not fully employed in the interests of the whole community. This position applies to an even greater extent in the colonies.

The facts in the colonies speak for themselves. In October, 1945, Mr. George Hall, in a speech in Parliament, estimated that there were two million lepers in the British Empire. Major-General Hay, Chairman of the Tuberculosis Association of India, in his 1945 annual report, estimated that the number of

open cases of tuberculosis in India was 2,500,000, with 500,000 deaths annually. There were only 124 clinics and 70 hospitals and sanatoria, totalling 4,384 beds, to deal with these cases. Mr. Amery, in Parliament on April 17th, 1945, gave the number of deaths in India from smallpox as almost 50,000. In Bengal alone in 1941 there were nearly 400,000 deaths from malaria and over 100,000 from cholera and dysentery. On July 28th, 1944, Mr. Amery estimated in Parliament, that in Bengal in 1943, 700,000 human beings died from starvation or from endemic diseases which broke out on a large scale where there was malnutrition. Professor Arnold Sorsby estimated the number of blind in the native population of the British possessions in Africa, Asia, and Indonesia in 1945 as being considerably more than 10,000,000.

The "well-being" of the children in the colonies was vividly described by Miss Mary Darlow, O.B.E., of the Social Service Department of the Colonial Office, at a conference held by the National Society of Children's Nurseries in May, 1948. She said: "Compared with young Britons reared in the United Kingdom, Colonial children live infinitely more dangerously, and yet all the dangers are preventable. First of all, I want to talk to you about the children's weights. It was a sad fact that all the children without exception whom I saw weighed at this little clinic were at least one-third below the standard weight of children in the United Kingdom of the same age. This is probably due to the danger of malaria which affects many babies as early as the second month of life. The second point is the almost entire absence of fresh milk in Colonial territories, and the high price of dried or condensed milk. This means that the child is often breast-fed until possibly two years of age and that its diet necessarily suffers. The lack of a balanced diet, and the high starch content of bananas, rice and many other staple foods, perpetuate malnutrition which is almost universal.

"Food and water are often dirty, or carried in dirty containers, which brings a real danger both of dysentery and typhoid. In a small two-roomed house, still less in a one-roomed hut, storage facilities for food are lacking. Even where the food and drink are superficially clean, they are often infected, and practically 100 per cent. of African children have worms. At one clinic, one child, a tiny baby, had yaws, and one had marks suggesting a still more dreaded disease, leprosy.

"The prevalent worm- and fly-borne diseases come from nothing more deadly than failure to dispose correctly of household refuse, and still more of human excreta. The proper construction and due use of latrines is almost the most important lesson that can be taught in the Colonies."

The average expectation of life in the industrialised countries is fifty-seven years; in the backward countries only twenty-seven years. With an infant mortality rate in some colonies four or even five times as high as that in the United Kingdom, with millions of mothers dying or crippled in childbirth, there is extensive human suffering and misery with an enormous wastage of human life. The medical services to deal with these problems are, to quote a committee which investigated the medical services of Trinidad, "grossly deficient."

These facts should be engrained in the minds and consciences of all humanitarians who are seeking the advancement and progress of society. They should be especially noted by those doctors who, after studying the English figures for sickness and death, yet maintain that we have progressed almost as far as we possibly can with the general prevention of disease and that medical officers of health should now seek other outlets for their activities. No English doctor can rest with an easy conscience while millions of colonial subjects are suffering and dying from preventable diseases. The world cannot advance to prosperity as long as whole communities are retarded by sickness and disease.

Professor P. M. S. Blackett in his book, *The Military and Political Consequences of Atomic Energy* (1948), indicated that the proper use and application of atomic energy could, within a measurable period of time, bring up the standard of living of even the most backward countries, such as India and China, to the level of that of the United States of America. If the total energy per head in the U.S.A. is rated at 100, that of India and China is as little as two. Professor Blackett produces evidence to show that there are powerful interests in the U.S.A. whose leaders will obstruct the development of atomic energy for industrial purposes because they fear that the present industrial premacy based on oil, coal and steel would be undermined.

A large proportion of the world's population, within reach of the scientific knowledge and potentialities of the twentieth century and standing on the threshold of the [illegible] universal

abundance and prosperity, still lives in the ways of the nineteenth century, held back by forces darker and more evil than any known in history.

In the study of the development of the English services we shall find that in the last century we ourselves suffered from similar conditions, but with this difference: that the knowledge necessary to combat the various diseases had not yet been gained.

The study of how we struggled to overcome disease is not an easy one. The dividing lines between sickness, disease and health cannot be clearly defined.

If any hundred members of the public were asked what health is we should get many varying answers, but generally they would fall into two distinct classes: a feeling of well-being, i.e. the absence of symptoms, and the absence of disease. Being healthy is something more than this.

Doctors in London, Canada and South Africa thought it would be a good idea to investigate normal healthy people, but when they came to examine people who thought they were perfectly healthy they found that only one in ten had nothing the matter with them. The position is even more serious, for there are many departures from health which doctors cannot detect. If doctors were asked to examine a hundred Glasgow children under the age of two years from the tenements, and compare them with a hundred children of the same age from Birmingham, they would not be able to detect any appreciable differences between them. Yet, in a measles epidemic, for every child who died in Birmingham, three children would die in Glasgow.

We know that the children in our modern and secondary schools are shorter and weigh less than the pupils of the public schools; we also know that generally they suffer more from illnesses. No doctor examining individual children, however, can forecast which are going to suffer nor, apart from the weight and height and other general tests, can he point to any marked differences which explain the reason why certain illnesses are more common among those children.

We are therefore a long way from detecting the early departures from health and the early beginnings of illnesses. We can detect a case of diabetes, of gastric ulcer or of cancer, but we know practically nothing of the states that lead to them. Our

definition of health, from a scientific point of view, would have to be widened to include not only the absence of symptoms and the absence of disease, but also the absence of conditions that lead to illnesses. We can take even this a stage further.

There may be no symptoms, nor any illness, nor any specific condition leading to illness, yet by being given additional food a child may more readily grow taller and put on weight. In other words, there is not only a normal state of health, but also an optimal state of health and well-being. The questions we have just discussed are, however, for future research and action. They are mentioned simply to show that however successfully we may organise the treatment of illnesses, there will still remain wide scope for health workers, reformers and the Government.

Even though we appreciate that the promotion of health is a complex affair and that improvement of the environmental conditions is essential to preserve health, we must not ignore means to improve our medical services. War to-day is total and the war against diseases must equally be all-embracing. In the recent controversies surrounding the introduction of the National Health Service Act, 1946, there was a school of thought whose ideas and interests, though rooted in the past, declaimed a pseudo-revolutionary doctrine. They said, "Do not let us waste energy in organising new services for combating sickness. Let the Government rather concentrate on improving homes and people's dietary and thus build up health." Nobody denies the importance of these measures, and we shall be dealing extensively with this aspect when we describe the development of the health services, but it is significant that this line of argument arose in quarters where, generally, so-called extra-medical activities directed to improving environmental conditions were not enthusiastically encouraged.

In 1933, eighteen eminent physicians and surgeons of the British Medical Association Committee for Rheu[illegible] The loss of work-time from this disease was estimated at 5,500,000 days per annum, representing one-sixth of the total loss from sickness amongst insured workers. They reported the role played by insanitary environment, over-fatigue and malnutrition in the development of the disease.

They said that "the well-being of those engaged in industry, the provision of properly ventilated work-rooms, of dwellings free from damp, of bathing facilities, of proper food, of hours of

work organised to avoid undue fatigue and to allow for rest pauses, are most important in maintaining the general health and resistance to disease." This crippling disease was certainly widespread and important; the measures recommended could play a large part in its prevention. Doctors could give valuable assistance in the active implementation of these recommendations, but the report continues: "these, however, are largely sociological problems and though the medical profession *may* urge the adoption of such precautions, the execution of them requires communal or co-operative action." We can all agree with the latter, but it would be interesting to discover how far, in the last sixteen years, the medical profession has exercised its discretion in encouraging the responsible authorities to adopt the suggested precautions.

While we are dealing with the subject of rheumatism, it is interesting to see how another important body dealt with this problem. The National Federation of Trade Union Societies met at the end of May, 1933, and paid special attention to this subject. They said: "Much may be expected from slum clearance and better housing. Climate was much less important than defective hygiene in the home. Stuffy rooms and workshops, unsuitable food and clothing, want of fresh air and unfavourable working conditions do far more to lower resistance to rheumatic diseases than climate . . . the sufferer often did not give up work until the stage at which treatment was most likely to be successful was past." Here is a marked similarity to the report of the eminent physicians and surgeons. To the non-expert the recommendations for a remedy would appear to be simple, even though their application might be difficult. This body recommended the "wise provision and administration of additional benefits so that sickness and disability might be lessened and *thus*, in the long run, expenditure reduced." It would appear that the state of their accounts was at least equally as important as the state of the health of their members.

With this type of experience before us, with the poor record of the medical profession in the past in sponsoring and encouraging activities for improved conditions, it is with some scepticism that we greet the advice that the Government should concentrate on the improvement of social conditions, rather than on the reorganisation of the medical services. There is no reason why both aspects should not be tackled at the same time by the

Government and all interested persons. The problem of a naked, starving man is not met by saying "first get him clothes and then we will feed him." If we are interested in his survival we must assist him to overcome both deficiencies at the same time.

It will be interesting at this stage to examine some general effects of environment on the health of the people. Overcrowding, insanitary houses, insufficient food—all affect our sickness and death rates.

The infant mortality rate, the number of deaths of infants under one year of age, has always been a sensitive index of the living conditions in an area. Dr. Hersch maintains that it is the best single index of the degree of civilisation attained in a country. He stated that a high infant mortality shows a condition of poverty and inferiority, and that a low mortality reflects the best hygienic conditions, the greatest advances in medicine, bacteriology, chemistry, public education and intellectual progress. Dr. W. J. Martin compared the rate of England and Wales in 1935–9, 55 per 1,000, with that of New Zealand, 32; Holland, 38; and Australia, 39. He showed that the rate was much higher in the poorer social classes IV and V, than in the richer social classes I and II. He suggested that the pre-war rate for the whole country could be reduced probably by one-half.

The problem of infant mortality in Scotland has always been a major one and the Department of Health for Scotland instituted an inquiry into the possible factors involved. A quarter of the births of the country take place in the city of Glasgow, which is notorious for its slum conditions. Glasgow has the largest infant mortality rate of all the cities of Great Britain; during 1934–8 it was 99; the second largest rate was Sunderland, 80. The report suggested that the proportion of inadequately fed mothers in Scotland was high, resulting in insufficient breast feeding and inadequate and unhygienic artificial feeding. Scotland had also lagged behind in the provision of maternity and child welfare services, and because of overcrowding in the hospitals the incidence of infectious diseases was high. Some of the conclusions reached in the report were that a substantial reduction in the infant mortality of Scotland could be achieved by improving the social and environmental conditions; by enlarging and improving the child welfare services; and by the provision of more maternity hospitals.

If we compare the rates in different towns, we receive confirmation of the above findings. A poor county borough, such as Newcastle-on-Tyne or Gateshead, each with an infant mortality rate of 66 per 1,000 live births in 1938, has a much higher rate than a richer county borough, such as Oxford (35 per 1,000) or Bath (28 per 1,000). A comparison in a depression period (1935) shows even greater differences, with Newcastle at 86 per 1,000 and Gateshead 90 per 1,000, while Oxford's figures were 31 per 1,000 and those of Bath 35 per 1,000. The difference between the richer and poorer boroughs is not accounted for by difference in medical services but by the contrast in living conditions. This view is supported by the fact that when general conditions improved in the poorer boroughs, viz. in 1938, following the depression, the infant mortality rate improved. The nation, with its falling birth-rate, cannot afford this wastage of human life in infants.

Similar differences are recorded in a study of the general death-rate or the pulmonary tuberculosis death-rate. These differences are more marked if a poor area is compared with a rich area in the same city, e.g. Glasgow (1948):

	Persons per acre	*Infant mortality rate*	*Tuberculosis case rate*
Poor Suburbs			
Gorbals	154	70 per 1,000	4·3 per 1,000
Govan	71	71 per 1,000	4·0 per 1,000
Rich Suburbs			
Cathcart	9	20 per 1,000	1·4 per 1,000
Langside	36	19 per 1,000	1·7 per 1,000

The poor suburbs show infant mortality and tuberculosis rates two or three times higher than the richer suburbs.

It is said that only the rich can afford tuberculosis, but only the poor contract it. Tuberculosis is a dread disease. Over half the patients discharged from sanatoria are dead within five years, and there are up to 50,000 new cases every year.

Environment plays a large part in the development of the disease. The famous American textbook of medicine, "Osler", states: "Occupation has an influence in so far as insanitary surroundings, exposure to dust, close confinement, long, irregular

hours, and low wages favour the prevalence of the disease. Economic factors, social and home conditions are also of importance. Dwellers in cities in the dark, close alleys and tenement houses, workers in cellars and ill-ventilated rooms . . . are more prone to the disease." The famous English textbook, "Price," states: "Overcrowding, defective sanitation, dampness, dirt, lack of sunlight and insufficient ventilation are most potent factors in the spread of the disease, causing both lowering of resistance and increased facilities for direct infection." Referring to the effect of occupation, the author states that "the highest mortality from tuberculosis occurs in England amongst the workers in dusty occupations; thus, Cornish tin miners head the list. Any conditions leading to overwork or to underfeeding increase the liability to tuberculosis." An investigation into the occupations and working hours of cases of tuberculosis in Glasgow during the war years confirmed these statements. They showed that a combination of overwork, strain and ill-spent leisure played a major part in the increased number of cases.

Dr. Heaf, dealing with tuberculosis in industry, emphasised that "light work under bad conditions can be more harmful than heavy work under good conditions, as is seen by comparing the figures for farm labourers, stone-quarriers, smiths and steel forgers with those of hairdressers, barmen, costermongers and waiters." Certain dusts are particularly important. The death-rate among the grinders of Sheffield from pulmonary tuberculosis in 1938 was four times the rate for all persons over fifteen in Sheffield. Tuberculosis was especially common in those workers who suffered from silicosis.

Insanitary conditions and overcrowding have repeatedly been proved to play an important part in the causation of the disease. In certain districts in Liverpool, containing back-to-back houses, the death-rate from pulmonary tuberculosis was 4 per 1,000 (average of three years). After reconstruction the death rate in the same areas fell to 1·9 per 1,000 (average of three years). Sir John Robertson, in *Housing and Public Health* (1925), compared the death rates from tuberculosis in slum areas in Manchester and Birmingham (3·32 and 1·93 per 1,000) with those of areas which were mainly artisan (1·07 and 1·11 per 1,000) and found that in the slum areas the rate was from two to three times that of the artisan areas. The Registrar-General, in his Statistical Review for 1934 and 1935, referred to

the fact that the death-rate from pulmonary tuberculosis of females aged fifteen to twenty-five was highest where there was a high average of persons per room, i.e. where there was most overcrowding. As in the case of infant mortality, in order to combat tuberculosis a considerable amount of work requires to be done in improving environmental conditions, in addition to the direct improvement of the medical services.

Environment also plays a major part in the development of sickness, diseases and accidents in industry. Its influence has already been noticed in discussing the causes of rheumatism and tuberculosis. In addition, 30,000,000 weeks are lost yearly from such illnesses as respiratory complaints, psychoneurosis, gastric disorders, etc., and to the causes of these inferior factory conditions contributed their share. Accidents numbering over one-quarter of a million a year with 1,000 deaths are also largely preventable by improving factory conditions of work. This subject will be dealt with more fully when we describe the industrial medical services.

Good, adequate nutrition has always been important in building up resistance to disease. Here the first essential is to maintain an adequate diet for all members of the community. Dr. G. C. M. M'Gonigle produced evidence from Stockton-on-Tees to show that improved housing conditions could be accompanied by increase in death and sickness rates if less food were purchased because of increase in rents. Sir John Boyd Orr wrote in *Food, Health and Income*: "The rapid advance in the science of nutrition in recent years has shown that the influence of diet on health and physique is profound. It has been proved that much of the ill-health which afflicts human population can be attributed directly to deficiencies in diet, and there is a certain amount of evidence indicating that increased susceptibility to certain infectious diseases, such as tuberculosis, and other pulmonary and intestinal disorders in young children, may also arise from a faulty diet."

While a sufficient diet is the first essential, it is not the only factor. Good quality and standards of food are also important in avoiding illnesses, especially food-poisoning.

Another example of the importance of environment may be illustrated by the problem of dealing with road accidents. Region 1 may have an excellent system of dealing with road accidents, a perfect ambulance service, a perfect hospital, a

perfect hospital team, with a first-class rehabilitation system. Mr. Citizen, however expertly his broken limb may be set in Region 1, will prefer to travel in Region 2, where, although the medical service may not be as perfect as in Region 1, the roads are safer, better controlled and better lit, so that the chances of a broken limb are fewer.

It is evident from these illustrations that society cannot fight disease merely by improving the medical services. An attack must also be made on the harmful environmental conditions which are such potent factors in the development of disease. It thus becomes a struggle, not only of the doctors, the scientists and the reformers, but of the large majority of the population. No good or lasting success can be achieved without the united efforts of large sections of the population against the great disease-producers, insanitary conditions, overcrowding and malnutrition. Doctors must especially realise that a victory in the improvement of the medical services is a battle half won. Their efforts must also be concentrated on the general improvement in the conditions of living of the people. In this sphere it is obvious that the doctors cannot enter the battle alone. They must unite their efforts with those of all progressive sections of the people.

All parties during the Second World War recognised the fact that our medical services were ripe for reform. The National Government's White Paper *A National Health Service*, published in February, 1944, described the existing health services as follows: "A complicated patchwork pattern of health resources, a mass of particular and individual services evolved at intervals over a century or more—but particularly during the last thirty or forty years—and for the most part coming into being one by one to meet particular problems, to provide for particular diseases or particular aspects of health or particular sections of the community. Most of these services, though progressively expanded and adapted as the years have gone on, are still broadly running on the lines laid down for them at the start and are administered largely or, partly, as separate and independent entities." The main fault was that there had not been a serious attempt to co-ordinate or plan the health services. The avowed aim of all interested bodies was the establishment of a "comprehensive" medical service, a service which would be made available to all people and would cover all necessary forms of

medical care. It was described in the National Government's White Paper as a health service organised "at home, in the consultant room, in the hospital or the sanatorium, or wherever else is appropriate—from the personal or family doctor, to the specialist and consultants of all kinds, from the care of minor ailments to the care of major diseases and disabilities."

The Labour Party's pamphlet, *A National Service for Health*, published in 1943, followed the recommendations of the Beveridge Report, 1942 (para. 427), and called for "a comprehensive health service so that for every citizen there is available whatever medical treatment he requires, in whatever form he requires it, domiciliary or institutional, general, specialist, or consultant, a service which will ensure also the provision of dental, ophthalmic, and surgical appliances, nursing and midwifery, and rehabilitation after accidents." There was a marked similarity in the aims of all parties, although there was some considerable divergence in the method of the attainment of these aims.

The Minister of Health, in a foreword to the Labour Party's pamphlet, *A Guide to the National Health Act* (1946), said: "We are trying to secure that in the future the medical and health resources of the country are available to everybody in a rational and organised way, irrespective of personal means." In moving the Second Reading of the National Health Service Bill on April 30th, 1946, the Minister of Health concluded his speech with these words: "I believe it will lift the shadow from millions of homes. It will keep very many people alive who might otherwise be dead. It will relieve suffering. It will produce higher standards for the medical profession. It will be a great contribution towards the well-being of the common people." Whether these fine words are accurate predictions or merely the heady fumes of irrational optimism it is the purpose of this study to discover.

All governing parties have agreed that any workable solution must "use and absorb the experience of the past and the present building it into the wider service." For a correct perspective and understanding of the future development of the National Health Service it is necessary to study both the past and the present and their interconnections.

The agencies which deal with the medical services are, broadly, voluntary agencies based on charity, the State, insurance, and private practice.

Voluntary agencies have for various reasons played an important role in this country and will undoubtedly be encouraged to continue their good work. The State, emancipating itself from the shackles of the Poor Law, will play an ever larger and more important part and will assist in co-ordinating all these agencies. The State in the past, unfortunately, based its social security legislation and its medical services on the Poor Law. The new National Health Act, together with the National Insurance Act, 1946, have buried the Poor Law. We must beware that the spirit of the Poor Law does not return from the grave to rule us. Insurance or self-help, previously the choice of the more careful and usually more skilled workers, has now become general with the introduction of compulsory National Health Insurance. Private practice, which has played a large part in the development of our medical services, is expected to diminish considerably in the future. The future services will be based on the aforementioned three agencies, but whereas in the past these services have arisen in a completely unplanned way with little relationship to one another, in future all services will have to be co-ordinated for harmonious working, with special emphasis on prevention. It is essential to study the growth and development of these agencies in the past and present, in order to appreciate fully the roles they can play in the future.

We shall see that the medical services have varied throughout the ages according to the general standards of living, the struggle for their improvement, the advance of medical science, and the attitude of the Government. This development has been uneven. There has not been a slow and gradual progress to a complete abolition of poverty with a steady and comprehensive application of medical science. Standards of living have at times advanced rapidly, but at other times they have almost stood still or actually retrogressed, as, for instance, in the great depression and slump of 1932–5. The struggle for their improvement reached high levels in the Chartist period in the 1840's and in the great struggles of the miners in the 1920's, reaching low levels in the Victorian era and in the First World War.

The attitude of the government in power has to a large extent depended upon its political complexion, whether it was Tory, Liberal or Labour. As has already been mentioned, the State medical services were largely based on the Poor Law founded

by the Statute of Elizabeth. Even to-day in determining the legal meaning of charity the courts are guided by the list of charitable objects set out in the preamble to the Statute, 43 Eliz., c. 4, 1601. It will be interesting to give this list in full, for it sets the standards for social security legislation for the next 300 years. The list of charitable objects comprised the following:

The relief of aged, impotent and poor people.

The maintenance of sick and maimed soldiers and mariners, schools of learning, free schools and scholars in universities.

The repair of bridges, ports, havens, causeways, churches, seabanks and highways.

The education and preferment of orphans.

The relief, stock or maintenance for houses of correction.

The marriage of poor maids.

The supportation, aid and help of young tradesmen, handicraftsmen, and persons decayed.

The relief or redemption of prisoners or captives.

The aid or ease of any poor inhabitants concerning payment of taxes.

The Statute appears almost modern in its scope, which illustrates the fact that the placing of an Act on the Statute Book is no guarantee of its correct application in practice.

The three landmarks in the development of the State medical services were the Poor Law Amendment Act of 1834, the Local Government Act of 1929 and the National Health Service Act of 1946. The Act of 1834 set up Boards of Guardians elected by "Unions" formed by the grouping of parishes. These Boards were the first permanent local authorities charged with communal medical functions and directly responsible to the central authority, the three paid Commissioners of the Poor Law. This act was the forerunner of the first Public Health Act of 1848. The Local Government Act of 1929 transferred the functions of the Board of Guardians to the councils of counties and county boroughs. Finally, the National Health Service Act of 1946 transferred practically all medical services to the control of the central Government either directly, as in the control of hospitals through the Regional Hospital Boards, or indirectly, as in the control of the general medical services through the executive councils or the preventive health services through the local health authorities.

For the purposes of this study, however, it will be more convenient to divide the historical survey into three periods: the first period from the sixteenth century until 1848, the passing of the first Public Health Act; the second period from 1848 until 1919, the passing of the Ministry of Health Act; and the third period from 1919 until to-day, the passing and implementation of the National Health Service Act of 1946.

CHAPTER II

THE BIRTH OF THE HEALTH SERVICES: SIXTEENTH CENTURY–1834

THIS PERIOD MARKS THE growth of manufacturing industry in England which completed the change from an agricultural to an industrial form of economy. Poverty was especially marked at the beginning of this period, because the change was unplanned, and the casualties amongst the agricultural tenants were many. A great army of landless and propertyless men was created, firstly by enclosures, secondly by the break-up of feudal retainers following the Civil War, and finally by the dissolution of the monasteries.

The enclosures were a natural development in agriculture, the initial stimulus being the rise of the Flemish wool manufacture and the corresponding increase in the price of wool. This change from arable farming to stock-rearing required larger units with fewer tenants. The common fields where the tenants had their holdings were enclosed and concentrated and the tenants dispossessed. This process, which began in the middle of the fourteenth century, became more marked in the Tudor period. It was again intensified at the end of the eighteenth century and the beginning of the nineteenth century when large-scale arable farming had to be introduced in order to supply food to the growing industrial towns.

The break-up of the bands of retainers of the nobles was encouraged by the royal power to prevent the continual revival of civil war after the Wars of the Roses. The nobles, turning to the peaceful management of their estates, felt that these retainers were superfluous "everywhere uselessly filling house and castle." The dissolution of the monasteries in 1536 and 1539 added thousands of monastic servants to the ever-growing army of the unemployed. The estates of the Church were given to royal favourites or were sold to speculative farmers and townsmen at ridiculous prices. They converted their holdings into large estates, and drove the copyholders off the land.

These three streams of retainers, monastic servants and

copyholders went to swell the river of unemployed that began to flow through the land. There was no means of damming the flow for there was little work to be had, and the divorce of the peasant from his land prepared for his entry into the developing industries.

This period, however, was only the beginning of the Industrial Revolution; the great demand for labour was yet to come. In the meantime the dispossessed peasants and the disbanded retainers were an unnecessary burden and a distinct menace. The medical care of the population, based crudely on the charity of the past, had received a cruel blow from the disbanding of the monasteries. The main aim was to provide medical attention as cheaply as possible. Treatment was considered an unnecessary additional burden, except in epidemics, when fear stimulated the authorities to employ crude measures to combat the fevers. There was no serious attempt to practise preventive medicine.

As the industries at that time were developing slowly, the Government tried two methods of dealing with the increasing poverty, firstly by trying to restrict the enclosures and secondly by harsh, repressive laws against the poor. The first measure largely failed, for the justices of the peace, who were supposed to enforce these laws, were the very landlords who were responsible for the enclosures. In addition, it was necessary to develop large-scale farming to feed the growing towns.

The second method, the repressive measures against the poor, while unsuccessful in curing unemployment, set the pace for the treatment of the population until 1834. Sturdy vagabonds had their ears cut off, and were sentenced to death for a third offence. Vagabonds included any able-bodied common labourer who loitered and refused work for such "reasonable" wage as was commonly given. Refusal to work led to the man becoming a slave, forced by the use of a whip to work with a chain of iron about neck, arm or leg, and hunted down and branded if he ran away. Unlicensed beggars were flogged and branded with a hot iron with marks on forehead or on the cheek. The legally guaranteed right of the impoverished countryside to a share in the tithes had been confiscated with the abolition of the monasteries. There were paupers everywhere throughout the land, and in 1601 official recognition of them was given by the Poor Law Act, which levied a poor rate and authorised justices

of the peace to appoint unpaid overseers with paid assistants to administer relief. This Act also laid the primary responsibility upon the family: "It shall be the duty of father, grandfather, mother, grandmother, husband or child of a poor, old, blind, lame, or impotent person or any other person unable to work, if possessed of sufficient means, to relieve and maintain that person." Convenient houses for the sick and impotent were to be established by the justices of the peace.

In 1662 the Settlement Act was passed, which placed the responsibility of the poor on specific parishes, forbade migration, and by leasing out the poor to local farmers served as a subsidy to wages. Money collected for the poor rate was wasted in hounding potential paupers from parish to parish and in persecuting vagrants. Part went into the pockets of the unpaid parish officers who collected and spent the rates, as the justices of the peace who audited the accounts were not very competent. What remained was sparingly distributed as outdoor relief.

In 1772 the workhouse test was inaugurated: the poor who refused to live in the workhouses were to be refused outdoor relief. This Act stimulated the widespread erection of workhouses.

The standards of living for the majority of the population in this period were very primitive. Walter G. Bell, in his book, *The Great Plague in London in 1665*, gave a detailed and well-documented description of the living conditions in London at that time. The following are samples of the descriptions: "Foul streams like the Fleet, defiled from every overhanging house and neighbouring alley. . . . Laystalls of rotting town refuse, the sweepings of the streets, houses and middens, were piled high near inhabited quarters . . . low overhanging wooden houses, ill-kept, dark and congested, covered the ground in seemingly impenetrable rookeries of filthy courts and blind alleys. Back-to-back building was customary, to save cost and space. . . . Summer flies pestered the houses in such multitudes that they lined the walls, and where thread or string hung down, it was presently thick set with flies, like a rope of onions. Ants covered the highways, swarming so thickly that a handful at a time might have been taken up, and the croaking of numerous frogs was loudly heard even before the ditches sheltering them could be seen."

Sir John Simon, in his book, *English Sanitary Institutions* (1897),

described the London of this period as follows: "In general it had only alleys rather than streets: narrow, irregular passages, wherein houses of opposite sides often nearly met above the darkened and fetid gangway. The houses themselves, mostly constructed of wood and plaster, had hereditary accumulations of ordure in vaults beneath or beside them. Unsunned, unventilated dwellings, they, from when they were built, had been saturating themselves with steams of uncleanliness, and their walls and furniture must have stored an infinity of ancestral frowsiness and infection."

The medical and nursing standards were also primitive. The first institutions were based largely on charity, with a marked religious influence. Provision was made in the house of the bishop or the monastery for pilgrims who became sick, and similar provision was made for the sick poor in the area. Nursing and treatment were of a simple nature and it was rare for a physician to be in charge.

Hospitals had from two to 100 beds and provision was made for the poor and needy as well as for the sick. A few of the voluntary hospitals were founded and endowed by pious churchmen in the Middle Ages, but few survived the purge of the monasteries, St. Bartholomew's and St. Thomas's being notable ones that remained. These hospitals for the poor were mainly institutions where the sick poor could receive care and attention of the "home help" type of to-day.

It was only with the advance of the science of medicine that these hospitals gained their world-wide reputation. In 1789 John Howard, following his famous report on the prisons in 1774, gave his impressions of these hospitals. Middlesex Hospital was described as close and dirty, with beds of wood with testers which made the air breathed by the sick even worse than the air breathed in the ward. St. Thomas's had no water-closets, while both Westminster and St. George's were dirty. The staff was the worst feature. The nurses were rough and untrained, the porters extorted illicit fees; the bed-linen was seldom changed and the patients left unwashed. It was pre-Listerian medicine and surgery, and the death-rate inside the hospital was far higher than the death-rate outside. This was recognised by the authorities, who demanded deposits on admission to defray funeral expenses.

Fevers, especially the plague in the Middle Ages, terrified the

Government. Walter G. Bell, in *The Great Plague of London in 1665*, showed how the Government dealt with epidemics of fevers. The Court and Government, shelving their responsibilities, fled from London; their main concern was to escape the Plague. They did not return for seven months. During that period 100,000 persons died. The Privy Council, sitting with the King, concerned itself with the plague on only three occasions, two of which were concerned solely with protecting the King and the Court from infection. They had a precedent for this. In 1563 the dreadful Plague attacked London, killing 1,000 per week. Queen Elizabeth fled to Windsor, and set up a gallows in the market place to hang "without judgment" all those who came from London.

The well-to-do soon followed the examples of the Court and Government, and there began the great exodus from London, described by Pepys as "all the town almost going out of town, the coaches and wagons being all full of people going into the country." Merchants and tradesmen soon followed, leaving behind unemployed journeymen and servants to swell the crowded populations in the poorest quarters.

Sir Edmond Bury Godfrey, the magistrate, "condemned the callous indifference to their responsibilities of many of the wealthier exiles from the West-end" in the following words: "The poor people cry out upon the dearness of fuel and want of employment by reason of the King and the Court having been so long out of town, and some of the courtiers, nobility and gentry forget their debts as well as their charity.

"It was a crying scandal of the time that great numbers of these emigrants, whether of fashion or business, in their haste to put the Plague behind them and find a safe refuge left no bounty for their poorer and less fortunate neighbours and, moreover, left the pest rate unpaid. They could not be traced." Relief in these circumstances was very meagre, 2*s.* to 3*s.*, and the privation of the people lowered their resistance and enabled the Plague to spread.

The administration of London was paralysed; the Courts were adjourned, the judges and lawyers having fled from Town. The energies of those remaining behind were devoted almost entirely to combating the Plague. Their only solution was quarantine and the destruction of infected goods. Infected houses were closed, the doors sealed with staple and padlock, enclosing

both the sick and the healthy. They were only opened for the dead to be removed. Rarely did they open to set free the living and the cured. Whole streets and areas were dealt with in this manner. Pest-houses had been established in Queen Elizabeth's reign, and whilst sufficient in non-epidemic years were hopelessly inadequate in epidemic times. These "pest-houses," the forerunners of infectious diseases hospitals, were built outside the city, where patients could be conveyed on a magistrate's order. They lived up to their name, for they were simple wooden shacks where no treatment was given. The patients were largely left on their own to recover or, as was more often the case, they were left to die.

The practice of medicine at that time was mainly empirical, based on unscientific theories. The physicians in general attended the wealthy classes; their main concern in an epidemic was to find a refuge in the country whither their rich clients had fled.

During the period of the Great Plague in London, "the College of Physicians was deserted by the Faculty. Sir John Alston, the President of the College of Physicians, went out of London, and Dr. Sydenham—a great name in seventeenth-century medicine—afterwards wrote a short treatise on the Plague which he did not stay to see. These and others whose practice was among the wealthy classes had the poor excuse that their patients, having gone into the country, they must needs go to them."

There was little free domiciliary treatment, as it was not until 1687 that the College of Physicians authorised free treatment of the population. As in many of the poor homes there was a privy at the foot of the main staircase, the physician's visit was as brief as possible. The lower classes were treated by apothecaries, and the very poor were treated by so-called "wise women" with household remedies, who probably did less harm than the physicians.

Mr. Bell graphically summarised the position in the Preface to his book: "This book tells a tragedy of the poor. A few men—a very few—of birth, position and wealth stayed in London, sharing the suffering which was the lot of all . . . but in its immensity and in overwhelming proportion it was 'the poore's Plague.' " Smallpox added to the toll of death in London to the tune of 1,800 to 2,000 annually.

The Plague of London followed the English Revolution and

the Restoration. Organisations of the people barely existed so there was no organised opposition to the scandalous behaviour of the Government. Although many people died of starvation, the expected "hunger riots" did not take place. The national economy, still based largely on an agricultural basis, did not yet require the enormous number of recruits which industry was soon to demand. The Government, therefore, did not have the same incentive to deal with the Plague as was the case in succeeding fever epidemics. The Great Fire of 1666, which destroyed the insanitary dwellings, the narrow streets and the accumulation of excrement and refuse, was the most important factor in banishing the Plague.

In the reign of James II, the College of Physicians proposed the establishment of free dispensaries, but this move was opposed by the apothecaries, who were more interested in their "living" than in that of their patients. In 1770 the first dispensaries for the poor were established in London, many with a strong religious influence, dispensing their religion more freely than their medicines.

Midwifery was of a very primitive nature at this time, and was mainly conducted by ignorant, illiterate "handy-women." In 1726 the first Professor of Midwifery was appointed at Edinburgh University. In London, hospital provision was supplied by a small lying-in hospital attached to the Westminster Workhouse. In 1750, the City of London Lying-in Hospital was founded at the same time as the Queen Charlotte's Hospital.

The treatment of foundlings was appalling. Children were murdered by being left exposed in the streets, or put out to nurse under most vile conditions. In 1739, in order to prevent the exposure, desertion and murder of infants, the Foundling Hospital was established. Owing to the great demand for places and the terrible records of death in the bills of mortality, Parliament assisted the hospital financially from 1756 to 1760.

An Act was passed in 1767, enabling parish children to be sent out of London to be nursed, and there was a distinct improvement in the death-rates of mothers and children as a result. J. Howlett, in his *Examination of Dr. Price's Essay on the Population of England and Wales* (1781), estimated the average annual reduction in the London burials as a result of the Act as 2,100. The fate of these children, however, was often no better, for they were trained for spinning or weaving or a similiar trade and

transported in their thousands to the mills of Lancashire, Derby and Nottingham, where the mill-owners worked them to death.

A large proportion of these children came from the workhouses, where they were accommodated thirty to forty in a ward, with from six to eight in a bed. These children were apprenticed to the manufacturers in the Midlands and the North at a very early age. Many of them died before their apprenticeship was complete at the age of fourteen or twenty-four. Some were cast adrift when their master died and many were got rid of through the press gang or for work on a plantation. This wholesale migration from the South ceased when the manufacturers found it just as cheap to employ the children of the people who flocked to the new towns.

J. Aikin, in *A Description of the country from thirty to forty miles around Manchester* (1795), wrote: "Children of very tender age are employed; many of them collected from the *workhouses* in *London* and *Westminster* and transported in crowds, as apprentices to masters resident many hundreds of miles distant, where they serve unknown, unprotected and forgotten by those to whose care nature or the laws had consigned them. These children are usually too long confined to work in close rooms, often during the whole night: the air they breathe from the oil, etc., employed in the machinery, and other circumstances, is injurious; little regard is paid to their cleanliness and frequent changes from a warm and dense to a cold and thin atmosphere are predisposing causes to sickness and disability and particularly to the epidemic fever which so generally is to be met in these factories."

J. Fielden, in his book, *Curse of the Factory System* (1836), described the life of these children as follows: "In the counties of Derbyshire, Nottinghamshire, and more particularly Lancashire, the newly invented machinery was used in large factories built on the sides of streams capable of turning the waterwheel. Thousands of hands were suddenly required in these places, remote from towns; and Lancashire, in particular, being, till then, comparatively thinly populated and barren, a population was all that she now wanted. The small and nimble fingers of little children being by very far the most in request, the custom instantly sprang up of procuring apprentices from the different parish workhouses of London, Birmingham and elsewhere. Many, many thousands of these little, hapless creatures were sent

down into the North, being from the age of seven to the age of thirteen or fourteen years old.

"The custom was for the master to clothe his apprentices and to feed and lodge them in an 'apprentice house' near the factory; overseers were appointed to see to the works, whose interest it was to work the children to the utmost, because their pay was in proportion to the quantity of work that they could exact.

"Cruelty was, of course, the consequence. . . . In many of the manufacturing districts, but particularly, I am afraid, in the guilty county to which I belong (Lancashire), cruelties the most heart-rending were practised upon the unoffending and friendless creatures who were thus consigned to the charge of master manufacturers; they were harassed to the brink of death by excess of labour, . . . were flogged, fettered, and tortured in the most exquisite refinement of cruelty; . . . they were in many cases starved to the bone while flogged to their work and . . . even in some instances . . . were driven to commit suicide. . . . The beautiful and romantic valleys of Derbyshire, Nottinghamshire, and Lancashire, secluded from the public eye, became the dismal solitudes of torture, and of many a murder.

"The profits of manufacturers were enormous; but this only whetted the appetite that it should have satisfied, and therefore the manufacturers had recourse to an expedient that seemed to secure to them those profits without any possibility of limit; they began the practice of what is termed 'night-working,' that is, having tired one set of hands, by working them throughout the day, they had another set ready to go on working throughout the night; the day-set getting into beds that the night-set had just quitted, and in their turn again, the night-set getting into the beds that the day-set quitted in the morning. It is a common tradition in Lancashire, that the beds never get cold."

The worst feature of the treatment of the population in this period was the workhouse. Originally established to keep down the poor rate, it soon became a home for those who were abandoned, sick or infirm, orphans, the mentally defective, the mentally disordered, the unmarried mother, the aged and infirm. The "workhouse test" of 1722 stimulated the building of these forbidding structures. The case of Maidstone, described in the *Account of the Workhouses in Great Britain*, published in 1732, gives a good example of the methods used to reduce the poor rate. The report first pointed out that the cost of maintenance

in the "house" was half that of the weekly pay outside. Secondly, half the numbers of the poor, rather than submit to the confinement and labour of the workhouse, did not claim their allowance. The report went on to boast that with the introduction of these new measures the poor rate in the town was reduced from £1,000 to £530. It continued by saying that if all the poor were maintained in the workhouse then the cost could be still further reduced to £350. It is therefore not surprising that the treatment of sick persons and of children in the workhouse was scandalous. Often the inmates were given 2*d*. per day to roam the streets, from which, frequently after thieving, they came back drunk late at night. So bad were conditions in the workhouse that some of the inmates committed crimes to obtain their emancipation by being sent to prison. A House of Commons report in 1767 shows that out of every 100 children born in London workhouses in 1763 or received in them under the age of twelve months, only seven were alive in 1765. In 1772 the Parish Office report that they were obliged to put thirty-nine children in three beds. In the Holborn Workhouse, of 460 inmates, the children were leased out to a Barnet contractor at 3*s*. 4*d*. per head per week. Some contractors paid 4*s*. 6*d*. to take the more unruly elements.

The development of steam power and machinery was the signal for the rapid growth and acceleration of the Industrial Revolution. The flying shuttle was invented by John Kay in 1733, the spinning jenny by Hargreaves in 1765, Arkwright's water-frame in 1769, and Crompton's mule jenny in 1779. These machines revolutionised the textile industry and were set up in buildings which were the prototypes of the modern factory. They spelled the ruin of those working with hand looms. James Watt's discovery of steam power in 1781 made it no longer necessary for factories to be sited in lonely valleys, dependent on the rather fickle water power, which was subject to the vagaries of the seasons. Factories could now move to towns where they were nearer the markets and where there was a more plentiful supply of labour

With a few honourable exceptions, [illegible]re ruthless, harsh and selfish. These were [illegible]h guaranteed success and riches. Wh[illegible]e economically prosperous, its human [illegible]d for generations by these unscrup[illegible]

of riches. Encouraged by the theories of economists such as Nassau Senior, who with Chadwick was responsible for the Report of the Commission on the Poor Law Amendment Act of 1834, they contended that the entire profit of the mill was derived from the last hour of work.

The views of doctors excused the pace which was set for the maximum exploitation of human labour. Dr. Whatton thought that employment involving twelve hours' standing each day might be harmful for a child of six, but not for a child of ten, for "the labour is so moderate that it can hardly be called labour at all." He was sure that spinning was not unhealthy and could be carried on for more than twelve hours a day by a child under sixteen. Dr. Hardie stated that the inhalation of cotton flue was not injurious, "because the daily expectoration throws off the cotton; here is no Accumulation that takes place in the Lungs." Dr. Wilson thought that a lad of fifteen might well be expected to work twelve hours a day, exclusive of meals, and that it was not necessary for the child to have recreation and amusement to maintain him in health. These views, supported by Dr. Ure, whose description of the work of the children in the factories is given below, encouraged the mill-owners in their rapacious drive for riches irrespective of the human casualties. Dr. Ure referred to the children as follows: they "seemed to be always cheerful and alert, taking pleasure in the light play of their muscles. . . . It was delightful to observe the nimbleness with which they pieced the broken ends . . . and to see them at leisure, after a few minutes' exercise of their tiny fingers, to amuse themselves in any attitude they chose. . . . The work of these lively elves seemed to resemble a sport, in which habit gave them a pleasing dexterity."

The Government Commission which investigated the question of child labour in 1833 gave a different picture of some of the factories and the work of the children. The old and small mills were reported as "dirty; low-roofed; ill-ventilated; ill-drained; no contrivance for carrying off dust and other effluvia; machinery boxed in; passages so narrow that they can hardly be defined; some of the flats so low that it is scarcely possible to stand upright in the centre of the rooms." In addition, there was the danger from the unfenced machines and the harsh, cruel way in which the children were often treated by the overseers. The Commission found that the immediate effects of the work on the children were

"fatigue, sleepiness and pain," and the remote effects, "deterioration of the physical constitution, deformity, disease, and deficient mental instruction and moral culture."

Ten years later the Children's Employment Commission on Trades and Manufactures published their report on January 30th, 1843. Conditions had not improved; they gave instances of children working at three and four years of age; not infrequently at five, while in general regular employment commenced between seven and eight. The number of hours worked was most commonly ten, exclusive of the time taken for meals, but in great numbers it was fifteen, sixteen and even eighteen hours consecutively. The children were described as "for the most part stunted in growth, their aspect being pale, delicate and sickly, and they present altogether the appearance of a race which had suffered general physical deterioration. . . . The diseases most prevalent amongst them . . . are disordered states of the nutritive organs, curvature and distortion of the spine, deformity of the limbs, and disease of the lungs, ending in atrophy and consumption. . . . A large portion are in a lamentably low moral condition." These conditions persisted for at least another twenty years.

Mr. Boughton Charlton, a county magistrate, speaking as chairman of a meeting held at the Assembly Rooms, Nottingham, on January 14th, 1860, said: "Children of nine and of ten years are dragged from their squalid beds at two, three or four o'clock in the morning, and compelled to work for a bare subsistence until ten, eleven or twelve at night, their limbs wearing away, their frames dwindling, their faces whitening, and their humanity absolutely sinking into a stone-like torpor, utterly horrible to contemplate."

Epidemic fevers found a fertile soil in these conditions, and after a few alarming outbreaks an investigation by medical men, organised by the Manchester Board of Health, reported as follows (in 1796):

1. It appears that the children and others who work in the large cotton factories are peculiarly disposed to be affected by the contagion of fever, and that when such infection is received it is rapidly propagated, not only amongst those who are crowded together in the same departments, but in the families and neighbourhoods to which they belong.

2. The large factories are generally injurious to the constitution of those employed in them, even where no particular disease prevail, from the close confinement which is enjoined, from the debilitating effects of hot, impure air, and from want of the active exercises which nature points out as essential in childhood and youth, to invigorate the system, and to fit our species for the employments and for the duties of manhood.

3. The untimely labour of the night, and the protracted labour of the day, with respect to children, not only tends to diminish future expectations as to the general sum of life and industry, by impairing the strength and destroying the vital stamina of the rising generation, but it too often gives encouragement to idleness, extravagance and profligacy in the parents, who, contrary to the order of nature, subsist by suppression of their offspring.

4. It appears that the children employed in factories are generally debarred from moral or religious instruction.

In 1760, the earliest recorded agitation in England for the protection of child labour had appeared as an anonymous letter in the *Public Advertiser*. The author exposed the ill-treatment of chimney-sweeps' boys and the lack of clothing supplied by their masters. After this letter, Jonas Hanway investigated the conditions of the "climbing boys." He found that girls, as well as boys, were employed to sweep chimneys. Children, from the age of five upwards, were compelled to climb chimneys absolutely naked. They were often beaten to compel them to ascend and they often had to put out fires in the chimney. Some of them were burned to death, many fell and were crippled for life, and the majority suffered from skin diseases because of their contact with the soot. The boys were sometimes actually bought and sold or hired out by a master who kept an excessive number of apprentices. Hanway, in 1785, published his *Sentimental History of Chimney Sweepers*, appealing for government action, but it was not until 1788, two years after Hanway's death, that an Act, emasculated by the House of Lords, was passed to regulate the employment of these boys.

The Act was a dead letter from the start. Forty years later, Select Committees of the House of Lords, appointed in 1817 and 1818 to investigate whether any amendments to the Act were required, found the same horrors which Hanway had described

still prevalent. It was not until 1840, as a result of the agitation of the Earl of Shaftesbury, that a new Act was passed dealing with these abuses. As no provision was made for inspection, this Act would also have remained a dead letter if private individuals and organisations had not continually pressed for its implementation. Nevertheless, over twenty years later, in 1862, there were still twenty-six boys employed, contrary to the Act, by chimney-sweeps in Birmingham alone.

In the same year, a chimney-sweep, who lived near Hemel Hempstead and who was the only person in the county to use machines instead of boys, prosecuted one of the masters employing boys. He had secured a police constable as a witness. The magistrates dismissed the case and ordered the prosecutor to pay 12*s.* costs for daring to expose the abuses against the Act.

The history of the "chimney boys" has been given in detail as an example of the Government's and employers' attitude to essential reforms. The same applied to other classes of workers in different sections of industry. For instance, between 1802 and 1833, the period of new factory legislation, Parliament passed five general labour laws, but was shrewd enough to refrain from voting a penny towards paying the necessary official staffs for inspection and enforcement. With these conditions prevailing, it is not surprising that the abuses and horrors which existed in the 1760s were still present a century later.

The increasing demand for labour in the new factories and in the growing large towns gave an added stimulus to enclosures. There were 200 Acts accounting for 300,000 acres between 1700 and 1760 and over 200 Acts comprising over 2,000,000 acres between 1761 and 1800, with a similar number up to 1850. The crisis following the Napoleonic Wars added to the plight of the agricultural workers. Cobbett, in describing them, wrote: "I see them as thin as herrings, dragging their feet after them, pale as a ceiling, and sneaking about like beggars."

An example of how the landlords carried out the enclosures and dispossessed the agricultural smallholders is given in the case of the Duchess of Sutherland. By similar methods in the past she had already reduced the population in the county to 15,000. "During the years 1814–1820 these 15,000 inhabitants, about 3,000 families in all, were systematically hunted away and extirpated. All their villages were destroyed and burned, all their tilled fields were converted into pasture.

"British soldiers were placed at Her Grace's disposal for carrying out these measures, and the redcoats came to blows with the natives. One old woman perished in the flames of her cottage, refusing to leave it. Thus did the Duchess gain possession of 794,000 acres of land, which had from time immemorial belonged to the clan. She assigned to the evicted inhabitants about 6,000 acres by the seashore, this amounting to 2 acres per family. The area in question had hitherto lain waste, bringing in no return to the inhabitants. The Duchess, in the goodness of her heart, actually went so far as to let this land to the clansmen at an average rent of 2*s.* 6*d.* per acre, payable by those who for centuries had shed their blood for her family. The whole of the stolen clanlands she divided into twenty-nine huge sheep-farms, each inhabited by one family, usually consisting of imported English farm servants.

"By the year 1825, the 15,000 Gaels had been replaced by 131,000 sheep. The remnant of the aborigines, outcasts on the seashore, were trying to gain a living as fishermen. They had become amphibians, living, as an English writer says, half on land and half on the water, and withal only half living on both."

The number divorced from the means of their livelihood was increased by the handicraftsmen in the homes who found it impossible to compete with the new factories using mechanical power. The dispossessed smallholders, the bankrupt handicraftsmen flocked into the new towns seeking work and a living. Work was not always immediately available, and of those who found work many were impoverished by illness, sickness, or factory accidents. The number of paupers increased by leaps and bounds. The old Poor Law system, which only gave relief to a pauper in the parish where he was born and always held over the head of any potential pauper the threat of deportation to his birthplace, was dealt a death-blow by this wholesale migration which resulted from the Industrial Revolution.

Inadequate wages was also a factor in creating paupers. In 1795, with wheat at 75*s.* a quarter and wages only 8*s.* per week for agricultural workers, it was impossible for a man and his family to exist; after "bread riots" in which food was seized and sold at a reduced price in almost every county in England, the Speenhamland system was inaugurated. This regulated the amount of relief to "every poor and industrious man" according to the price of bread. In effect this became a subsidy to low wages

and the ratepayers suffered, whilst the large employer gained at their expense. The whole working population was pauperised. The Speenhamland system was also an encouragement to the growth of population, as children became a source of income. Bastardy was actually stimulated and in some districts the possession of two or three illegitimate children was considered as an advantage and looked upon as a dowry.

It was in this period that Malthus produced his famous theory on the growth of population. In the first edition of his pamphlet (1798), he maintained that the population grew much faster than the production of food which could support the population. This process, if unchecked, would produce starvation and famine, and the only restrictions on population were vice and misery. The essay ran into six editions, the last appearing in 1816. He was bitterly attacked because of this doctrine, and in the later editions, e.g. 1803, modified the principle by referring to "moral restraint" as an additional check to the increase of population. He still maintained, however, the completely erroneous teaching that population increased in geometrical proportion and that food increased in arithmetical proportion. He was never able to prove this theory, and with the increase in capacity of industrial production and the improvement in agriculture it was clearly shown that an additional citizen was not merely another mouth to feed, but also an extra pair of hands. With modern methods of production, he can more than support himself if given the opportunity. We still have the Neo-Malthusians with us whose doctrine is one of "moral restraint." They conflict somewhat with the other pessimistic school of thought which maintains that we are facing ruin because of a declining population.

The latest edition of the *Encyclopædia Britannica* (1946) after disposing of the Malthusian doctrine with powerful arguments, proceeds to state that it is possible that it applies to the countries of the East. The *Encyclopædia* omits the real reason for the popularity of the Malthusian doctrine, which is given in an earlier edition (1911). Malthus used his theory to condemn the Poor Law system with its indiscriminate doles and bounties. The author of the earlier *Encyclopædia* article says: "It can scarcely be doubted that the favour which was at once accorded to the views of Malthus in certain circles was due in part to an impression very welcome to the higher ranks of society that they

tended to relieve the rich and powerful of responsibility for the condition of the working classes by showing that the latter had themselves to blame and not either the negligence of their superiors or the institutions of the country." It was a convenient doctrine for it discouraged all active attempts to improve the conditions of the people which would induce them to become more prolific and thus worsen their conditions.

Similarly to-day the Malthusian doctrine is used as a cloak and an excuse for the inactivity of governing circles in eliminating conditions of poverty and malnutrition in the East. The East, like the West, when it becomes modernised, will soon prove in practice the falsity of the Malthusian doctrine.

CHAPTER III

THE BIRTH OF THE HEALTH SERVICES (*CONT.*): 1834-48

THE GROWTH OF POPULATION between 1800 and 1831 was 5 million, compared with 3 million for the previous century and 1 million each for the preceding two. The towns began to attract population—the dispossessed agricultural smallholders, the ruined hand-workers, the demobilised soldiers returning from the Napoleonic Wars, and the emigrant Irish labourers fleeing from the oppression and starvation caused by absentee landlords. Manchester grew from 35,000 in 1800 to 353,000 in 1841; Bradford and Oldham, in a similar period, grew from 300 to 23,000 and 38,000 respectively. Between 1801 and 1841 the population of Leeds grew from 53,000 to 152,000; Birmingham from 23,000 to 181,000; Sheffield from 46,000 to 111,000.

The poor rate was mounting. From £700,000 in 1750, it had stood at £2,000,000 in 1790, rising to nearly £4,000,000 in 1800 and later to nearly £7,000,000. The "Swing" riots of the labourers in 1830 for a living wage in which agricultural machines were smashed, hayricks fired and workhouses destroyed, and the Luddite riots centred in Nottingham, in which factory machines were smashed, were easily suppressed by the Government, but they demonstrated the feeling and temper of the people. Following a severe epidemic of cholera, a commission was appointed to investigate the Poor Law, and revealed a multitude of abuses.

In spite of the appalling sanitary conditions in the new towns, in spite of the numerous deaths from infectious diseases, the Government had not introduced any suitable public health measures. Sir John Simon, in his classic work, *English Sanitary Institutions* (1897), summed up the situation as follows: "Thus, in 1830, when William the Fourth began his reign, and equally in 1837 when the reign ended, the new knowledge was virtually unrecognised by the Legislature. The Statute Book contained no general law of sanitary intention, except (so far as this deserves to be counted an exception) the Act providing for

quarantine, under which well-intentioned but futile Act, the Lords of the Council were supposed to be always on the look-out for transmarine dangers. Against smallpox, Parliament usually voted annually £2,000 to support a National Vaccine Board which had a few vaccinating stations in London and furnished the public with vaccine lymph. Outside these two matters, the Central Government had nothing to say in regard to Public Health, and Local Authorities had but the most indefinite relation to it. Various important towns had their special Improvement Acts for certain purposes; but among the purposes Health had hardly begun to stand on its own merits."

In 1832 the Government appointed a Royal Commission, with Chadwick as Secretary, to inquire into the working of the Poor Laws. The Royal Commission on the Poor Laws ignored the possibility of sanitary reforms. Their remedy, based on "Malthusian" doctrine, was harsh and repressive and was embodied in the famous Poor Law Amendment Act of 1834. Lord John Russell considered that the Act had "saved the country from social evils if not from social revolution." The Act abolished all outdoor relief and made workhouses the only places where relief could be granted. The able-bodied inmate must be "subjected to such courses of labour and discipline as will repel the indolent and vicious."

The principle of "less eligibility" was also established, and the relief of the pauper kept his living conditions lower than that of the least prosperous workers outside. This principle is admirably described by a Poor Law inspector in 1903 in a report to the Local Government Board, in which he bemoaned the fact that the inmates of the workhouses were enjoying too much comfort. He said: "The guiding considerations on this point, laid down by the Poor Law Commissioners in their Report of 1839, are too frequently forgotten. They may be briefly stated thus: The fundamental principle with respect to the legal relief of the poor is, that the condition of the pauper ought to be on the whole less eligible than that of the independent labourer. A public establishment, *if properly arranged*, secures to an inmate a larger amount of bodily comfort than is enjoyed by an independent labourer in his own home. His rooms are larger, better ventilated, and better warmed; his meals are better, and more regularly served, he is more warmly clad, and better attended on in sickness. Hence the only mode, consistent with humanity,

of rendering the condition of the pauper inmate less eligible than that of the independent labourer is to subject him to such a system of labour, discipline and restraint as shall be sufficient to outweigh in his estimation the advantages which he derives from the bodily comforts he enjoys."

This was the considered opinion of a Poor Law inspector. One can imagine, with this type of mentality prevailing, how many establishments were "properly arranged." There is no indication here that the inspector has the slightest idea of the real causes of poverty, sickness or disease. He actually went a stage further and extended these inhuman principles to those who were incapable of working. He said: "There is a danger in these days, in the anxiety to make the old and infirm inmates of our workhouses comfortable, of forgetting that, even in their case, there must be a degree of discipline and restraint to counterbalance the additional comforts and advantages and consequent attractions of a properly arranged workhouse."

The main aim of the Act was to abolish the Speenhamland system of subsidising wages from the rates. The obvious solution of raising wages was not even considered. In the opinion of the authorities, the only way to relieve the rates of their heavy burdens was to reduce the subsidies and to discourage applications for relief.

The administration of the Act was placed outside popular control under the direction of three commissioners at Somerset House who were nicknamed the Three Kings, the Three-headed Devil, or the Three Bashaws. The workhouses, known to the people as "bastilles," came under the control of unions of parishes instead of single ones. These unions had to elect a board of guardians who were responsible to the Three Kings of Somerset House. This central authority could issue either general orders, which were subject to supervision and control by Parliament, or special orders, which were not. In the seven years they were in power not one general order was issued. In the worst bureaucratic fashion, identical special orders were issued to all the unions. Their attitude to the administration of the workhouses is well illustrated in a letter addressed to the Poor Law Commissioners by Sir F. B. Head, Assistant Poor Law Commissioner, the designer of the workhouses: "My principle for a poor house is this: Build poor men's cottages; but, instead of having one long street, bend it into a quadrangle,

which forms also a prison, having within itself an area of ground in which the Board can introduce any system it may choose. . . ." This plan in its naked simplicity was carried out in many unions.

The reaction of the people was swift. Workhouses were stormed and burnt, and a campaign against the Poor Law was one of the aims of the Chartist Movement. The farm labourers, the hand-weavers and spinners, though driven by competition to starvation levels, had managed to survive with the help of the poor rate. Now they were offered the factory or the workhouse, and the conditions in the workhouse were made so bad that even the dread factory was attractive in comparison.

The rapid growth of the population led to a tremendous spurt in building. Factories, warehouses, houses and slums were all built in an unplanned fashion, higgledy-piggledy, with no concern for the health of the inhabitants. The main drive was production and profit. The conditions of living at that time beggar description. Streets were generally unpaved, rough, dirty, filled with vegetable and animal refuse, without sewers or gutters, but supplied with foul, evil-smelling, stagnant pools. The houses were back to back, crowded together in narrow streets, with no direct water supply, no sanitary conveniences and with little light and air.

The health of the population was still further undermined by appalling conditions in the factories, where both children and adults worked long hours. The factories were overcrowded, ill-lit, ill-ventilated, damp, with no safety measures against dangerous machines or noxious vapours and substances. The diet of the people was bad and inadequate. The potatoes were poor, the vegetables wilted, the cheese old and of poor quality, the bacon rancid, the meat lean and tough and often half-decayed. The dough for making bread was often mixed with human sweat, discharge from abscesses, cobwebs, dead cockroaches and decayed German yeast, in addition to alum, sand and other mineral substances. In many industries the workers were compelled to purchase at the company's stores inferior foods at grossly inflated prices as credits against their wages.

An example of the dangers resulting from the adulteration of food was given in a report entitled 'A Milk Walk' which appeared in the *Bristol Times* of June 30th, 1855. It described how a milkman was seen to add to his milk water from a running

stream. This stream "received a large proportion of the sewage of the village of Stapleton, and the entire sewage of the workhouses of Fishponds and of Stapleton—establishments counting between them some 1,200 inmates, *and two large infirmaries*!" The *Inverness Advertiser* reported that an examination of all the milk-carts coming into that town had led to the discovery that only two out of a dozen on the east side of the river carried milk entirely unadulterated.

It is not surprising that in this atmosphere epidemics began to spread. In 1831, 21,000 died from cholera alone. In the year 1837 there was an outbreak of typhus in London. At the same time there was a bad harvest, rising prices and an increase in unemployment. The Commissioners of the Poor Law were alarmed at the increase in the numbers requiring relief as the result of unemployment and the disablement or death caused by the infectious fevers. In order to strengthen their case with the Home Secretary for the suppression of nuisances, they appointed three doctors, Dr. Neil Arnott, Dr. Southwood Smith (the chief physician of the London Fever Hospital) and Dr. James Phillips Kay (an Assistant Commissioner), to make local examinations in the parts of London where fevers were most prevalent. The reports of these doctors in 1838 showed that in London in an area with a population of 77,000, 14,000 were attacked by fevers and one in five had died. The reports showed that "in quarters inhabited by hundreds of thousands of the labouring classes . . . the general fact as to lodgement was: crowding more or less dense, in courts, alleys and narrow streets almost insusceptible of ventilation, in dwellings . . . not fit to be inhabited by human beings; while, all around the dwellings, the utter absence of drainage, the utter omission of scavenging and nuisance-prevention, and the utter insufficiency of water supply, conduced to such accumulations of animal and vegetable refuse, and to such poundings of ordurous liquids, as made one universal atmosphere of filth and stink."

Dr. Southwood Smith went on to say: "While systematic efforts on a large scale have been made to widen the streets, to remove obstructions to the circulation of free currents of air, to extend and perfect the drainage and sewerage, and to prevent the accumulation of putrefying vegetable and animal substances in the places in which the wealthier classes reside, nothing whatever has been done to improve the conditions of the districts

inhabited by the poor. . . . Such is the filthy, close and crowded state of the houses, and the poisonous condition of the localities in which the greater part of the houses are situated from the total want of drainage, and the masses of putrefying matters of all sorts which are allowed to remain and accumulate indefinitely, that during the last year, in several of the parishes, both relieving officers and medical men lost their lives in consequence of the brief stay in these places which they were obliged to make in the performance of their duties. Yet in these pestilential places the industrious poor are obliged to take up their abode; they have no choice; they must live in what houses they can get nearest the places where they find employment.

"The public, meantime, have suffered to a far greater extent than they are aware of, from this appalling amount of wretchedness, sickness and mortality. Independent of the large amount of money which they have to pay in support of the sick, pauperised in consequence of the heads of those families having become unable to pursue their occupations, they have suffered still more seriously from the spread of fever to their own habitations and families."

These reports were sent to the Home Secretary, Lord John Russell, and in a covering letter Chadwick, the secretary to the Commissioners of the Poor Law, referred to the heavy burden thrown on the poor rates by "these constantly recurring causes of destitution and death" and urged that powers be given to the Board of Guardians to suppress nuisances and enforce sanitation. The letter continued: "The most prominent and pressing of the first class of charges for which some provision appears to be required, are for the means of averting the charges on the poor rates which are caused by nuisances by which contagion is generated and persons reduced to destitution. . . . Labourers are suddenly thrown by infectious disease into a state of destitution for which immediate relief must be given. In the case of death, the widow and the children are thrown as paupers on the parish. The amount of burthens thus produced is frequently so great *as to render it good economy* on the part of the administrators of the poor-laws to incur the charges for preventing the evils where they are ascribable to physical causes, which there are no other means of removing."

A comparison between the death rates from fevers in 1837 (July–December) with that of 1937 (population of same size)

gives some indication of the conditions prevailing about a century ago:

	Deaths	
	1837	1937
Smallpox	5,811	0
Measles, scarlet fever . .	7,252	255
Whooping cough. . .	3,044	209
Typhoid, typhus, etc. . .	9,047	47
Erysipelas	482	80
Respiratory diseases and tuberculosis	27,754	4,188
Maternal mortality . .	1,265	339

The authorities were compelled to act because the fevers affected the rich as well as the poor, and produced a costly burden on the rates. The medical reports of the doctors and the Commissioners were presented to Parliament, and public opinion was aroused. The House of Lords in 1839 therefore requested that the inquiries into the causes of fevers which had been limited to London should be extended to the whole of England and Wales. A Health of Towns Association was formed at the same time in order to stimulate sanitary reforms in the towns. On February 4, 1840, Mr. R. A. Slaney, in a House of Commons debate on social conditions of the people, moved that a select committee should be set up "to inquire into the causes of discontent among great bodies of the working classes in populous districts." A reason given for this discontent was "the want of legislative provisions for the preservation of their health and the comfort of their homes." In the course of the debate many references were made to the influences of the Chartist Movement. The Home Secretary, however, obtained the withdrawal of the motion, for he objected to its political content: "as to the civil condition of the working classes he had no objection to an inquiry, but he thought it not wise to institute inquiries into their political condition."

The general tenor of the discussion gave a clear indication of the attitude of the Government to the prevention of fevers by means of sanitary reforms. On the one hand, there were the rising tempers of the people organised in the Chartist Movement, the rich and governing bodies' fear of the spread of infection and the heavy cost of poor law relief. On the other hand, there were

the vested interests of the new landlord class, who were mainly responsible for the insanitary conditions in the towns, and the new class of manufacturers, who were afraid they might have to bear the expense of the major sanitary reforms. These opponents entered the political arena, and during the next few years a long-drawn-out legislative battle was fought with the vested interests manœuvring a prolonged, delaying, rearguard action. In March, 1840, Mr. Slaney introduced a modified motion for a Select Committee "to inquire into the circumstances affecting the health of the inhabitants of the large towns, with a view to improved sanitary arrangements for their benefit." This motion was passed and a Select Committee was appointed. The Committee made its report within three months and recommended a general Building Act, a Sewerage Act, the setting up of local boards of health and the appointment of sanitary inspectors. The Committee also suggested that the following matters should be considered in the interests of public health—burial grounds, water-supply, public open spaces, lodging-houses, baths, and local powers for clearing and improving sites. The report of this Committee was shelved and no immediate effective action taken. In 1840, however, some advance in the Government's approach to preventive medicine was shown by the provision of free public vaccination against smallpox. The Poor Law Board, however, organised public vaccination so badly that for the next thirty years "throughout the English system of public vaccination there were flagrant evidences of unskilfulness."

The Health of Towns Association reported in 1840: "The Thames was now made a great cesspool, the Serpentine was notorious as an open sewer, and smells, disgusting odours, and unwholesome effluvia abounded." In spite of this alarming report and subsequent legislation, the condition of the Thames did not improve for at least twenty years. Dr. William Budd, in his classic work on typhoid fever, described the condition of the Thames in 1858 and 1859 in the following words: "For the first time in the history of man, the sewage of nearly three millions of people had been brought to seethe and ferment under a burning sun, in one vast cloaca lying in their midst. The result we all know. Stench, so foul, we may well believe, had never before ascended to pollute this lower air. Never before, at least, had a stink risen to the height of an historic event. . . . For

many weeks the atmosphere of parliamentary committee-rooms was only rendered barely tolerable by the suspension, before every window, of blinds saturated with chloride of lime, and by the lavish use of this and other disinfectants. More than once, in spite of similar precautions, the Law Courts were suddenly broken up by an insupportable invasion of noxious vapour. The river steamers lost their accustomed traffic, and travellers, pressed for time, often made a circuit of many miles rather than cross one of the city bridges." Dr. Budd used this example to prove that it was only *infected* sewage which was dangerous, but in conditions such as these there was no doubt in the public's mind that the opportunities of introducing infections were increased.

Lord Ashley, before he became the Earl of Shaftesbury, was taken in September, 1841, by Dr. Southwood Smith to see the East End slums. He wrote in his diary a description of the visit: "What a perambulation I have taken to-day in company with Dr. Southwood Smith. What scenes of filth, discomfort and disease! No pen or paint brush could describe the thing as it is. One whiff of Cowyard, Blue Anchor or Baker's Court outweighs ten pages of letterpress." He was so impressed with the misery he had encountered on his visit that he prevailed upon Peel to appoint still another Committee to inquire into urban conditions. In the meantime the Committee of the Poor Law Commissioners, which had been set up at the request of the House of Lords in 1839, had prepared its report, and it was presented to Parliament in July, 1842.

The report referred to the filthy and overcrowded houses, inadequate in water supplies and sanitary conveniences, to the inefficient methods of sewage and refuse disposal, and to the shocking state of the burial grounds. The report of the Committee was published in three volumes. The third volume was the work of Mr. Chadwick, Secretary to the Commissioners, and was entitled *General Report on the Sanitary Condition of the Labouring Population of Great Britain.* This volume was the most important of the three, but the Commissioners of the Poor Law were afraid to acknowledge their Secretary's conclusions as their own, and therefore published it under Mr. Chadwick's name alone. It produced convincing evidence that the fevers were caused by the insanitary conditions of the labourers' dwellings and laid emphasis on the fact that the expenditure

of money on reforms would be saved by the fewer demands upon Poor Law relief. The infection killed the bread-winner of the family and gave rise to destitution among the orphans and widows. General sanitary reform was recommended to deal with these evils: "the expense of public drainage, of supplies of water laid on in houses, and of means of improved cleansing would be a pecuniary gain, by diminishing the existing charges attendant on sickness and premature mortality. These measures would increase the expectation of life of the labouring classes by thirteen years at least."

The three-volume report caused a great stir amongst the public, and it was estimated that 10,000 copies of the *General Report* were distributed by sale or gift. This report was strengthened by the reports of eminent doctors. Dr. William Budd gave the following description of the effect of the typhoid fever epidemic of 1839 on the people: "Even in the highest class of society, the introduction of this fever into the household is an event that generally long stands prominently out in the record of family afflictions. But if this be true of the mansions of the rich, who have every means of alleviation which wealth can command, how much more true must it be of the cottages of the poor, who have scant provision even for the necessaries of life, and none for its great emergencies! Here, where fever once enters, *want* soon follows, and *contagion* is not slow to add its peculiar bitterness to the trial. As the disease is, by far, most fatal to persons in middle life, the mother or father, or both, are often the first to succumb, and the young survivors being left without support, their home is broken up and their destitution becomes complete.

"How often have I seen in past days, in the single narrow chamber of the day labourers' cottage, the father in the coffin, the mother in the sick-bed in muttering delirium, and nothing to relieve the desolation of the children but the devotion of some poor neighbour who in too many cases paid the penalty of her kindness in becoming, herself, the victim of the same disorder."

There was, however, an improvement in the harvest and in the state of unemployment in the country, so that, in spite of the immense propaganda and agitation in the country, the Government felt it could still afford to delay effective action. It adopted the well-tried measure of appointing another Royal Commission in 1843 to investigate the facts which were already

widely known and published. This Commission issued two reports, one in 1844 and the other in 1845, both of which entirely confirmed Mr. Chadwick's account of the existing evils and approved generally his recommendations for reform. The general agitation for the setting up of responsible public health authorities continued.

Mr. Martin, one of the Commissioners, wrote in 1845: "When to the crowding of men in health, we add crowding of the sick with each other and with the healthy—crowding of the living with the dead—a noisome and impure air—deficiency in food, clothing and fuel—a deficient and polluted supply of water—defective drainage and sewerage, with ill-constructed, crowded and ill-arranged habitations and streets . . . no wonder that disease, immorality and death—no wonder that epidemic follows epidemic—should be found among the poorer classes inhabiting our towns and cities. . . . The rich know nothing of the poor. . . . Bodies having the name of authorities, but really wanting in power, are everywhere to be found. They are elected also, in a popular manner but nowhere can we find either efficiency or responsibility."

The Government still delayed the introduction of adequate public health legislation. In 1847, however, with the threat of cholera, famine and unemployment, with the spirit and agitation of the people rising, the Government were goaded into action and the first Public Health Act of 1848 was passed. This provided for a central General Board of Health with local boards to abate nuisances and to deal with matters of health, including the appointment of medical officers of health and inspectors of nuisances.

There was a considerable amount of obstruction to the working of the Act by vested interests which were threatened by the advance of sanitary reform. The Earl of Shaftesbury, who was an unpaid member of the board, listed in his diary on August 9th, 1853, those vested interests forming the opposition which had led to the fall of the General Board of Health. He named "the College of Physicians, and all its dependencies, because of our independence, and singular success in dealing with the cholera, when we maintained and proved that many a Poor Law Medical Officer knew more than all the flash and fashionable doctors of London. All the Boards of Guardians; for we exposed their selfishness, their cruelty, their reluctance to meet and to relieve

the suffering poor, in the days of the epidemic. There are the Water Companies, whom we laid bare and devised a method of supply which altogether superseded them. The Commissioners of Sewers, for our plans and principles were the reverse of theirs; they hated us with a perfect hatred."

Almost as soon as the Board took office there was an outbreak of cholera which lasted fifteen months and caused 54,000 deaths. The Board dealt with the epidemic a little more efficiently than in the past. They circulated information on the epidemic and advice on how to prevent the disease, and they sent medical inspectors to the affected districts to assist the local authorities in organising arrangements for relief for the people who had suffered.

The success of the Board was not so marked as the Earl of Shaftesbury indicated, as it had little control of the local boards of health which were set up and which were represented by town councils in municipal boroughs and councils specially elected by the ratepayers elsewhere. There was no system of inspection and there was no method of encouraging action on the part of the local boards. The central authority could hold an inquiry and set up a local board if the death rate exceeded 23 per 1,000 or if 10 per cent. of the inhabitants demanded it. Very little action on these lines was taken or could be expected in the atmosphere then prevailing, as described by the Earl of Shaftesbury.

The general medical treatment of the poor made little advance during this period. Except for a few dispensaries and infirmaries, the physicians were still not available for the majority of the population, who were compelled to call in cheap charlatans and to use quack remedies which did more harm than good. An immense number of quacks throve in the towns, and by means of advertisements, posters, canvassing, etc., built up practices among the poor. Vast quantities of patent medicines were sold; pills to promote sweating, pills to purge, pills to constipate, special prescriptions of Hippocrates, special prescriptions of the King's physician and thousands of others which claimed to cure all illnesses. The most harmful of these useless remedies was prepared with opiates and given to children to keep them quiet and give them 'strength' whilst their mothers were working; one apothecary alone used 13 cwt. of laudanum in one year in the preparation of it.

The treatment of the sick poor in the workhouses after the 1834 Act was even worse than ever. The whole atmosphere was conditioned by the attitude to the able-bodied poor. The harsh treatment was extended to the sick, especially as there was always a doubt in the master's mind of the inmates malingering in order to avoid the severe labour and discipline. There was no question of preventive medicine and the annual report of the Poor Law Commissioners recommended that the medical relief of the poor should not be encouraged to reach too high a standard. In the majority of poor law infirmaries and workhouse sick wards there was not a single paid nurse. In 1850, in the total number of over 600 workhouses and workhouse infirmaries, there were but 248 paid nurses, receiving salaries averaging £14 per year.

The diet in the workhouse was of the lowest standard, consisting chiefly of the worst possible potatoes, bread and oatmeal. It was less nourishing than that of the poorest labourer outside or even of the convicts in prison. In one workhouse, men put to crush bones for manure were eating the putrid scraps of meat and the marrow to supplement their meagre diet. This led to a debate in the House of Commons, and the setting up of a committee of inquiry. Their recommendation for dealing with this scandal was typical; not the obvious solution, an increase in the diet of these unfortunates; but the prohibition of bone-breaking in the workhouses.

It is convenient at this stage to summarise the background of the developing medical services.

The manufacturers' doctrine of *laissez-faire* was paramount. If only they could be left alone to pursue their own aims for expansion and profit, if only the State would not intervene in the conduct of their business, then the country's prosperity and supremacy in the world was assured. Their mad, unorganised, unsupervised scramble for profits led to the enslavement of millions of people and to their physical and moral deterioration. Isolated from their means of livelihood, torn from the soil by enclosures, made bankrupt by the new manufactures, the farm labourers and the hand-workers were flung unprotected on the labour market at the mercy of these new buccaneers of business. The machines and factories cost a great deal of money. They must be worked to their fullest capacity in order to produce more profits and accumulate more capital to build more factories

and buy new machines which would produce cheaper goods, so that they might sweep out of the markets of the world rivals from the other growing industrial countries.

This doctrine led to the utmost exploitation of human labour, the minimum amount of money being spent on the safety and hygienic conditions in the factory and the least possible reward being offered for the labourer. It is remarkable how economists such as Nassau, Senior, writers such as Malthus, so-called reformers such as Wilberforce, and medical men produced theories and expressed opinions justifying these inhuman principles and methods. But just as there were these learned men whose theories, opinions and outlook were in sympathy with the factory-owners, similarly learned men, humanitarians, rose to champion the masses of the people. Robert Owen, the Earl of Shaftesbury, Jeremy Bentham, the doctors, Southwood Smith, Neil Arnott and James Phillips Kay, were outstanding figures in this struggle.

Novelists also played an important role in the fight for reforms. Charles Dickens, who was a friend of Dr. Southwood Smith, often accompanied him in his travels through the mean streets, visiting the factories, workhouses and hospitals and witnessing the sordid conditions in them. He helped to stir the public conscience by portraying graphically scenes from his experience. *Oliver Twist* (1838) exposed the cruelty and inhumanity of the Poor Law Board in the workhouse and in the schemes of apprenticeship; *Martin Chuzzlewit* exposed the inefficiency and dangers of the untrained nurse; *Bleak House* (1852–5) the evils of slum property and the vile burial-grounds; and in *Hard Times* (1854) he dealt with the inhuman conditions in industry. Other novelists assisted in arousing the conscience of the public. Disraeli, in his novel, *Sybil* (1845), described child slavery in the mines and factories, and Charles Kingsley in *Alton Locke* (1850) described the "sweated" labour of tuberculous tailors.

Robert Owen established a model factory at New Lanark and proved in practice that good conditions for the workers and education for the children did not lead to financial losses. He also introduced co-operative stores and tried to convince other factory-owners and members of governments of the success of his co-operative principles. His utopian ideas, although successful only in a limited way in practice, were extremely important in their effect in spreading humanitarianism. They failed, however,

in the attempt to persuade manufacturers and governments to apply them widely, and the experiments failed when they were expanded.

The Earl of Shaftesbury has already been mentioned in relation to the campaign for the Board of Health. He also introduced two Acts in 1845 which humanised the treatment of the insane (Regulations of Lunatic Asylums and The Better Care and Treatment of Lunatics in England and Wales). He was also a pioneer in the battle for the introduction of factory legislation to minimise the abuses in the factories and to encourage the education of children.

Peel's Act, The Health and Morals Apprentices Act, 1802, the first factory Act, was passed before the Earl of Shaftesbury entered Parliament in 1826. This Act, however, was unsuccessful in remedying the glaring evils which resulted from the uncontrolled employment of children in the factories. The Act was totally ineffective in practice, for it relied upon unpaid, untrained inspectors to enforce the regulations. It set the model for future factory legislation, however, as it underlined the need for the regulation of working hours, with adequate facilities for inspection.

The first Act to employ factory inspectors was passed in 1833, when only four inspectors were appointed for the whole country. They were under the control of the Secretary of State. The Earl of Shaftesbury's Bill for the ten-hour day was defeated in 1833, but he succeeded in limiting the working hours to ten for women and young persons in his Bill, which was passed in 1847.

Mr. C. Turner Thackrah, a Leeds surgeon, gave considerable assistance to the campaign for improving factory conditions. In 1831 he published the first book in England on industrial diseases. He investigated 250 branches of English industry and the factors in each industry which produced disease, disablement or death. He laid the foundations of preventive medicine in the factories.

Just as the manufacturers were not restricted to the expression of their views by experts in all spheres in life and by their representatives in Parliament, the masses were able similarly to voice their demands for a better life. Unions of various kinds of labourers were formed. These unions were the successors to the old combinations of craft industries, which had been tolerated

because of their small size and limited influence. As the number of actual and potential members grew with the development of industry, the Government took action to suppress them. This happened especially in periods of industrial discontent and after the French Revolution the Combination Laws of 1799 and 1800 were passed and all combinations were made illegal.

Although the law applied equally to employers and their workmen, it was only the workmen who were prosecuted in their thousands for the magistrates were often the employers in the district. Spies were sent into the unions and wholesale arrests were made. Strikes were fought with considerable bitterness, but were usually broken with the assistance of all the powers of the State, including the use of troops. The people first exercised their wrath against the machines, and in the beginning of the century the Luddites destroyed the new machines which were being installed.

After the slump in 1815, riots spread throughout the country. Thousands of iron-workers and colliers had been thrown out of work, 300,000 men had returned from the Napoleonic Wars to swell the numbers of unemployed, and the price of bread had risen as a result of the Corn Law of 1815. In London and Westminster there were riots against the passing of the Corn Bill, in Bridport against the high price of bread, at Bideford to prevent the export of grain, at Bury St. Edmunds to destroy machinery, at Newcastle by colliers, at Nottingham by Luddites, at Merthyr Tydfil against a reduction of wages, at Glasgow, where blood was shed, against the harsh treatment of the unemployed.

The Government, scared by this agitation, took countermeasures. The Habeas Corpus Act was suspended in 1817 following the "discovery" of a great conspiracy. The people arrested in the course of these disturbances rarely received a fair trial before the prejudiced judges—judges such as Mr. Justice Alderson, who regretted that the court was not able to give severer sentences, and Lord Justice Ellenborough, who described the punishment of transportation as "a summer airing by an easy migration to a milder climate."

Some of those convicted were hanged, some received long terms of imprisonment, and many were sentenced to transportation to the colonies. The Hammonds in their book, *The Village Labourer*, gave the following description of the fate of those

banished from their country's shores, a description gleaned from official reports and Marcus Clarke's famous novel, *For the Term of His Natural Life*: "Children of ten committing suicide, men murdering each other by compact as an escape from a hell they could no longer bear, prisoners receiving a death sentence with ecstasies of delight, punishments inflicted that are indistinguishable from torture, men stealing into the parched bush in groups, in the horrible hope that one or two of them might make their way to freedom be devouring their comrades—an atmosphere in which the last faint glimmer of self-respect and human feeling was extinguished by incessant degrading cruelty."

The Hammonds then gave a description of the persons responsible for these unspeakable cruelties: "And this system was not the invention of Nero or Caligula; it was the system imposed by men of gentle and refined manners, who talked to each other in Virgil and Lucan of liberty and justice, who would have died without a murmur to save a French princess from an hour's pain or shame, who put down the abominations of the Slave Trade, and allowed Clive and Warren Hastings to be indicted at the bar of public opinion as monsters of inhumanity; and it was imposed by them from the belief that as the poor were becoming poorer, only a system of punishment that was becoming more brutal could deter them from crime."

A hunger march of "Blanketeers" from Manchester to London to protest against the suspension was forbidden, the leaders arrested and the marchers attacked and broken up at Stockport. Huge meetings were held all over the North and Midlands demanding reform and the repeal of the Corn Laws. The Government replied to the meeting at St. Peter's Fields, Manchester, on August 16th, 1819, with the famous Peterloo massacre, where troops charged a peaceful meeting and killed eleven people and injured about 400, including over 100 women. The leaders were arrested and imprisoned, and Cobbett, one of the foremost, was forced to emigrate temporarily to America. In November, 1819, the six Acts prohibiting all agitation or campaigns for reform were passed.

In 1824 Place and others succeeded in obtaining the repeal of the Combination Laws. Unions began to spring up overnight and a Grand General Union, the forerunner of the Trades Union Congress, was established in 1829. This gave rise to the National Association for the Protection of Labour in 1830,

membership of which soon rose to 100,000. The National Association, however, failed, and in 1834 the Grand National Consolidated Trades Union was formed. In this new conception of one big union was incorporated the need to aim at a different order of things, "in which the really useful and intelligent part of society only shall have the direction of affairs, and in which a well-directed industry and virtue shall meet their just distinction and reward and vicious idleness its well-merited contempt and destitution."

The instinctive desire of the labourers to achieve emancipation was confused by the vague moralising "Owenite" attempts to obtain their freedom from enslavement, want and hunger. They failed because they ignored the strength and character of the real forces ranged against them. National membership of the new union reached half a million and strikes broke out everywhere. Differences of opinion arose, however, between Owen and the left-wing leaders, and the fact that the union's political agitation was restricted to the established parties of landowners and manufacturers led to the collapse of the Grand National in 1834.

With the collapse of the industrial wing of the people, the political wing developed. The London Working Men's Association was formed in June, 1836, and early in February, 1837, drew up a petition to Parliament containing the famous six points which became the basis of the People's Charter. These six points demanded equal electoral districts, abolition of the property qualifications for M.Ps., universal manhood suffrage, annual Parliaments, vote by ballot, and the payment of M.Ps. The six points, drafted in the form of a Parliamentary Bill, became the Charter which was supported by hundreds of thousands of people all over the country. A mass petition was to be presented to Parliament and if it was rejected a political general strike was to be called. The petition was, however, rejected and the Government struck back at the movement with mass arrests, the brutal use of police and troops, and by making the organisation illegal in 1840. The movement revived in 1842 and a second petition with over 3 million signatures was presented to Parliament but this was also rejected.

Strikes against wage reductions began in Lancashire and spread throughout the land. The well-tried methods of mass arrests and the use of troops and hunger forced the strikers back

to work. With a revival of trade between 1843–6, the wave of Chartism again receded, only to flow strongly again with a third petition in 1848, accompanied by severe bread riots in Glasgow. This time the collapse of the Chartist Movement was complete, with little hope of revival, as England entered into a twenty-year period of trade expansion and prosperity.

The development of the medical services during this period can now be examined in their proper perspective. This was the period of the real development of industry in England. The introduction of machinery and steam power altered the methods of production, and changed the face of the country and the conditions of living. The manufacturers wanted nothing but freedom to follow their "own enlightened self-interest" which altogether would produce "the greatest happiness for the greatest number"! The landowners, who were being superseded by the new rising factory owners, fought the worst abuses of the factories and of the slums in the towns while they continued the exploitation of the farm labourers. (On the estates of the Earl of Shaftesbury labourers earning 7*s.* to 8*s.* per week were being charged 1*s.* 6*d.* and 2*s.* for the rent of their cottages.)

The workmen who flocked to the towns and the factories formed their own organisations in industrial trade unions and in the political movement of the Charter in their struggle against the terrible living and working conditions and the corrupt forms of government. The Government was scared at the peak period of agitation of the masses of the people and also by the recurring epidemics that crippled whole towns and industries and placed such a heavy burden upon the rates. The *laissez-faire* doctrine envisaged the minimum of Government intervention. The Government, however, had to act to suppress the rising spirit of the people; to take measures against the epidemics and to organise the education of the new rising school of workmen so that their skill could compete with foreign manufactures.

It was in this atmosphere of struggle that the first Public Health Act was born. So ended the turbulent period of the Industrial Revolution, which marked the beginning of a new public health service.

CHAPTER IV

THE GROWTH AND DEVELOPMENT OF THE HEALTH SERVICES: 1848–75

THE BEGINNING OF THIS period marks the great development of England as an industrial power. This was the era when, with the flag of Free Trade nailed to the masthead, England's ship of trade swept the seven seas. This was the period of Victorian prosperity, with relative tranquillity. The national income was approximately doubled between 1865 and 1898, while the income "from overseas" increased ninefold in the same period. The people had been defeated in their efforts against the new factory system and the Poor Laws that accompanied it. England's monopoly position was challenged by Germany and other Powers at the end of the century, which resulted in the Great War of 1914–18.

In spite of this general wave of prosperity, there were the usual slumps, the official list of persons on relief rose from 851,369 persons in 1855 to 1,079,382 in 1863; unemployment rose from 1 per cent. to 12 per cent. in 1879 and, after declining, rose to 10 per cent. in 1885–6.

The position of the skilled worker improved, and he settled down to trade unionism on a "business-like" basis, but there was very little improvement for the unskilled worker. The harsh and repressive order of the 1834 Act was still the rule, and the conditions under which he lived remained as bad as ever. Nevertheless, the State afforded a measure of relief in taking a lead in sanitary reform, in factory legislation, and, after the turn of the century, in the building of a public health service. Charity, stimulated by religion, began to play a part in the establishment of dispensaries, hospitals and other voluntary organisations, and showed the way to the adoption of official schemes.

Private charity functioned for several reasons. Firstly, there was the religious and "liberal" humanitarian philosophy of this period which attempted to relieve the misery and suffering of the masses of the people. Secondly, there was a proportion of

the landlords and factory-owners who felt conscience-stricken after they had made their fortunes. Thirdly, there was the more practically-minded section of this community who dispensed charity in their own interests, i.e. to prevent infectious diseases which might affect them, to conserve the strength of the industrial pool of workers for competition with foreign industrialists, and, finally, as a stepping stone to society and the House of Lords.

The charitable organisations which arose for these different reasons carried out their work with a complete disregard for the real needs of the people. The annual report of the Council of the Charity Organisation in 1889 gave clear examples of this in the following words: "Relief is used, and charities are established by the promoters of all kinds of religious and moral views, as agents to supplement their work.

"School Boards introduce relief indirectly where, as they believe, without relief they cannot educate. Clergy and ministers frequently use relief as a potent element in their ministrations. The Church Extension Association uses relief to extend the Church. The Salvation Army is developing into a large relief society. Everyone wants to put a bounty on the success of his own endeavours."

There was no association between the charitable bodies and the official bodies of the Poor Law dispensing relief, with the result that there was a mad scramble for contributions from the rich and an equally mad unorganised scramble for relief from the poor. There was no external audit of control of these charities, and many were wasteful and some were fraudulent. In these circumstances, it is not surprising that "some mischief, sometimes far-reaching mischief, was done to the classes whose benefit had been intended." Miss Potter referred to the Mansion House Fund for the London Unemployed of 1885 in her paper on the dock labourer of East London as follows: "Eighty thousand pounds dribbles out in shillings and pence to first-comers. The far-reaching advertisement of irresponsible charity acts as a powerful magnet. Whole sections of the population are demoralised, men and women throwing down their work right and left in order to qualify for relief; while the conclusion of the whole matter is intensified congestion of the labour market—angry, bitter feeling for the insufficiency of the pittance or rejection of the claim."

An illustration of the irresponsible and indiscriminate provision

of charity was given in the Royal Commission on the Poor Laws Report (1909), where a lady with the intention of relieving the poor in the area "drove down in a carriage in a very poor street and there distributed promiscuously a dozen half-bottles of champagne and a dozen half-pound bunches of grapes."

The report of the Royal Commission on the Poor Law of 1909 neatly summarised the effects and results of sporadic private charity in these words: "It depends upon accident or whim, upon the popularity of a mayor or the circulation of a newspaper, whether a fund will be raised at all, or of what amount. It depends on what particular set of volunteer workers get hold of the administration whether there will be any care or no care taken to see that the distribution of doles of money or food does not do more harm than good."

One of the best known of charitable organisations and the one which did least harm was the Charity Organisation Society. The Charity Organisation Society, with Octavia Hill as one of the founders, was formed in 1869, ten years after the formation of the Jewish Board of Guardians. The Society was based on the same principles as the Board, i.e. to assist the poor in health and sickness without the stigma of pauperism. Unfortunately, however, some of the maxims of the Poor Law were adopted. They would help only the "hard-working," the "honest," but not the "lazy" and "those who try to get something for nothing." This attitude was often carried to extremes and prevented the efficient dispensing of relief to all the deserving cases. The voluntary workers came from the upper classes without any effective training in this work, and they did not always correctly understand or consider the poor in their social setting.

A move was made in 1889 in the House of Lords to inquire into the methods and organisation of private charity. There was a suggestion that they should be controlled and co-ordinated by public bodies, such as the new county councils, which had been set up in 1888. Unfortunately, this remained a suggestion only, and for the next fifty to sixty years private charitable organisations carried on in their usual wasteful fashion.

Apart from the general spirit of "liberal" humanitarianism, the drive for improved conditions was inspired by the need to preserve a large core of industrial workers in the fierce competition with other growing industrial powers. After the turn of the century, the growing Labour Movement contributed a

great deal to the movement for the expansion of the medical services.

Industry, in producing the instruments and in stimulating and developing the sciences of physics and chemistry, helped to produce the great medical discoveries of the last half of the nineteenth century, such as those of Simpson in anæsthetics, Pasteur, Ehrlich and Koch in bacteriology and chemotherapeutics, Lister in surgery, and Röntgen in X-rays. All these discoveries, which opened up the fields of preventive medicine, had their effect on the developing medical services.

Pasteur's discovery of micro-organisms, made during his study of the causes of fermentation in 1857, laid the foundation for the development of the new science of bacteriology. Bacteriology became the major weapon in the battle for public health. The science of bacteriology made rapid strides with the development and improvement in the microscope and the methods of staining bacteria with aniline dyes as discovered by Ehrlich. Following the work of Koch on the growth of bacteria on solid media and his methods of identifying them, there was a tremendous development in the discovery and isolation of individual bacteria between 1870 and 1905. In this period the following organisms were discovered: the bacillus of leprosy (Hansen), the gonococcus (Neisser), the typhoid bacillus (Eberth-Gaffky), the bacilli of tuberculosis (Koch), of cholera (Koch), of diphtheria (Klebs-Löeffler), of tetanus (Nicolaier), of plague (Kitasato and Yersin), the pneumococcus (Friedlander), the meningococcus (Weichselbaum), the spirochæte of syphilis (Schaudinn) and the malarial parasite (Laveran and Ross). The discovery of the bacteria causing the disease was the key to the solution in the fight against the disease. The fight was helped forward by Ehrlich, who used dyestuffs to kill bacteria and to treat diseases. This method of research led to his discovery of salvarsan, which became the most potent weapon against syphilis. The discovery of the organisms causing disease made its greatest contribution to progress through the public health services, for, with knowledge of the germ which caused the disease, the methods of spread became known and preventive measures could be adopted against infection.

For the individual patient the most noteworthy advances were in surgery. The discovery of the use of anæsthetics in 1838 enabled the surgeon to develop his skill with a technique shorn

of haste, worry and anxiety. The introduction of antiseptic surgery by Lister in 1867 made surgery safe from infection. Advances in the making of instruments extended the surgeon's powers both in diagnosis and in actual operation; probably the most important instrument in the field of diagnoses was the X-ray machine. The physician was also aided by the new sciences based on physics and chemistry, biochemistry, pathology and pharmacology.

With the growth of medical science and the advance of surgery, treatment became more expensive, so that the number of persons who could not afford to pay for their medical attention increased. This development had a profound effect upon the authorities' provision of medical attention, for it would have been difficult to treat almost the entire population as paupers, especially as the skilled, and later the unskilled, workers were forming trade unions which could resist this official policy. Many of the people who now required medical assistance came from the better classes of the community, and they or their relations contributed payment towards their treatment. This trend applied to the patients treated in the charitable voluntary hospitals as well as in the Poor Law infirmaries. As early as the beginning of the century Guy's and St. Thomas's hospitals started "paying wards" for the more affluent patients, and Guy's and the London Hospital charged out-patients a small fee. Almoners were therefore appointed to the hospitals, and their duties were best summarised by Miss Nussey, Almoner of the Westminster Hospital. They were to "ascertain the home conditions of the patients with a view to: (*a*) Eliminating those who could afford to pay privately for advice; and (*b*) Ensuring, as far as might be, a fair chance to those who are eligible for treatment, of profiting by it."

This modification of the extremely harsh policy towards anyone requiring official assistance was extended to the operation of the general public health policy. As the advance in the provision of public health services for the majority of the population lagged far behind the advance and development in the medical sciences, public opinion was aroused and the organisations of the people began to voice demands for reforms in the health services.

The conditions of the homes of the people improved but little in this period. In 1801, the average number of persons per

house was 5·67; in 1901 it was still 5·2, and the number of paupers just under 800,000. The state of these homes is best illustrated by the reports of the medical officers of health, who helped materially in the promotion of sanitary legislation and reform.

Dr. Hunter, in the Eighth Public Health Report (1865), referring to the overcrowding in London of twenty colonies of 10,000 persons each, said their misery exceeded anything he had seen in the rest of England. "To children born under its curse [overcrowding] it must often be a very baptism into infamy." He continued: "It is not too much to say that life in parts of London and Newcastle is infernal."

Describing agricultural labourers' cottages in the Public Health Report of 1864, Dr. Hunter said: "His walls are of mud and stones, his floor the bare earth which was there before the hut was built, his roof a mass of loose and sodden thatch. Every crevice is stopped to maintain warmth, and in an atmosphere of diabolic odour, with a mud floor, with his only clothes drying on his back, he often sups and sleeps with his wife and children. Obstetricians who have passed parts of the night in such cabins have described how they found their feet sinking in the mud of the floor, and they were forced (easy task) to drill a hole through the wall to effect a little private respiration."

Dr. Embleton, of the Newcastle Fever Hospital, in the Eighth Public Health Annual Report (1865), said: "There can be little doubt that the great cause of the continuance and spread of typhus has been the overcrowding of human beings, and the uncleanliness of their dwellings. The rooms in which many labourers live are situated in confined and unwholesome yards or courts, and for space, light and air and cleanliness are models of insufficiency and insalubrity, and a disgrace to any civilised community. . . . The whole house badly supplied with water and worse with privies; dirty, unventilated, and pestiferous."

Dr. Bell, a Poor Law officer in Bradford, ascribed the terrible mortality of fever patients in his district to the housing conditions: "The beds—and in that term I include any roll of dirty old rags, or an armful of shavings—have an average of 3·3 persons to each—many have five to six persons each, and some people I am told are absolutely without beds; they sleep in their ordinary clothes, on the bare boards—young men and women,

married and unmarried, all together . . . many of these dwellings are dark, damp, dirty, stinking holes, utterly unfit for human habitations; they are centres from which disease and death are distributed amongst those in better circumstances, who have allowed them to fester in our midst."

Dr. Simon referred to the sanitary dangers to which poverty is almost certainly exposed, and described the quarters of the poor as those with the "least drainage, least scavenging, least suppression of public nuisances, least or worst water supply, and, if in town, least light and air!" He pointed out that poverty was not the deserved poverty of idleness, but the result of the scant pittance received by the indoor operatives, which was "only a circuit, longer or shorter, to pauperism." In another report, Dr. Simon said: "Vice, ignorance, and brutality are amongst the chief causes of disease. . . . The people in the slums must find it difficult not to be vicious and ignorant and brutal." It was reports such as these, coupled with the discovery by Dr. Snow in 1854 of the connection between cholera and water pollution, which stimulated the authorities to action on sanitary reform.

Dr. John Snow investigated the famous "Broad Street Pump" outbreak of 1854, which caused 616 deaths, and solved the riddle of the mode of communication of cholera. He proved that cholera was a water-borne disease and was largely spread by the contamination of the water supply. He recognised that impure water was not the only cause of the widespread character of this disease, and in the second edition of his work on the subject he wrote: "It is amongst the poor, where a whole family live, sleep, cook, eat and wash in a single room that cholera has been found to spread when once introduced, and still more in those places termed common lodging-houses, in which several families were crowded in a single room." He referred to the greater prevalence of cholera in institutions for pauper children. "In the asylum for pauper children at Tooting, 140 deaths occurred among 1,000 inmates. . . . The children were placed two or three in a bed, and vomited over each other when they had cholera." He pointed out that the reason why in 1832 Westminster suffered more than St. George, Hanover Square and Kensington, which at the same time had the same water supply, was because of "the poor and crowded state of part of its population. The number of cases of cholera communicated

by the water would be the same in one district as in the other; but in one district the disease would spread also from person to person more than in the others."

In the north districts of London, which suffered much less from cholera than the south districts, the mortality was chiefly influenced by the poverty and crowding of the population. In Newcastle and Gateshead the mortality was greatest in the districts which were most crowded, "the deaths being much more numerous in the parishes which contained a great number of tenements consisting of a single room, than in those which consisted chiefly of houses occupied by one family."

The rich did not entirely escape, and in one instance Dr. Snow describes a case where a landlord was hoist with his own petard: "The drainage from the cesspools found its way into the well attached to some houses at Locksbrook near Bath, and the cholera made its appearance there in the autumn of 1849, and killed many people. The people complained of the water to the gentleman belonging to the property, who lived at Weston, in Bath, and he sent a surveyor, who reported that nothing was the matter. The tenants still complaining, the owner went himself, and on looking at the water and smelling it, he said that he could perceive nothing the matter with it, and he drank a glass of it. This occurred on a Wednesday; he went home, was taken ill with cholera, and died on the Saturday following, there being no cholera in his own neighbourhood at the time."

Dr. Snow concluded his work with the prediction that "if the precautions he recommended were applied, then he felt confident that this disease may be rendered extremely rare, if indeed it may not be altogether banished from civilised countries." Industry could now supply cast-iron pipes and other sanitary fittings and thus the basis of efficient water and sewerage schemes was established.

Following the severe epidemic of cholera in 1854, Dr. Simon, in the Preface to a reprint of his annual reports as Medical Officer of Health to the City of London, referred to conditions in the country as a whole. He submitted "that the law was practically caring very little for the lives of the people," and he suggested legislation particularly for "the uncontrolled letting of houses unfit for human occupation; the unregulated industries of sorts endangering the health of the persons employed in them; the unregulated nuisance-making industries; the unchecked adulterations

of food; the unchecked falsifications of drugs; the unregulated promiscuous sale of poisons; and the absence of legal distinctions between qualified and unqualified medical practitioners." He pointed out that "if given wages will not purchase such food and such lodgment as are necessary for health, the ratepayers who sooner or later have to doctor and perhaps bury the labourer, when starvation-disease or filth-disease has laid him low, are in effect paying the too late arrears of wage which might have hindered the suffering and sorrow."

In 1858, the Medical Act was passed which regulated the registration of qualified doctors, distinguishing them from the unofficial "quacks." In the same year the Privy Council took over the medical duties of the General Board of Health.

In 1865 and 1866, there was yet another severe epidemic of cholera. Dr. Simon, the Chief Medical Officer, again exposed the fact that "vast numbers of the poorer population, in both town and country, were atrociously ill-lodged," living under conditions which "were hotbeds of nuisance and disease." He emphasised that there was "gross inefficiency in the law which purported to protect the public health." In 1866 a Sanitary Act was passed embodying the suggestions made by Dr. Simon.

Dr. Simon, speaking of the most important effect of the Act, said: "The grammar of common social legislation acquired the novel virtue of an imperative mood"—permissive powers having been converted into duties, e.g. in the compulsory provision of water. The Act also empowered urban authorities to make bye-laws for tenement houses; to isolate infectious diseases; to deal with overcrowding in dwelling places and insanitary conditions in workshops; and to erect public health hospitals outside the Poor Law.

Except for isolation hospitals, however, few were built and the Central Authority gave little or no encouragement to the implied decentralising of the care of the sick. Even the isolation hospitals which were established were unsatisfactory.

This is illustrated by a report of the Local Government Board on infectious disease hospitals in 1880–1, which gave an alarming picture of the inadequate services supplied. Hospitals—badly constructed, badly sited (in Blackpool the building was near the cemetery), inadequately staffed (in some hospitals a resident caretaker was the sole staff), inadequately heated (in one ward the temperature fell to 38° F. in the winter), with windows

which could not open, with ill-ventilated earth closets opening directly on to the ward—this was the general description of many. In one hospital the charge for accommodation was made so prohibitive that no patient was admitted and "the building itself was being permitted to fall into decay and the disinfecting apparatus was being consumed with rust." In others the patients "were so classified that the more well-to-do did not come into needless communication with those who were in receipt of relief."

A further illustration is given by the report of Dr. Sweeting, who investigated the administration of the borough of Weymouth following the epidemic of scarlatina in 1901. His investigations showed that the hospital administration had "entirely broken down during the epidemic in many important particulars especially as to overcrowding, understaffing, improper mode of excremental disposal, and premature discharge of patients." There were twelve beds crowded into a six-bedded ward, and twenty-one patients shared the twelve beds. There were no night nurses, and the caretaker and the trained nurse (a young woman of twenty-five) had to sleep in the male wards. Patients, including children, were required to empty bed-pans and slops and do menial work in the wards. Some patients were discharged with ringworm and vermin. The closet pails were full to overflowing and no earth or ashes had been used to mitigate the nuisance.

Cases of general illness were still accommodated in the unsatisfactory mixed workhouses. From 1866 onwards the Poor Law Board attempted to persuade the Board of Guardians to transfer their patients to an infirmary which would be organised by joint committees. The Board of Guardians, jealous of their authority, refused absolutely to relinquish control of the care of the sick. The result was that "the tuberculous, the cancerous, the venereal, the maternity cases, the children, the senile, and even sometimes the infectious" were all herded together in the mixed workhouse. In London, in 1867, the Poor Law Board set up the Metropolitan Asylums Board and took the control of the infectious sick and the imbeciles from the Board of Guardians. Apart from a few large towns, however, for the next seventy years or so the Board of Guardians continued to accommodate the sick in the mixed workhouse.

In 1868 there was a considerable public outcry against "the

disorderly state of the sanitary laws" and against the innumerable authorities who had no effective power for dealing with the various nuisances which were causing the epidemics. A Royal Sanitary Commission was appointed in 1869 and completed its investigations in 1871. The Commission recommended the creation of a central ministry to supervise the local authority's work under the Poor Law and their duties with regard to health matters. They also recommended the division of the country into urban and rural sanitary districts, each with an elected council and a medical officer of health. The general consolidation of health legislation was also recommended. The Government were still not prepared to introduce these extensive reforms, but after another severe epidemic of cholera in 1871 the medical duties of the Privy Council were transferred to a new central board, the Local Government Board.

This Board, which was formed in 1871, absorbed the staffs of the Poor Law Board, the General Register Office, the Local Government Office and the medical department of the Privy Council. The Local Government Board was therefore mainly a reconstruction of the Poor Law Board.

The Poor Law Board already had an unenviable reputation in dealing with medical matters. In 1849 there had been the scandal of an outbreak of cholera in one of their boarding-out establishments in Tooting, where 180 inmates died. There had been severe criticism of their vaccination arrangements and their work in respect of the outdoor sick poor. The reports of a commission appointed by the *Lancet* had exposed the "scandalous mismanagement" of the workhouses and workhouse infirmaries. It was obvious that the main concern of the Board had been to make the absolute minimum of provision for the needy and sick; just sufficient to restrict scandals and prevent popular outcry.

This spirit of the Poor Law administration is best illustrated by a quotation from a report of the Rev. Dr. Clutterbuck, an inspector of workhouse schools, in the Local Government Board's Annual Report of 1876. He said: "We have no right to put a premium upon poverty by treating paupers as a specially favoured class, on whom exclusive benefits are to be showered simply because they are paupers. . . . I do not advocate lavish expenditure upon paupers as such, but money must be spent upon the cure of pauperism. . . . Depression in trade; the ever-widening antagonism between capital and labour; the growing

spirit of Communism; the widespread intemperance and immorality—these and other elements are at work to give birth to a vast array of paupers." Firstly, he advocated a severe reduction in the already low standards of relief. Secondly, he proposed the spending of money on so-called "general causes of poverty," but he completely ignored the real causes of poverty: the disabling and death-dealing infectious diseases, the industrial diseases and accidents, the insanitary conditions of factories and dwellings, and low wages.

The association of low wages with relief was emphasised by an inspector in a report on pauperism and relief in 1890. He referred to the fact that out-relief kept down the general rate of wages. "The virtual abolition of out-relief in the union of Bradfield raised the wages of charwomen throughout the union by 6*d.* a day." The employers were using out-relief as a subsidy to low wages. The inspector did not advocate the obvious solution, that of raising wages. His solution was much simpler: "It is in the interest of the poor, rather than of the rich, that I plead for the practical abolition of outdoor relief."

As the spirit of the Poor Law exists even to-day, it is interesting to trace its history a little further. Twenty years after the Rev. Dr. Clutterbuck's report, a Poor Law inspector showed the first glimmerings of the real causes of poverty. In the Local Government's Annual Report of 1897 this inspector quoted from Dr. Thresh's report on the housing of the working classes in the Chelmsford and Maldon Rural Sanitary Districts. The doctor's report said: "That houses such as have been described are, in their present condition, really unfit for human habitation will probably be admitted by all . . . rheumatic and chest conditions are caused by living in such damp and draughty dwellings. Infectious diseases cannot be isolated nor can any illness be properly treated in them. Apart from serious illness, they are the cause of depression of vitality generally, affecting the bodily vigour and activity as well as the spirits, and rendering the system unable to withstand the onslaught of disease.

"I believe that many families are pauperised from time to time on account of sickness produced by living under such unhealthy conditions, and that many labourers become permanently disabled at a prematurely early age, and have to be entirely supported by the rates for the remaining term of life, from the same cause. If, therefore, such sickness can be prevented and

if the working years of our labourers can be prolonged, not only do the labourers benefit in health, but the burden of expense borne by all the ratepayers is diminished, so that the advantage gained affects all classes of the community. . . ." The inspector continued: "Unfortunately, cottage property in the Eastern Counties has often fallen in bad hands. Small speculators buy up the worst cottages and let them at high rents. The result is that they have no very keen interest in the stamping out of overcrowding, or in closing unsanitary dwellings." After the deduction of rent, it was estimated that the labourer's wages were 10*s.* 5*d.* per week.

Here was an inspector of the Poor Law who was beginning to realise that poverty was not invariably the pauper's own fault and that preventable sickness and disease played an important part in the causation of pauperism. The inspector, however, found it difficult to make appropriate recommendations on how to remedy these conditions. His contribution to the solution of the problem was a pious comment on the Medical Officer's report. He said: "This argument seems sound, and is *worth noting* as coming from an expert in rural Poor Law work."

Even the Royal Commission of the Poor Law twelve years later found it difficult to solve successfully the "mysteries" of the causes of pauperism. Their investigators reported: "Unhealthy conditions of work, excessive hours and low wages have been found in certain occupations, and that *poverty and suffering* are caused by them is indisputable. That *pauperism* directly results, except in individual instances, *there is no evidence to show.*" It was admitted that a large amount of pauperism was caused in old age because the aged worker found it impossible to work in a competitive labour market and to support himself adequately. It is difficult to see how the worker with low wages, living in poverty, could save sufficient for his old age to avoid the inevitable pauperism. This Poor Law spirit has hampered the progress of the public health services for over a hundred years, and therefore the formation of the Local Government Board in 1871 marked no great advance in the administration of the Poor Laws.

In 1872, Medical Officer of Health appointments were made compulsory for all local authorities, but they were recruited mainly from the Poor Law service. Unfortunately, much of the Poor Law atmosphere was transferred as well. Dr. Simon, the

Chief Medical Officer, and his staff resigned because they were made subordinate to the lay administrative staff and therefore had little executive function in the new administration.

In 1875 the great consolidating Public Health Act was passed. This Act consolidated all previous public health legislation and divided England and Wales into urban and rural districts with elected councils. It was very important as it remained the principal statute affecting the health services until 1936.

CHAPTER V

LIVING CONDITIONS: 1875–1919

GOOD RESULTS WERE SOON shown as a result of the sanitary reforms. Manchester, which had 38,132 privy middens in 1871, had them reduced to 606 in 1883, most being converted into pail closets. Deaths from fevers of 901 per million living between 1861 and 1870 dropped to only 374 per million living in the decade from 1871 to 1880, the general crude death-rate being reduced by about 25 per cent. The mortality rate from typhoid, which had risen until 1869 (371 per million persons living), became steady and then declined (1891–5, 175; 1911–15, 47).

Although there was an improvement in the sanitary conditions following the 1875 Public Health Act, vested interests, as after the 1848 Act, hindered progress. Ten years after the passing of the Act, Dr. Ballard in the Supplement to the Local Government's Annual Report for 1885–6 reported "On Sanitary Survey made in anticipation of Cholera" as follows: "Drainage: In some towns the old sewering is so defective as to be almost more an injury to the place than an advantage. . . . Sometimes there were no sewers provided at all. . . . Sometimes superficial highway drains, roughly constructed, and never intended to carry anything but surface water, were found to receive domestic sewage, the overflows of cesspools, sometimes multiple. Cesspools placed even beneath occupied dwellings were found to be the habitual recipients of all kinds of domestic liquid filth."

He wrote of the overcrowded and insanitary conditions of the labourers' dwellings and made special reference to the miners: "For the miners working in shifts, it is found convenient to take into a cottage two sets of lodgers who occupy all the beds in the dwelling not at night only, but both by night and by day; one set entering and lying down to sleep in the same room and in the same bed that had been vacated just previously by other lodgers. I am not aware of any attempt having been at any time made by a sanitary authority to deal with this sort of occupation." He described the attitude of the responsible

authorities to the insanitary conditions as follows: "All authorities show a disposition to deal tenderly with the private interests involved in interference with structural faults . . . it is the very districts which are in the most unwholesome condition in which this sanitary apathy of the authorities is most observable . . . a not uncommon practice is the retirement of members from board meetings as soon as the sanitary business commences; or to refer important matters to parochial committees as the surest way of shelving them." The fact that medical officers of health were appointed from the Poor Law district medical officers, with very little extra pay, and that inspectors of nuisances were untrained (a "watchmaker," a "grocer," a "beershop-keeper," an "elderly man without experience" were appointed in various towns), was "not conducive to efficiency of administration."

These Reports (1885–6) indicated that, although the public had won a great victory for sanitary reform in the passing of the Public Health Act of 1875, they had failed in practice, for the struggle had not been pursued with the same fervour and the victory was not consolidated. Although the Government was prepared to give way as a result of the public's pressure and agitation to the extent of passing an Act embodying many sweeping reforms, it was not prepared to carry them into action once the agitation became less intense. The people responsible for implementing the Act were often most unsuitable for their job. In addition, the fact that the people on the committees charged with the abolition of slum conditions were those very same people who were financially interested in maintaining slum conditions was not conducive to the promotion of effective action.

The First Report of the Royal Commission on the Housing of the Working Classes, published in 1885, stated: "From various parts of London the same complaints are heard of insanitary property being owned by members of the vestries and district boards, and of sanitary inspection being inefficiently done, because many of the persons, whose duty it is to see that a better state of things should exist, are those who are interested in keeping things as they are." A study of the official Reports shows that the sanitary reforms envisaged by the Public Health Act were not carried out in many places for many years, and there are places in the country even to-day where the standards

of sanitary conditions do not conform with those laid down in the 1875 Public Health Act.

The following are a few examples of such reports. A medical report on the sanitary conditions in Bridgwater in 1885 stated: "Revoltingly filthy places noted in Dr. Blaxall's inspection in 1874 are in the same condition still." A report on Hull by the Local Government Medical Officer after the cholera epidemic of 1893 noted that "Hull is in great part a midden-privy town." In the same Local Government Annual Report there was a description of the water supply of Rotherham: "That the Public Water Supply should be in part derived from gathering grounds of which the conditions are such as to render possible dangerous pollution of the water thence collected, is a matter of great gravity. But that a supplementary source of this supply should be a spring which rises in the very centre of the town and, therefore, emerges through a soil polluted by the contents of privy middens, is a condition of distinctly perilous sort. Rotherham had in 1891 actual experience of loss of life and health from fever due to specific pollution of the water supply; but the Sanitary Authority do not appear to have profited by the lesson."

In 1904, after epidemics of typhoid, Dr. Buchanan reported on the sanitary conditions of Sheerness: "Many of the older dwellings of the place have been put up, so to speak, anyhow. Often they are damp, ill-ventilated, and seriously dilapidated; some inhabited houses are described as beyond repair. In certain parts of the town, dwellings are packed together with little or no open space belonging to them. House drains are frequently leaky, and yards improperly paved and channelled, or not paved at all. Insanitary conditions were found with the more recent dwellings as well as in the older properties. Overcrowding of persons was common, and high rents were not infrequently obtained for miserable accommodation. Sanitary administration was ascertained to be almost a dead letter."

A description of housing and sanitary conditions in Lancashire was given in the Ministry of Health's special report (No. 68) of 1932 on "High Maternal Mortality in Certain Areas": "Most of the towns still suffer from the hasty and indifferent building of the days of rapid industrial expansion. Primitive sanitary arrangements existed for many years in some areas, *and in some districts they have not been dealt with completely.*"

The diet of the people in this period showed little improvement. The annual reports of the Local Government Board referred to the adulteration of food, which continued on a large scale. Water was often added to milk: in one case at Sheffield it was no less than 48 per cent. The report of 1891–2 continued: "It must be remembered that an addition of even 10 per cent., which is probably less than average, enables a dishonest milkman to keep ten cows instead of eleven." Colouring matter was often added to the milk to give it an appearance of being rich after it had been watered. Chicory was often sold as coffee and in two cases where 90 per cent. was chicory the Analyst for Salford suggested "that the presence of the trace of the genuine article must have been due to the accidental use of a coffee scoop to weigh out the chicory!"

Margarine was often substituted for butter and preservatives were often added to the butter. Cotton oil and mineral oil were sold as olive oil. The Analyst of West Sussex commented: "Such a mixture, I need hardly point out, is utterly unfit for human food, mineral oils being absolutely indigestible." It is interesting to compare these reports of 1891 with the report of the Public Analyst for Northamptonshire of 1947. He referred to samples of mineral oils which he regarded as seriously unsatisfactory: "These mineral oils are nothing more than a sub-grade liquid paraffin and have been bought by retail grocers and sold for use for cooking and frying. . . . Its food value is nil. . . . It is unsuitable for use as a food on other grounds than its actual food value." *Plus ça change. . . .*

The battle for good quality food which is carried on to-day is of the same type as that described by the Analyst for Kent in 1890: "There are often most ingenious forms of adulterations, introduced as special branches of industry, which arise anew, for a time flourish, and then gradually die out. 'Works chemists' of the highest skill in each special department of the food trade are continually engaged in the endeavour to produce articles that can be sold at a greater profit than the things they resemble at perhaps a less price. This gives rise to a perpetual conflict between the falsifier on the one hand and the public analyst on the other."

An example of this struggle was given in the report of the Public Analyst for Cheshire in 1911. Formalin was being used as a preservative in milk and it was an objectional substance.

The dairymen were circularised by the manufacturers concerning a preservative sold by them under a fancy name, which they claimed could not be detected by the Analyst. The Analyst commented: "[The preservative] has been most ingeniously prepared, evidently by some skilled chemist, for it is a mixture of sodium nitrite and formalin, the sodium nitrite being added to prevent the formalin being detected by the ordinary test." The Analyst counter-attacked: "It will be interesting to the manufacturers of this preservative to know that by certain modifications this new preservative can easily be detected when added to milk."

Dr. Smith conducted an inquiry on behalf of the Privy Council into the distress prevailing among the worst-nourished section of the English working class. He found serious deficiencies in the diet of the agricultural labourers affecting mainly the women and children, and as for the urban workers, "They are so ill-fed that assuredly among them there must be many cases of severe and injurious privation." Although food improved a little after 1860, bread was still the main article of diet.

In 1863 there was an official inquiry into the dietary and conditions of work of criminals. The report showed that the convicts were better off than the ordinary workmen or inmates of the workhouses. "From an elaborate comparison between the diet of convicts in the convict prisons in England and that of paupers in workhouses and of free labourers . . . it certainly appears that the former are much better fed than either of the two other classes: the amount of labour required from an ordinary convict under penal servitude is about one-half of what would be done by an ordinary day labourer."

The Public Health Report of 1864 stated that the English agricultural labourer got only a quarter as much milk and only half as much bread as the Irish labourer. Referring more specifically to his diet, the report said: "A morsel of the salt meat or bacon . . . salted and dried to the texture of mahogany, and hardly worth the difficult process of assimilation . . . is used to flavour a large quantity of broth or gruel of meal and leeks, and day after day this is the labourer's dinner." In 1892 the children of Bethnal Green subsisted almost entirely on bread with no other solid food for seventeen out of twenty-one meals in the week. Breast feeding declined considerably. One-third of the poor children of the large cities had obvious rickets.

With four million workers earning less than the Rowntree minimum scale before the First World War, malnutrition at the opening of the twentieth century was more rife than since the great dearths of medieval times—and this was the prosperous era of Great Britain.

In the factories the increased speed of working the machines with few safeguards led to an increase in accidents. This was made worse by the fact that in many workplaces, including even the mines, children were in charge of safety measures. Varicose veins, digestive disorders, anæmia and debility, respiratory diseases, especially tuberculosis, and industrial poisoning were very common results of working in factories. The factories were overcrowded, ill-lit, ill-ventilated, dirty, and smoke-begrimed. Discipline was strict and fines were levied for talking, for whistling or for resting on boxes. The Factories Acts were passed to regulate the worst of these abuses. The second report of the Children's Employment Commission in 1864 was an important factor in the promotion of these Acts. It was stated that one of the motives for the Acts was to conserve the strength of the adult worker for future and more profitable use in the factory. Other effects of the Acts were the elimination of the small factory-owners and the restriction of competition.

Factory supervision, however, was inadequate, owing to shortage of staff. When, in 1871, 1,000,000 workshops and 300 brickworks were transferred from the ineffectual local authorities to the factory inspectors' supervision, only eight persons were engaged to deal with this additional work.

An inter-departmental committee was set up to report on the physical deterioration of the population which was evidenced by the rejection of from 40 to 60 per cent. of recruits for the Boer War. In 1904 the committee presented its report, in which it criticised the neglect of the Local Government Board to "consider questions of public policy in the sphere of health," the failure to "bring influence to bear on backward districts," and the "holding in permanent suspense the powers conferred on it in some spheres of its public activity." They reported that in London, the "very low" standard of 300 cubic feet of space per adult for bedrooms, and of 400 cubic feet for rooms occupied day and night which "ought to be enforced," was ignored. Manchester still had 3,000 back-to-back houses, and 206 insanitary common lodging-houses with 5,831 inhabitants. In

Sheffield there were 15,000 back-to-back houses and the drainage was very bad; many rubble sewers were still in existence and a number of the unpaved courts receiving the contents of middens were saturated with filth. The number of deformed persons was "something terrible," and the infant mortality rate in one district was as high as 234 per 1,000 births. The conditions in the Potteries were even worse than in Sheffield, as the health committees were packed by the owners of slum properties.

The recommendations of this inter-departmental committee were in advance of their period. They suggested the following: (i) periodic measurements of heights and weights of the school and factory population; (ii) registration of sickness; (iii) registration of house-owners, with special reference to slum property; (iv) a special inquiry into the causes and effects of over fatigue; (v) systematic medical inspection of children in schools, young persons in mines, factories and workshops; (vi) registration of still-births; (vii) a special inquiry into the problem of notifying syphilis, and into the adequacy of treatment.

It needed amongst other things a war, with the startling discovery of the lack of effective man-power, to stimulate the Government to investigate measures for reducing the numbers of physically sub-normal in the population. Many of these excellent recommendations have not yet been adopted in practice. It was not until 1907 that the first steps were taken to remedy these conditions, when the Education Act of 1907 was passed. This Act introduced medical inspection and treatment for schoolchildren.

CHAPTER VI

MEDICAL CONDITIONS: 1875–1919

THE MEDICAL TREATMENT OF the population during this period is admirably described in the reports of the Poor Law Commission of 1909, especially in the Minority Reports, which were mainly the work of the Webbs. One of the reasons for the establishment of this Commission (1905–9) was the conflict between the Poplar Board, with its Labour Party representatives, and the central authority on the questions of the treatment of the aged in the workhouse and the granting of out-relief to unemployed men. It is interesting to study the provision made for the people from birth to old age.

(*i*) *Maternity Services*

Domiciliary treatment was of the most primitive order. Monetary allowances were hopelessly inadequate, although the treatment in different places was extraordinarily diverse. 2*s*. per week was often the sole amount allowed to an expectant mother and 1*s*. or 1*s*. 6*d*. for the child when born, the mother's allowance then being stopped. The Board would not recognise the fact that there were now two persons to support instead of one. Delivery was performed by the district medical officer or a midwife, although until 1910 the "handy woman" was permitted to deliver the mothers unaided. The proportion of midwives effectively trained was relatively small and in 1918 there were still 21 per cent. untrained midwives who were qualified by virtue only of previous practice. There were many restrictions on the issue of midwifery orders by the relieving officer, and in an emergency they were often issued too late. In an emergency there was no encouragement for the district medical officers to call, for the relieving officers often refused to issue an order after the emergency had passed. The restrictions applied particularly to mothers who had already had three, four, or five children, on the assumption that these mothers were experienced in child-bearing and did not require medical assistance. In Scotland the position was even worse, for it was

illegal for the authorities to give medical or midwifery attendance or food or other necessaries to the wife *so long as she was living with her husband.*

The local authorities provided about 2,000 midwives under the 1902 Act, but it was not until 1918 that satisfactory arrangements were made for the payment of fees to doctors who were called in by the midwives in an emergency. Before 1918 some authorities would only pay their own district medical officer, some required a certificate from the relieving officer first, others conducted an inquiry, while many made no arrangements at all. The nature of many of these schemes made them impossible to operate in these emergencies.

There was no attempt at ante-natal, post-natal or infant welfare. The conditions of delivery at home were most primitive, with very little opportunity of or attempt at antisepsis. 5,000 infants lost their lives yearly, while the reason for a third to a quarter of the number of blind was preventable ophthalmia neonatorum, dating from birth.

Hospital accommodation was mainly provided by the workhouse. Over 15,000 mothers, 3,000 in London alone, had their confinement in workhouses. In some areas 70 per cent. of the births were illegitimate, and many of the mothers had neglected syphilis. Unemployed respectable wives had to mix with these infected cases and with dissolute prostitutes in the general mixed workhouses. Up to half the mothers who were delivered in the workhouses were not in receipt of relief on admission. They were the respectable wives of working men who entered the workhouse because they could not afford the additional cost of the confinement at home. They paid, however, in a different way. Owing to the high infant mortality in the workhouse, the price of the service was often the lives of their children.

Voluntary agencies assisted in supplying medical staff for domiciliary confinements, but this system was confined mainly to London and a score or two of the larger towns. The main consideration of the agencies was the out-patient training of doctors, and the work was performed under most unhygienic circumstances. The hospital bed provision was very small, catering for only one in twenty of the total births.

Though the standard of obstetrics in the hospital wards was often high, the women's dependence on a "letter" of admission had a demoralising effect. As with the domiciliary service, the

maternity department of the hospital was run more for the training of doctors and midwives than for the benefit of the mothers. Some hospitals still had a high maternal mortality rate and some lost three to four times as many babies as others.

Rescue homes were established largely by religious bodies supported by voluntary contributions and to a small extent by payment from patients or friends. These homes catered for girls with their first illegitimate child. The Salvation Army homes often kept the mother for a period of three months to a year and trained her for domestic work, while the child was farmed out to a foster-mother. Most voluntary institutions were limited to London and the big towns and their contact with the patient was very brief, with little or no follow-up. The voluntary agencies varied considerably in their degree of efficiency, but they all suffered from the same defect. They only dealt for a limited period of time with the person needing help. There was no scheme for preventive or educational work. They only solved the girl's problem temporarily, and she was sent out to face the world and its difficulties again alone, without friends, without hope or encouragement, and without even any show of interest in the outcome.

(ii) Care of the Child

There was a distinct need for more care and supervision of the child. There were a few voluntary day nurseries, mainly in London, where there were places for 2,000 with a charge of 3*d.* to 4*d.* per day. There was no official inspection of these institutions. Many of them were completely unsatisfactory—overcrowded, ill-ventilated, dark, dirty and foul-smelling. They were in charge of inexperienced women, who often spread infection by preparing the babies' milk in unclean bottles.

The Notifications of Births Act of 1907 made it possible to extend visits by health visitors, but even with the aid of voluntary helpers only a proportion of one in forty of the population was reached by them. The friendly advice of how to feed, wash, clothe and look after the baby was laying the foundations of important preventive health work. In Huddersfield and some other places the health visitors were qualified medical practitioners.

Milk was provided at reduced cost at special milk depots in Liverpool and in the metropolitan boroughs, etc. In all these

places general medical advice on rearing the baby was given and the basis for the modern infant welfare centre was established. In Finsbury the supply of milk was conditional on the babies being brought to be weighed and examined regularly; at the same time, general advice was given. In Glasgow a woman doctor visited the home of every mother attending in order to help her to rear the child in the home.

The great importance of this work was that, not only was the mother being taught how to care for the child, but she was given a sense of responsibility which was backed by expert and efficient technical assistance. She became part of a preventive health system, and the authorities began to pay more than just a passing interest in her. The fact that the harsh deterrents of the Poor Law, the humiliation and the stigma of pauperism, were absent was another important advance.

The care of children was one of the worst features of the administration of the destitution authorities. Almost a quarter of a million children were under the care of the boards of guardians. There were 50,000 children in Poor Law institutions, 15,000 of whom were accommodated in the mixed workhouses. The 170,000 who were on outdoor relief, subsisting on sums of *1s.* or *1s. 6d.* per week, were undernourished, badly-dressed, bare-footed, and housed under the most insanitary conditions. The mother did everything possible to keep the children out of the dreaded workhouse.

Child welfare was non-existent under the Poor Law Authority and the mother was given no advice on methods of rearing the child. As the report of the Commission said, "the mothers may feed their infants properly, or give them potatoes and red herrings; they may lock them up in a room all day (since the Guardians make it necessary for the mothers to go out to work), or they may leave them (with dummy teats or 'comforters') with the most careless neighbours; they may overlay them in bed; they may even insure their little lives with one of the industrial insurance companies, and use some of the Guardian's outdoor relief money thus hideously to speculate in death—all without the slightest instruction, without any warning or prohibition, and without any attention by the destitution authority, out of whose funds these infants are being maintained." At least 5,000 children under the age of one year died each year as the result of these conditions.

An attempt was made to justify the savage and inhuman provisions of the authorities by invoking the doctrine of the "survival of the fittest." It was alleged that the community was strengthened and the race improved by the death of these infants. There was no scientific justification for this deliberate condemnation of thousands of children to death. The struggle for existence of these children was determined beforehand by the Authority's policy of starvation.

Thousands of the children were in the infirmaries where there were no separate wards for children. The nurseries in the workhouses were generally unsatisfactory. They were overcrowded, ill-lit, ill-ventilated, "too often a place of intolerable stench, offensive to all the senses, under quite insufficient supervision, in which it would be a miracle if the babies continued in health." The staff consisted of the paupers themselves, usually the more or less mentally defective ones. The children were improperly fed, the babies were invariably cold, wet and dirty, and fatal accidents were common. In these circumstances it was not surprising that the death-rate of infants in workhouses in 450 unions in 1907 was two and three times as great as that of the infants outside. In assessing these findings, it should be appreciated that the death-rate of infants in the general population was far too high as a result of insufficient food, warmth and care, insanitary conditions and lack of medical and nursing attention.

Over 6,000 children were boarded out in the union at a cost of 1*s.* to 1*s.* 6*d.* per week. There was no medical inspection or satisfactory supervision of these children. The relieving officer was the only person who controlled this service, and he was concerned more with placing the children than the circumstances in which they were placed. Local government inspectors frequently reported cases of neglect and cruelty, and children with grave illnesses often received no medical attention.

The female inspectors in particular reported on such cases from year to year. They gave examples of children "overworked, given no play, kept in an indescribably dirty condition, and without proper clothing," of children "bearing the marks of a severe thrashing," beaten cruelly with a stick. The fact that the foster-parent often insured the life of the child gave that foster-parent a financial interest in the child's death. In the circumstances it is not surprising that the best care and attention

was not lavished on the child, who already belonged to the category of the unwanted.

These inspectors estimated that ophthalmia, ear trouble, enlarged tonsils and adenoids, and decayed teeth were very common amongst boarded-out children and were often left untreated. They pointed out that the visits of inspection from the guardians were useless, "a mere waste of public money." "They have no idea how to inspect, and therefore find little or nothing for themselves; whilst the expense of their journeys considerable." The questions the visiting committee invariably asked were: "Are you unhappy in your home?" and "Would you like to return to the Union?" As the Inspector of the Local Government Board commented, "with the prospect of the second suggestion being fulfilled, the children will seldom ever answer the first question in the affirmative." It was in these circumstances that boards of guardians received pictures of happy, contented boarded-out children.

The 10,000 children who were boarded out beyond the boundaries of their union were somewhat more fortunate than those in the union. They came under the supervision of a local voluntary committee, responsible for choosing the foster-parents and for frequent visitation of the home. The children were also specially supervised by the three lady inspectors of the central authority, and in addition the master of the elementary school had to report quarterly on the progress of the child.

There were no arrangements, however, for medical inspection or supervision of these children, and, as the poorest homes were chosen and the payment was only 3*s*. to 5*s*. per week, with 10*s*. a quarter for clothes, the standard of upbringing of these children was extremely low and in many cases there was serious neglect.

A medical investigator summed up the position as follows: "The children are regarded as belonging to the Poor Law authority, and their whole management is pervaded with the Poor Law spirit. They are a burden on the rates; no more should be done for them than the absolute minimum demanded by necessity. It is the duty of the guardians to keep down expenditure, and to see that the pauper children shall not be better cared for than the children of the poorest labourer. Proposals as to better treatment, better feeding and better control hardly belong to the sphere of Poor Law work."

At a cost of £200,000 per year, 11,000 were cared for in

schools and institutions. More than one in four of these children were in uncertified places, which were supported partly by public funds, but mainly by voluntary contributions. They were administered by voluntary commissions, mostly religious (fifty-five were Roman Catholic institutions, accommodating 5,000 [illegible] Twenty of these institutions, with 700 places, catered [illegible]d and deaf. These homes were subject to official [illegible]er 1871, but the inspectors' duties were restricted [illegible]vision of the clothing and feeding of the children. [illegible]ere was no supervision of the standards of provision of medical work ucational facilities, which were often very unsatisfactory. crow nmittee reporting on one of these homes said: "The impres-stencleft on our minds was of dirt, discomfort and inefficiency." [illegible]pe places could not be found for all children in the home of [illegible]er-mothers, the system of "scattered homes" was started by [illegible]ffield in 1893 and soon spread to about sixty unions. Five thousand children were in scattered hostels, where the conditions were at least more homely than for the 20,000 who were accommodated in boarding schools ("barrack schools"). Both these types of institution lacked facilities for recreation and training and were costly to run, although the teachers were of the poorest quality.

Receiving homes were established near the workhouses as probationary schools for children of unfit parents or for those who were in and out of workhouses. These homes were, however, very difficult to supervise and suffered from their connection with the Poor Law.

Children of vagrants were accommodated in the casual wards with their parents. In the case of 15,000 orphaned and deserted children, the Poor Law authority assumed parenthood, branding them with the stamp of pauper for the remainder of their lives.

The Home Office dealt with 30,000 children in 211 industrial reformatory schools, at a cost of £600,000 yearly. There was no co-operation between the authorities, and the Destitution Authority failed completely to do any preventive work.

The children at the elementary schools were described by Booth at the beginning of the century: "puny, pale-faced, scantily clothed, and badly shod, these small and feeble folk may be found sitting on the school benches in all the poorer parts of London. They swell the bills of mortality as want and sickness thin them off, or survive to be the needy and enfeebled

adults whose burden or helplessness the next generation will have to bear." Neglected children were being swept into the maelstrom of industry. "It is one of the saddest stories in our history."

Many of the children attending the elementary schools were suffering from lack of medical attention and treatment. A large proportion of them had diseased tonsils and adenoids, running ears, defective vision, dental decay, ringworm and untreated cuts and sores. This problem produced a conflict between the school and Poor Law authorities. The board of guardians, assuming a progressive spirit, complained that their school boards were driving the people to pauperism by requiring a medical certificate when the child was absent from school on account of illness. The parent could not afford a doctor and therefore was compelled to approach the relieving officer for a medical order for the district medical officer to issue the required certificate. They maintained that the school board should employ a medical man to visit such children to examine and certify them for these purposes. The school board, on the other hand, maintained that tens of thousands of children were plainly destitute of medical attention and that the board of guardians had the statutory duty of supplying it by issuing medical orders through the relieving officers.

Both authorities considered the other responsible. Neither authority did anything to institute a remedy. The board of guardians, when criticising the school boards, ignored the maxim that charity begins at home. Children under the direct care of the Board of Guardians in Liverpool and elsewhere were found by a Children's Investigator to be in a filthy and neglected state and there were "innumerable cases of untreated sores and eczema, untreated erysipelas and swollen glands, untreated ringworm and impetigo, untreated heart disease and phthisis." The National Society for Prevention of Cruelty to Children often had to be called in to deal with children who were under the supervision of the board of guardians.

As the guardians often neglected their duties, the local health authority permitted the medical officer of health to organise some form of medical examination in the school on the pretext of discovering infectious disease or sometimes more openly to discover physical defects which rendered the children unfit to benefit from education. In many districts the local education authority appointed school medical officers and school nurses

to examine the schoolchildren, test eyesight and in some instances even provide treatment.

The feeding of schoolchildren had its origin in the work of charitable voluntary agencies which were generally formed to meet crises of underfeeding of children in times of unemployment or severe winters. The distribution of food by these agencies was irregular, inadequate and unco-ordinated. "Sometimes doles of soup, bread and pudding were shovelled out to crowds of hungry children without any attempt being made to secure the ordinary decencies of civilised meals. In some of the centres no plates, cups, forks or knives were provided; the children fed like hungry animals, snatching the food out of their hands. Sometimes dinner tickets were distributed, which had to be presented at eating-houses of a cheap type, where the children were fed without any responsible supervision; and where, moreover, the tickets could sometimes be exchanged for cigarettes and sweets."

The existence of this destitution was slowly recognised by the local education authorities, but they were "under no legal or even moral obligation to see that their pupils were properly cared for out of school." However, they began to appreciate that it was useless to spend money on teaching children who as a result of underfeeding could not absorb the education. Here, as with the problem of medical inspection, there was considerable confusion. The boards of guardians were obviously failing in their duty to relieve the destitution among schoolchildren, while the local education authorities had no power to raise the money required for school feeding from the rates. Charitable agencies attempted in a haphazard and unsatisfactory way to bridge the gap. A Local Government Board inspector had an easy solution to the problem. He said: "The laws of the land are perfectly adequate for bringing every man who neglects his children by starving them to the police court. If the law was stringently administered, you would stop the starving of children to a great extent."

The Boer War, when 40 to 60 per cent. of the recruits were rejected as unfit for service, threw into relief the whole of this problem of the physical unfitness of the nation. The low physical standards of the recruits was an important factor in persuading the Government to institute a school medical service for the inspection of schoolchildren to prevent the development of physical defects.

The Interdepartmental Committee on Physical Deterioration also recommended the feeding of the children of the very poor. The Conservative Government of 1905 resisted any major change and merely authorised the board of guardians to give relief to the child of an able-bodied man without requiring him to enter the workhouse. Proceedings were taken against the parent for the recovery of the amount spent on feeding the child, but in any case, whether the amount was recovered or not, the parent became legally a pauper and was disfranchised.

This measure of feeding the children of the very poor was a complete failure, for in at least 80 per cent. of the cases the guardians decided that the parent could feed the child with tickets for use in cheap eating-houses were issued to the remaining parents.

In 1906 a Liberal Government was returned with 29 nominal representatives of the new Labour Party, and this Government introduced the first "Provision of Meals" Act as a result of increased pressure from the Labour Party and trade unions.

The Act embodied the recommendations of the Select Committee, which said "that the local education authority ought to undertake the administration rather than the board of guardians." This was allowed up to the limit of a rate of ½*d.* in the £1. This rate was, however, insufficient in the years of depression and many larger boroughs were subject to surcharge because of their expenditure for school meals.

Another drawback was the fact that no provision was made for school meals during the school holidays. The number of children served with meals in the first year was over 100,000, but the county areas paid little attention to the Act. In London 29,000 children were provided weekly with meals; in 1911 the figures reached 41,000. Simultaneously, the amount of money raised by charity for school meals fell from £17,000 in 1908 to £950 in 1914.

(iii) District Medical Service

The general medical service of the Destitution Authorities was particularly poor. The administration was governed by the principle laid down by the Poor Law Commissioners in 1840, i.e. "To provide medical aid for all persons who are *really* destitute, and to prevent medical relief from generating or encouraging pauperism; and with this view to withdraw from the labouring classes, the administrators of relief and the medical

officers all motives for administering medical relief, unless where the circumstances render it absolutely necessary." This short-sighted, inhuman policy ignored completely the introduction of preventive measures.

One hundred and twenty thousand of the 915,000 paupers were acutely ill. Domiciliary treatment for them was carried out by 3,[illegible]an district medical officers paid from £10 to £400 per year. [illegible]4[illegible]se sums were hopelessly inadequate, working out at about [illegible]nd 6d. per visit. The posts were held out to competitive tender a[illegible]were often accepted by the doctors at low rates to keep ou[illegible]ca[illegible]npetition. In one instance a doctor offered to do the job f[illegible]mit[illegible]ng for one year in order to outbid another applicant for t[illegible]

[illegible]ke[illegible]s no real interest in the treatment of the patients. [illegible]y re[illegible]rep[illegible] is given in the doctors' treatment of varicose ulcers. [illegible]'d sess[illegible]passa[illegible]cers were treated with linen rags borrowed from neighbours or donated as charity by the rich. Payments to doctors included the supply of drugs and dressings; lint, gutta-percha tissue and other nonporous materials were seldom provided by the doctor, for, as one of them said, "the bad legs would ruin him"! The situation was made worse by the fact that the doctors were at the beck and call of the relieving officer. The relieving officer often issued medical orders marked "urgent" in order to avoid responsibility and sometimes merely to spite the doctor. On the occasions, however, when the doctor had been called out by the patient in an emergency without a medical order, the relieving officer often refused to sanction the visit "on some frivolous pretext or other." The treatment supplied was only given on loan, and the relieving officer's visits were not directed to discovering whether the patient required any further relief, but to find out whether he had any undisclosed resources. Another deterrent was the removal of the children of sick adults to the dreaded workhouse. The guardians were particularly anxious to discourage applications for medical relief for they had an unwarranted fear that it would lead to claims for other forms of relief. There were hardly any facilities for domiciliary nursing, and many districts had no district nurse available.

The cost of this service was £500,000 yearly, but there was no supervision of the doctors' work. The doctors were casual in their work. They relied on the easily prescribed "bottle of medicine" methods of treatment and paid no attention to any

preventive medicine which might consume additional time or energy. There is no doubt that this system tended to increase the amount of pauperism in the population, for the patient did not consult a doctor until the later and more hopeless stages of the disease. The result was that the workhouses became filled with neglected cases of incurable phthisis, inoperable cancers, incurable Bright's disease, chronic disability caused by overlooked rheumatic fever, rheumatism and heart disease. The patients only became eligible for Poor Law medical relief at a stage when they were past being capable of deriving benefit from it.

There was a considerable amount of dissatisfaction with this service. One district medical officer reported that the patients in most instances were treated as a "shade only above a criminal," while the Hon. Sydney Holland summarised the position when he said: "The poor people are very dissatisfied with the medical relief that they get from the Poor Law authorities; it is given in a very grudging spirit, and they do not believe in it."

The position was made worse by the fact that the treatment of the patient varied according to the area in which he lived. In some areas the medical provision for cases of phthisis, accidents or even infectious diseases, etc., was made only by the Poor Law authority. The patient therefore automatically became a pauper and he or his relations were liable to pay for the whole cost of the treatment.

In other districts, however, the sanitary authority or the voluntary hospital supplied these services free, without stigma of pauperism. The position was complicated by the fact that patients in voluntary hospitals, when they reached the chronic stage, were often transferred to Poor Law infirmaries and were thus transformed into paupers.

(iv) Workhouse Infirmaries

The greatest scandal of the Poor Law administration was the treatment of the 60,000 patients in mixed workhouses. The 1834 Act made no special institutional provision, and the sick-room was provided only in the workhouse. Although there was a steady growth of these facilities, the restrictions on the personal liberty of the inmates was a strong deterrent to prospective applicants. The infirmary became the dread of the people and only in the last resort a refuge—a place in which to die.

The buildings set aside in the workhouse for the sick inmates were completely unsuitable as hospitals. Some of the buildings had originally been factories, and they had small, ill-ventilated rooms, with inadequate bathing and sanitary arrangements. They were staffed by local general practitioners who were grossly underpaid—the salary was often as little as £70 per year, inclusive of drugs. Their treatment was perfunctory, inadequate and unsatisfactory, and generally they spent only a few minutes in the workhouse two or three times a week. The doctors were encouraged to prescribe alcohol, as this was the only drug for which the guardians paid. In one case the doctor left a curable syphilitic patient untreated because, as he said, "I cannot afford it; my salary is not sufficiently adequate for me to find the expensive drugs necessary." Hundreds of phthisis patients were given up as hopeless because there was no provision for them.

The nursing was performed by pauper assistants who had no medical training. The quality of the nurses in the country as a whole had improved as a result of the efforts and example set by Florence Nightingale in the Crimean War in 1855. The Government had been seriously alarmed for "the number of men who were disabled by preventable disease amounted to more than one-third of the whole strength of the army which went out of England." Florence Nightingale and her staff of nurses reduced the death-rate in the hospitals to one-nineteenth of what it was originally.

The Government learnt the lesson of the role of efficient nursing in preventing sickness and mortality in military hospitals, but did not apply it in their hospitals at home. The "nurses" employed in the workhouse infirmaries were given little encouragement to follow in the tradition of Florence Nightingale. The wages for nurses were as low as £20 per annum, so that there were often no applications for a post, and, on account of frequent changes, money which might well have been applied to increasing the salary, was spent on advertisements. Examples of the result of this policy of appointing nurses who were not qualified are given in the Local Government Board Inspector's report of 1899–1900, in which he referred to a "nurse" who had never seen a confinement case before and "had no idea what to do"; to a " 'nurse' who, being told to take a temperature, put the clinical thermometer into the chamber utensil"; and to a "nurse" who caused the death of a patient whilst endeavouring

to pass a catheter. The Inspector concluded: "The moral is that untrained housemaids at £20 a year are not effective understudies of the nurse's role."

The patients were completely mixed. The acutely sick, the lunatics, the tuberculous, the mentally defective, the pregnant women were all herded together in institutions of less than fifty beds. The standards of treatment were inevitably low for all these different types of case, as they were accommodated in one single ward. The noisy, turbulent atmosphere, the cries and howls of the lunatics and mentally defectives, the moans and groans of the dying seriously affected the acutely sick and the pregnant women.

These were the conditions which prevailed in the 300 rural workhouses. They were the only institutions serving as hospitals in nearly half the area of England and Wales. In addition to the "chronics" and the "seniles," they dealt with thousands of sick patients every year. The people were so discouraged from entering these scandalous institutions that they insisted on staying at home rather than be admitted to the infirmary. The result was that many were subsequently compelled to enter in a moribund state.

A large number of the urban infirmaries were equally as bad as their rural counterparts, but in the towns there was generally a steady improvement in the facilities provided. New sick wards were added to the workhouse, drugs and medicines were provided direct by the board of guardians, salaried ward-maids were employed and in some cases nurses and even a resident medical officer were appointed. Compared with actual needs, or with the staffing of the voluntary hospitals, the medical and nursing staffs were hopelessly inadequate in numbers and quality.

The construction and equipment of the wards was, however, of a higher standard. Dr. McVail reported on the wards as follows: "The best of them are excellent . . . the wards of most of them are quite equal to those of a first-class general hospital." The Poor Law spirit prevailed, however, and there was constant friction between the medical and nursing staffs and the master and matron of the workhouse. The development of these institutions was therefore very uneven, especially as the master and matron were still in charge, not only of the workhouse, but also of the infirmary. As the Webbs aptly put it: "To place

under the management of one man and his wife an institution which, whether large or small, combines the functions of rearing children from infancy to adolescence, treating sickness in all its forms from phthisis to cancer, from maternity to senility, controlling the feeble-minded, the imbeciles, the epileptics, and even the certified lunatics, reforming the mothers of illegitimate children, maintaining respectable deserted wives and widows, and setting to work the able-bodied of both sexes—not to mention the usual additional duty of harbouring vagrants—is to abandon all hope of getting expert training or specialised skill."

In London, the problems of dealing with the infectious sick and the imbeciles were much greater because of the numbers involved. In 1866, a report on the metropolitan workhouses by Mr. Farwell, a Local Board Inspector, gave a very clear indication of the inefficiency of the Guardians. His report showed that the sick wards were badly constructed, imperfectly ventilated and frequently insanitary. The number of beds was insufficient and the bedding was filled with flock which was in a lumpy condition.

Generally speaking, the food was badly cooked by the pauper inmates and was frequently served almost cold. The eating and drinking vessels were in many cases unclean. There was a deficiency of easy chairs, bed-rests, wash-hand basins, and even of combs, brushes and towels. The patients were nursed by paupers, "many of whom could neither read nor write, whose love of drink drove them to rob the sick of the stimulants which they should have given them, and whose treatment of the poor was, generally speaking, characterised neither by judgment nor by gentleness."

Faced with such reports and the breakdown in the isolation of London's fever patients, faced with the growing criticisms and rising anger of the public, the Poor Law Board was compelled to act. The administration of the infirmaries was removed from the control of the Boards of Guardians and was centralised in a new body, the Metropolitan Asylums Board. The new authority immediately took steps to improve the conditions of treatment in the London infirmaries. Medical superintendents were appointed to take charge of the accommodation for the sick and arrangements were made for the performance of operations. The wards were still understaffed and the Poor Law spirit still prevailed. Admission depended upon the order of the relieving officer,

whose main concern was with the general rather than the medical urgency of the case. There was no specialist staff in the infirmaries, no medical research was performed, and preventive medicine was not practised.

The Royal Commission Report of 1909 referred to these hospitals as follows: "Their work is divorced from the general current of clinical research, from laboratory experiments and statistical investigations of the officers of the public health authority. . . . They are shut to medical students." They became the dumping grounds of the voluntary hospitals, as they were compelled to accept all the varied cases which the voluntary hospitals refused to admit. The overworked medical superintendent and his two or three assistant medical officers had to deal unaided with "the acutely sick and 'mere' chronics; the expectant mother and the senile feeble-minded; children with measles or whooping cough and the sufferers in advanced stages of venereal disease; the phthisical, the cancerous, and the rheumatic; the man knocked down by a motor car and the charwoman with bronchitis. . . . Children suffering from infectious diseases had to be mixed up with adult patients."

These Poor Law infirmaries began to be used by skilled artisans and small shopkeepers, particularly in districts such as Camberwell, Woolwich or Wandsworth, where there were no other hospitals in the district. They were regarded as rate-aided by this new class of patients, and, through their organisations, played an important role in the demands for their improvement and for the elimination of the Poor Law atmosphere.

(v) Voluntary Hospitals

Many voluntary hospitals, based on charitable support from the public, were built in the second half of the nineteenth century. One of their declared aims was "to prevent loss of time in the factories." Their 25,000 beds (a quarter of the number in the infirmaries) were mostly in the large towns. The table on p. 100 shows that in 1906 even in the large towns the number of beds in the Poor Law infirmaries exceeded the number in the voluntary hospitals.

The Majority Report of the Royal Commission on the Poor Laws (1909) summed up the position with regard to the establishment of voluntary hospitals: "Voluntary hospital accommodation being of necessity dependent upon private generosity, its extent

is regulated by impulse rather than by actual requirements. There is no recognised standard of accommodation: nor is there, outside of London, any public body or authority whose duty it is to guide the charitable public in applying their beneficence in districts where it is most needed, or where the best results are likely to obtain."

	Beds in Voluntary Hospitals	*Beds in Poor Law Infirmaries*
London	10,224	16,300
Liverpool	1,172	2,000
Manchester and Salford	1,278	3,250
Birmingham	838	2,200
Leeds	450	1,000
Sheffield	550	800
Newcastle	417	350
Cardiff	235	500
Leicester	200	500

The voluntary hospitals admitted only the acute and interesting cases, invariably excluding the infectious diseases and chronics. This policy gave the hospitals a quick turn-over of patients, and gained for both the hospitals and the consultants a reputation for spectacular and skilled treatment. The skill and fame of the consultants were thus communicated to the general practitioners, who sent their cases to the voluntary hospitals. They were therefore encouraged to send their richer paying patients to see the consultants privately. It was largely by these methods that the practices of consultants grew.

The voluntary hospitals practised no form of preventive medicine. The patient was not admitted unless he was in the acute stage of the disease or required some complicated investigation or operation. He was usually discharged before he was completely well. Before the advent of Listerism, these hospitals were death-houses. In 1861 the bed mortality in the metropolitan hospitals was 90 per cent., in twelve provincial hospitals 83·2 per cent., while in twenty-five county hospitals it was only 39·4 per cent. Farr, the famous statistician, wrote: "The mortality of the sick who are treated in the large towns is twice as high as the mortality of the same diseases in patients who are treated in small hospitals in small towns."

The out-patient treatment of the poor was conducted in the

out-patients' departments of the hospitals and the "medical missions" or free dispensaries. Though these were free and presented no formality for the thousands that availed themselves of their services, it was only "interesting" cases who received any reasonable attention. For the majority it meant long waits in crowded, unhygienic waiting-halls, spreading diseases, receiving the same old bottle of medicine ("Rep. mist," i.e. the mixture as before), irrespective of its medical value. All kinds of sick cases were crowded together; men, women and children, with sores, ulcers, coughs and colds, and frequently even infectious diseases, often waited for hours in dirty, insanitary waiting-rooms; these conditions were "positive dangers to public health." The doctors were hopelessly overworked and the patient had to be put off with the stereotyped "How are you to-day?" "Put out your tongue." "Go on with your medicine." There was no inquiry into the patient's medical and sociological background; there was no domiciliary visiting or follow-up; there was no adequate physical examination.

In these circumstances it was not surprising that the Royal Commission Report of 1909 concluded that in so far as "any preventive or really curative effect is concerned it was little better than a delusion." The patients were often encouraged to visit the out-patients' departments of the voluntary hospitals in order to swell the number of attendances. Appropriate appeals, boasting of the numbers dealt with, could then be issued in order to attract contributions.

(vi) Dispensaries and Contract Practice

In the case of the "medical missions," matters were worse, for the standard of the doctors was inferior. There was no consultant or institutional provision, and the religious element predominated. The whole atmosphere was again curative and not preventive.

One of the major reasons stated for establishing a free dispensary was to prevent people from being disqualified from voting and thus to attract their support. In 1867 official Poor Law dispensaries were established by the Guardians in the Metropolis. They were certainly an improvement on the method whereby patients attended at individual district medical officers' surgeries. A dispenser was employed by the guardians and the doctor no longer had the responsibility of supplying medicines and dressings

from his meagre salary. The dispensary was conveniently situated and the patient could see the doctor at fixed hours. There was a "better check on the medical officer's treatment of cases," and the appointment gave the doctor "greater publicity, heightened his responsibility, and stimulated his energies."

The cost of providing a dispensary was "extremely small." The number of medical orders issued for attendances to the doctor was considerably reduced. It is difficult to estimate whether this was a reflection on the popularity of these dispensaries or whether the doctor shelved his responsibilities by sending the patients unnecessarily to the infirmary.

Other agencies for the treatment of the more highly skilled workers, numbering 6 million, were the insurance schemes, such as the "doctor's club," "friendly society," "medical provident association," "provident dispensary" or other contract practice. The service excluded three-quarters of the population (practically all the women), and some societies insisted upon an initial medical examination and excluded the "bad lives," although they were the very ones who specially needed this form of medical provision. For a small payment, payable weekly or quarterly while they were well, the members could obtain free medical attention and medicine when they were ill. This service, however, was most unsatisfactory, and there was continual friction between the secretaries of the friendly societies, the members and the doctors. The doctors claimed that their remuneration was far too small to give an adequate service and that wealthy people who should pay the normal fees took advantage of the scheme. The members, on the other hand, complained that the doctors' treatment was perfunctory, that they received better treatment if they paid as private patients, and that the doctor tried to recoup himself by charging fees to all the other members of the family. These mutual recriminations prejudiced the development of efficient measures for preventive and curative medicine.

The private "doctor's club" was even worse, for the doctor often struck off from his list patients who developed chronic illnesses, and sometimes abandoned the list completely if he felt it did not pay. The disadvantages of this service were described in the Royal Commission Report on the Poor Laws (1909): "The long waiting in the crowded waiting-rooms at the doctor's surgery tends to spread infectious disease, to injure the health of the patient and to cause a considerable loss of

time. The doctor should take account of the home conditions of the patient. He has time for none of these things. He reduces his domiciliary work as much as possible and encourages the patients to come up to his surgery for treatment, and it is extremely rare for him to report anything to the sanitary authority except cases of notifiable diseases. There is a tendency to pander to the medical superstitions of the sick rather than correct their bad hygienic habits. As one doctor explained, 'to satisfy the patients it is necessary to give them a lot of medicine. It the ...fec- a dark medicine with a strong taste, preferably of peppe...t be ...'

The service was by no means comprehensive. A ... " officer of health pointed out "that the self-supporting char...l of a medical club was largely an illusion. There are ma... diseases that a club doctor does not attempt to treat. The vast number of notifiable infectious diseases, lunacy, and an increasing number of cases of tuberculosis are treated in rate-aided institutions. Abdominal surgery, ophthalmic surgery, any surgical operation except the most trivial, and many other conditions are treated in hospitals that are supported by private charity. It is true to say that in a sense, these so-called 'self-supporting' medical agencies are partly supported by the rates and partly by private charity." These criticisms, though levelled at the unorganised insurance services of the beginning of the century, could be applied equally to the organised National Health Insurance service almost half a century later.

(vii) Municipal Hospitals and Public Health Services

The public health authorities furnished 700 municipal hospitals with 25,000 beds. They ranged from a cottage hospital with two beds to the Liverpool City Hospital, which had 938 beds, employed six resident and seven visiting doctors, and treated 5,000 patients yearly.

The Metropolitan Asylums Board in London was virtually a public health authority, and although originally it dealt almost entirely with infectious diseases, it gradually increased its facilities so that by the time it transferred its functions to the London County Council in 1930 it was dealing with practically every form of health problem. At first the patients could only be admitted as paupers, but following the Diseases Prevention Act of 1883 the stigma of pauperism was removed from the in-patients of their hospitals.

Originally the hospitals provided by the public health authority were restricted to infectious diseases, although this was not the intention of the Act which dealt with this matter. Barry Urban District Council set the pace in 1900 by erecting a hospital for non-infectious diseases which also dealt with accident and acute surgical cases. Brighton Municipal Hospital set the fashion for the treatment of early cases of tuberculosis. In 1906 they dually dealt with more cases of tuberculosis in their hospital who with any other disease, and at least half the known cases tuberculosis had treatment there. Manchester and Leicester followed suit and provided similar services. There were also municipal out-patient departments in Willesden for the treatment of impetigo, ringworm, scabies, ophthalmia, etc., while the Town Council of Newcastle-on-Tyne paid 100 guineas a year to the voluntary dispensary for 800 "letters" which entitled the bearers to two months' free treatment, including domiciliary visits, and admission to a voluntary hospital when required.

(viii) Public Health Services

The local authority also supplied free diphtheria antitoxin; Manchester and other bodies supplied anti-diarrhœa mixtures from police stations, and many authorities arranged for free baths for the treatment of pediculosis and scabies. The Medical Officer of Health was available as a consultant for infectious diseases and the public health laboratory, though often of a primitive nature, gave assistance in the diagnosis of them.

Health Visitors, at first voluntary (in Manchester in 1862 there were ninety-two), were later employed by the councils to carry health propaganda into the homes. At first there was considerable opposition to the health visitors entering the homes of the people, but before very long they were welcomed as friends of the family.

Nurses were employed by the councils to attend patients suffering from infectious diseases in their own homes in cases where admission to hospital was inadvisable. In Worcester this facility was extended to non-infectious patients. In cases of the more severe and dangerous types of infectious diseases—cholera, smallpox and plague—the "contacts" were paid half their normal wages while they were kept in cottages under observation.

The various public health services described were, however, not extended to the whole of the country. Their development

was sporadic and not all were provided complete even in the most progressive towns. A large town such as Norwich was reported, in 1906, as having made "no provision for the treatment of infectious ailments, such as measles, German measles, whooping cough, chicken pox and mumps; nor for the tuberculosis disease, nor for such contagious diseases as scabies and the other pediculi, nor for the venereal diseases."

In the 650 rural and small urban areas there were hardly any public health facilities at all, no sufficient or suitable infectious diseases hospitals, and no arrangements for home visits. Their medical advisers were part-time Medical Officers of Health who were advised by the councils not to be "meddlesome." Generally, there was no regular medical inspection of the age group one to five years, and in the schools children were usually only referred to the doctor on the advice of the teacher. There was no provision for the prevention or treatment of venereal diseases, and only advanced cases of tuberculosis were treated.

(ix) The Mentally Defective and Disordered

The mentally defective and disordered, numbering approximately 200,000, comprised one-sixth of all those requiring relief or assistance. They presented a special problem. Three authorities provided for these patients, the Local Government Board, the Lunacy Commissioners, and the Home Office. None of these authorities had any clearly defined responsibility, with the result that expenditure was unnecessarily high, mounting to a capital cost of £300 up to £500 per patient and an annual cost of £3,000,000. The county councils and county borough councils, as the local lunacy authorities, had 180 asylums accommodating 120,000 patients. The councils recovered the cost directly from one in ten, who then ranked as "private patients"; in the remaining nine out of ten the cost was recovered from the Board of Guardians. The guardians recovered the cost from the relations, who then, together with the patients, ranked as paupers even though the full amount had been repaid.

These asylums were relatively well staffed with doctors and nurses but when compared with general hospital standards or with actual needs they were deplorably inadequate. Treatment was given, however, and some 10,000 patients were discharged annually as cured.

The board of guardians, in addition to paying for the majority of the mentally defective or disordered in the county asylums, cared for about 60,000 in the ordinary wards of the general mixed workhouse. These patients were indiscriminately mixed with the ordinary inmates with terrible, tragic results. The signatories of the Minority Report on the Poor Laws (1909) said: "We have seen feeble-minded growing up in the workhouse year after year untaught and untrained, alternately neglected and tormented by the other inmates; idiots who are physically offensive or mischievous, or so noisy as to create a disturbance by day and by night with their howls living in the ordinary wards, to the perpetual annoyance and disgust of the other inmates. We have seen the imbeciles annoying the sane, and the sane tormenting the imbeciles. We have seen half-witted women nursing the sick, feeble-minded women in charge of the babies, and imbecile old men put to look after the boys out of school hours. We have seen expectant mothers eating and sleeping in close companionship with idiots and imbeciles of revolting habits and hideous appearance." Added to these idiots and imbeciles were the epileptics, who were also herded together with the other inmates. Here there was no specialised staff, no attempt at treatment and no cures. The imbeciles did practically all the manual work in the workhouse. The House of Commons Committee of 1899 recommended the removal of all imbeciles from the workhouses, and one of the opponents said: "If you remove the feeble-minded women from the workhouse, who will do the scrubbing?"

The local education authority dealt with 47,000 mentally defective children in day and residential schools. The children were often "boarded-out" so that they could attend the day schools. The education authority worked in splendid isolation, and its work was not in any way co-ordinated with that of the guardians or the councils. The education authority approached the guardians only when they disputed the responsibility for the care of a mentally defective child.

It is not surprising that in the face of these facts the Royal Commission on the Care and Control of the Feeble-minded (1904–8) recommended that all the mentally defectives should be removed from the workhouse. They stated emphatically that "a Poor Law authority cannot suitably undertake the care of the mentally defective."

(x) *The Aged and Infirm*

The aged and infirm, comprising one-third of the paupers, presented their own special problems. The solution of these problems by the Board went through various phases. At first the mixed workhouses were indiscriminately used, but the authorities felt that if special treatment was given to the aged the value of the workhouse as a test for the able-bodied might be undermined. They therefore decided to treat the aged with the same harsh, repressive measures as the able-bodied. This policy was somewhat modified by allowing the aged to remain on outdoor relief without offering the workhouse as a test. The relief given was, however, completely inadequate, ranging from 2*s.* to 2*s.* 6*d.* per week, and "no more was given than sufficed to sustain life." This policy, which reigned between 1834–71, was dictated by the fear that if conditions were made too comfortable for the aged and infirm it would encourage the able-bodied to fall into this category by discouraging them from being thrifty and saving for their old age.

Between 1871 and 1890 the harsh school of the "strict administrators" came into its own. The policy was to offer the "test of the house" to the aged and infirm on the same conditions as those of the able-bodied. This policy was based on the principle that the shame and disgrace falling on the family if the aged entered the house would encourage those relations, who were not responsible, to come forward and provide for the aged. If there were no such relations it was hoped that charitable organisations would come to the rescue. The whole policy was to emphasise the stigma of pauperism and what the Chief General Inspector of the Board officially described as "the degradation of parish support."

After 1890 a further change of policy took place. This was largely due to the agitation which grew up in favour of pensions for the aged and for their better treatment generally. The Liverpool Poor Law authority won the battle for a weekly allowance of tobacco for the well-conducted old men, irrespective of whether they were "employed upon work of a hazardous or specially disagreeable character."

The Royal Commission of 1893–5, set up as a result of public agitation, reported a departure from the harsh principles of 1871–90. The boards were advised to discriminate between their treatment of the deserving and the undeserving. New directions

were given to the guardians in the Central Authority's circulars of 1895 and 1896. They were recommended to partition sleeping wards into separate cubicles, so that aged and infirm couples could be provided with separate rooms. The aged were to be allowed to receive visits and to go out visiting. There was to be no distinctive dress and those who had "previously led moral and respectable lives" were to have a separate day room. The harsh policy was thus reversed and now conformed to the old recommendations of 1834, i.e. "the old were to enjoy their indulgences."

Although these improvements eased the suffering of the aged in some workhouses, there was no change in the majority of areas. The Majority Report of the Royal Commission on the Poor Laws quoted a description of a home for aged people as follows: "Defective in every particular . . . rooms were low, ill-lighted, and hopelessly overcrowded . . . no chairs except in the dining-room . . . total absence of books and newspapers . . . two officers for 268 inmates . . . it is impossible to conceive a more dismal and hopeless asylum for age."

Medical opinion, including the Association of Poor Law Medical Officers and the British Medical Association, was in favour of institutional provision for the aged. The authorities, however, were always haunted by the fear that if the conditions in the workhouse were made bearable, they might attract more inmates who could be dealt with much more cheaply in their own homes. With this short-sighted economic policy they ignored the fact that in the long run it was much more expensive, for, apart from the toll of human suffering and misery which it entailed, illness, infectious disease and physical and nervous strain increased the number of paupers among the relations who had to care for the aged.

Outdoor relief was given to those who still refused to enter the hated mixed workhouse with "its promiscuity, its brand of pauperism, and its chilling deterrence into which no Parliament will ever force anybody." These people lived in a condition "verminous and dirty beyond description," in rooms "stinking and loathsome"; "a positive danger to Public Health."

The third and slightly more humane policy, as described in the circulars of 1895 and 1896, was not extended to the aged in all the parishes; some still carried out the first two harsh policies. The more humane policy was nowhere extended to the

physically defective and crippled, the half-paralysed, blind and semi-blind, the gravely rheumatic and other persons who through chronic disabilities were unable to earn a living in a competitive labour market. The thousands in these categories were treated as harshly as the able-bodied destitute.

The third policy was gradually extended still further, and in 1908 the National Pensions scheme was established. With certain exceptions, all persons over the age of seventy became entitled as of right to a pension of 5*s*. per week, provided their income did not exceed £31 10*s*. per year.

(*xi*) *Recommendations of the Royal Commission on the Poor Laws* (*1909*)

Both the Majority and the Minority Reports of the Royal Commission on the Poor Laws (1909) agreed on the general principle of the transfer of the Poor Law functions of the guardians to the county and county borough councils. The main object of this reform was to infuse some humanity into the Poor Law administration and to introduce preventive measures.

The majority considered the pauper as a person with a "moral" defect and they suggested that voluntary charitable efforts, rather than official aid, should be encouraged. They recommended that councils should appoint Public Assistance Committees to deal with patients requiring relief or assistance. The Minority, on the other hand, considered that charity had a demoralising effect and should be avoided. They recommended that the various committees of the council should be responsible for administering prompt relief of the broadest possible kind for each specific condition. The patients should be treated as ordinary citizens and not placed in any special category of the poor, the troublesome, or the unwanted. The minority proposed the ending of the separation of the local Poor Law administration from the local authority services.

Eminent doctors strongly supported this proposal. Dr. Newman, Medical Officer of the Board of Education, and Dr. Newsholme, Medical Officer of the Local Government Board for England and Wales, spoke with authority and emphasis on this subject. Dr. Newsholme, concluding his remarks, said: "The present division of medical duties is gravely mischievous to public health and the unification suggested is very desirable."

It appeared at first that the Government might introduce a comprehensive medical service on the lines of the Minority

Report, but the agitation of the public for this reform was not sufficiently intense at this stage and the Government were unwilling to concede so marked a progressive change. Instead, they introduced a compulsory insurance scheme, the National Insurance Act of 1911, which was to be under the control of the National Health Insurance Commissioners.

The Government's action in this matter was all the more deplorable as it seriously delayed the setting up of a Ministry of Health, a proposal which had first been recommended as early as 1869 by a Royal Sanitary Commission. Both the Majority and Minority Reports on the Poor Law had severely criticised the out-dated, out-moded Local Government Board. The Board had remained well behind in the progress of medical science and the growth and development of public opinion. Their lay and medical administrators should have been encouraging the backward authorities to improve their services. Instead, their time was devoted to restricting and delaying the activities of the more progressive authorities. Not content with hindering the march of progress in the local authorities under their control, they quarrelled with other central bodies who were trying to initiate useful schemes of preventive medicine.

Although the Local Government Board showed no interest in the schemes for maternity and child welfare which were being introduced in various parts of the country, they continually disputed with the Board of Education as to whether the latter could inaugurate schemes for infant welfare.

(xii) Formation of the Ministry of Health (1919)

Between the issue of the Royal Commission's Reports and the formation of the Ministry of Health in 1919 the Great War of 1914–18 was fought. This major diversion in the struggle for reforms seriously impeded the development of an efficient State medical service. The Government nevertheless introduced some relatively minor reforms—for the mental defective (Act of 1913), for those with tuberculosis (Regulations, 1912, and Order, 1913—although it was not until 1921 that the county and county borough councils were required to make hospital provision and could organise after-care schemes) and for those with venereal diseases (Act of 1917).

A considerable amount of effective propaganda based on the Minority Report was organised and kept up for many years.

This had a profound effect on the public conscience, and public pressure for the establishment of a Ministry of Health became heavy and sustained. The Presidents of the Local Government Board between 1916 and 1918 received innumerable deputations from trade unions, political party conferences, Fabian women's groups, medical organisations; all demanding a Ministry of Health. Lord Rhondda, in a memorandum to the Cabinet in 1917, referred to the fact that public opinion was aroused in favour of a Ministry of Health. He added that there was great difficulty in providing adequate facilities for discharged soldiers and their dependents.

Opposition from vested interests was forthcoming as usual. The civil servants and officials of the Local Government Board, who were afraid of losing their jobs, the boards of guardians, who were afraid that a progressive policy at the centre would dispense with them, the local authorities, who were afraid of loss of power, the British Medical Association, who were afraid of a State medical service—all these bodies were in the vanguard of the opposition.

Public agitation was, however, intensified and gained a new impetus following the great influenza epidemic of 1918–19. Deputations to the Government increased in number and a national memorial was presented to Parliament. The Press, with *The Times* in the vanguard, reported these activities and generally supported the campaign.

This prolonged agitation gradually wore down and defeated the opposition, and in June, 1919, the new Ministry of Health was formed, with Dr. Addison as the first Minister. *The Times* reported on this victory as follows: "A fight for progress waged against considerable odds is now concluded. Few realise how nearly the scheme came to shipwreck on several occasions." Thus began a new era in public health, with a central department responsible for the health of the nation.

The Ministry of Health Act, 1919, dispensed with the Local Government Board, the powers and duties of which were transferred to the new Ministry of Health, together with the powers and duties of the National Health Insurance Commissioners, the Board of Education, and Privy Council (in so far as it was concerned with the Midwives Act) and the Secretary of State (with regard to infant life protection). The duties of the Minister were to prepare, carry out and co-ordinate measures to promote

the health of the people. They were described in the Act as including:

"(1) The prevention and cure of diseases;

"(2) the avoidance of fraud in connection with alleged remedies;

"(3) the treatment of physical and mental defects;

"(4) the treatment and care of the blind;

"(5) the initiation and direction of research;

"(6) the collection, preparation, publication, and dissemination of information and statistics;

"(7) the training of persons for health services."

Consultative councils were set up to assist the Minister. His powers and duties were comprehensive, but from the very outset of his career, not only was he saddled with the task of the general supervision of local government, but had, in addition, to carry the heavy burden of housing administration.

CHAPTER VII

SOCIAL AND POLITICAL BACKGROUND: 1875–1919

IT IS CONVENIENT AT this stage to summarise the background of the treatment of the people during this second period. The people had been defeated in their opposition to the growth of the factories and the general development of the industrial system. The general attitude of the authorities to the defeated people was as harsh and repressive as in the previous period. Even as late as 1906 the Chief Inspector of the Local Government Board declared that pauperism was the choice of the people, and he recommended the application of the inhuman principle of "less eligibility" to the children, the aged and the sick. The main reason for this harsh attitude was the drive for the most rapid and economical expansion of industry in order to defeat foreign competition and thus bring in the greatest profits. The people had been divorced from their means of livelihood, the land and handwork, but the conditions in the new factories and in the growing industrial towns were unattractive.

Measures were adopted to make the alternative to the hated factory less palatable in case the people found it a refuge from the terrible conditions in the factory. To make absolutely certain that there was no chance of malingering, the cruel policy was extended to the sick. Three important factors tended to modify this harsh attitude. Firstly, the fever epidemics (especially the four cholera epidemics, 1831–3, 1848–9, 1853–4 and 1865–6) resulting from the insanitary conditions in the factories and the towns alarmed the authorities, for the infectious diseases spread to the industrialists, landowners and aristocracy. Secondly, it was found necessary to conserve the industrial strength of the future adult worker and to train him to become more skilled than the workers of the foreign competitors. Finally, the workers began to organise themselves into trade unions and influential political parties, which resisted this inhuman policy. With the advance of scientific medicine the whole question of preventive medicine was brought into prominence. When medical

diagnosis and treatment were no longer confined to the stethoscope and a bottle of medicine, but included X-rays, radium, intricate surgical operations, etc., almost the whole population became destitute in respect of medical treatment "without being destitute in all respects." The highly organised skilled worker could not afford the new expensive treatments, and he began to demand a more humane spirit and approach to the patient. This demand had its effect in improving the methods of treatment of the rest of the population. As a result of these influences, a general humanitarian "liberal" element began to invade the Poor Law administration.

The development of organisations of the people was uneven. After the defeats of the labourers in their industrial and political struggles against the growth of the new industrial system, a new conception of trade unionism was developed. Instead of the workers being organised in a trade union embracing all trades, a trade union was formed for all workers employed nationally in *one* trade, usually a skilled craft. These craft unions survived the initial attempts of the employers to crush them, but subsequently they frequently collaborated with the employers and they introduced the doctrines of negotiation and compromise. The employers began to recognise the value of these skilled workers, not only in the struggle with foreign competition, but also in the struggle at home with the millions of unskilled workers. The skilled workers were placated by being given better conditions as a share, although only a very small share, of the proceeds of colonial expansion. They then played a useful role for the Government by modifying the demands of the majority of workers whose conditions were very bad indeed.

The new trade unions introduced business methods and were very cautious and exclusive. They soon became "prosperous" and they therefore discouraged strikes which involved them in an expenditure of money. They organised sick benefits, funeral and unemployment payments. These "friendly society" activities formed the basis of the future National Health Insurance Act. In 1860 these unions formed an official central leadership known as the "Junta," the forerunner of the Trades Union Congress, which was formed in 1871. Their policy (to quote the Webbs) was "restricted to securing for every workman those terms which the best employers were willing voluntarily to grant." In fact, "every workman" referred only to the skilled worker and they

ignored completely the millions of unskilled workers who were living under most insanitary conditions.

England's industrial monopoly began to be challenged by France, Germany and America, with the result that the slumps which occurred in 1875, 1880 and 1884 became more profound and recovery was slower and less complete. Inspired by the works of political writers and authors, political organisations and trade unions were formed to voice the needs of the masses of the unskilled workers. Many writers and authors were prominent in championing the cause of the people. The writings of Karl Marx (1818–83) and of his colleague, Friedrich Engels (1820–95), played an important role in influencing the birth and growth of the new movements. The most important writings of Marx were the *Communist Manifesto* (1848) and *Capital* (1867), and he also contributed actively in the formation of the First International (1864) and in the preliminary work for the formation of the English Social Democratic Federation. Engels contributed many works, notably *The Condition of the English Working Class in 1844*, and he helped to guide the leaders of the industrial trade unions and the new political parties.

The founders of the Labour Party were inspired by the works of Henry George, especially *Progress and Poverty* (1879), which criticised the ownership of land, etc., and Edward Bellamy's *Looking Backward* (1887), the famous book on the workings of a socialist State.

The works of the Fabian Society, the members of which included the Webbs, George Bernard Shaw, H. G. Wells, and Mrs. Besant, were the basis for the very foundation of English "municipal" socialism. Foremost amongst these works was *The Fabian Essays*, a collective book which covered a wide variety of social problems and had a profound effect upon public opinion. The prefaces and plays of Shaw were incisive in their social criticism. The writings of H. G. Wells, particularly *Mankind in the Making* (1905) and *New Worlds for Old* (1906), were striking critical analyses of society with constructive proposals for local government and national administration.

The Webbs, in their works, *The History of Trade Unionism* (1894), on *Factory Legislation and Industrial Democracy* (1897), *The Poor Law, the State and the Doctor*, and *English Local Government* (1910), set a new high standard in the methods and presentation of social research.

Charles Booth, in his detailed study of the *Life and Labour of the People of London* (1904), estimated that at least one in four of the working class were, at one time or another of their life, actually destitute and reduced to the workhouse. More popular expositions of socialist principles were Robert Blatchford's *Merrie England* (1894), with a sale of over a million copies, William Morris's *News from Nowhere* (1891) and Robert Tressall's *The Ragged Trousered Philanthropists* (1910).

The Socialist Democratic Federation and the Fabian Society were formed in 1884, while in 1888, after the famous Bryant and May ("the match girls' ") strike, the Gas Workers' and General Labourers' Union was formed. This was followed by the great dock strike of 1889, when 200,000 flocked into the unions of the unskilled workers. The policy of the new unions differed from that of the staid old craft unions. Their dues were lower, women were admitted to membership and they were not restricted to "friendly society" activities. A resolution of the General Railway Workers' Union in November, 1890, read: "This union shall remain a fighting one and shall not be encumbered with any sick or benefit funds."

In 1893 the Independent Labour Party was founded and was followed in 1900 by the formation of the Labour Party. The Labour Party was formed as a federation of the trade unions, the Fabian Society and the Independent Labour Party. While this new party represented the first independent mass political party of the workers, its leaders were content to follow the Liberals on almost all questions.

In 1906, twenty-nine Labour Members were returned to Parliament. The Government reacted strongly to these new movements which were growing amongst the workers. In November, 1887, the police, on the infamous "Bloody Sunday" in Trafalgar Square, broke up a demonstration with extreme brutality, killing three men and wounding and arresting 300.

In 1902, the judicial decision in the Taff Vale Case, which made the trade unions answerable in damages for all the acts of their officials, dealt a serious blow to the growth and development of the trade union movement. The Government, faced with persistent pressure by the trade unions, coupled with the support of the newly strengthened Labour Party Members in Parliament, had to pass the Trade Dispute Act of 1906, which reversed this judicial decision.

During the period 1893–1908 profits increased by 29·5 per cent., while wages rose by only 12 per cent. Strikes were frequent and widespread, culminating in the first national miners' strike in 1912, followed by big strikes of the dockers and seamen. In 1914 the Triple Alliance of miners, railwaymen and transport workers was formed to prepare for a general strike. The membership of the trade unions rose to nearly 4 million in that year.

The Co-operative Movement, formed in 1844 to give workers the benefits of the profits in the distribution of goods, had over 2¼ million members in 1905. It is against this background of the rising tide of workers' organisation and agitation that one should judge the Liberal reforms of 1906–14, which were sponsored by that shrewd politician, Lloyd George. The Pensions Act, and the Health and Unemployment Insurance Acts were passed to neutralise the effects of the Parliamentary Labour Party, whose outlook and policy were more "liberal" than socialist. The Acts also served as concessions to the workers in order to persuade them to "water down" the demands and agitation of the trade unions.

The Labour Movement recognised the fact that war, in itself, did not solve the problems facing the workers. They therefore undertook a pledge to oppose a war with a general strike. When, however, war actually broke out in 1914 the majority of the Labour leaders joined with the Government in prosecuting the war.

One of the first acts of the wartime Government was to declare strikes illegal in a number of industries. Strikes, however, took place. At first they were of an industrial character only, but later, especially after the Russian Revolution of 1917, they assumed a political complexion. Two hundred thousand miners in South Wales struck against the Munitions Act of 1915. In the same year a "rent strike" was called in Glasgow, where evictions were strenuously resisted by the housewives. As a result, the Government introduced the first Rent Restrictions Act. In May, 1917, there was a strike of a quarter of a million engineers, after the formation of the Shop Stewards' Clyde Workers' Committee.

Although the organisation and agitation of the workers were not as extensive as before the war, they nevertheless gained momentum as it progressed. They were especially stimulated by the Russian Revolution of 1917 and the general growth of

irest and agitation against the war which began to develop all countries towards the end.

War is always a brake on the carrying out of progressive forms. However, it always helps the campaign for these forms. People who are sacrificing their lives, their homes or eir meagre comforts must be given a better hope for the future sustain their morale in the fight. The Government promised land fit for heroes" and "homes with roses round the door." ter the war it found that "we could not afford these reforms." iis is illustrated by an extract from the Ministry of Health's eport of 1920–1, which reads: "It followed from the experiences the war that men's minds were turned towards projects for e development and extension of health services. Within the t twelve months a new and restricted conception of the mediate possibilities of securing improvements in the health the people by measures involving a call upon the public rse has been implanted in the minds of all concerned by their mmon experience."

The policy of progressive reforms was applied in paper schemes d plans, awaiting the time when bricks and mortar could be ed. This is again well illustrated by another extract from the ne Report of the Ministry of Health, which said: "So long the financial prospect remains unfavourable, the Department d the local authorities can profitably devote increased attention the task of surveying the whole field of health services and alth organisation, with a view to ensuring that, when the onomic situation permits fresh progress to be made, whatever tion is taken is based upon a mature and deliberate plan." nfortunately, apart from one or two short-lived booms, the untry in the inter-war years faced severe economic crises nich did not "permit fresh progress to be made."

The development of the medical services can now be examined its proper perspective.

The worst insanitary abuses of the Industrial Revolution were ercome by the application of the Sanitary Acts of 1848, 1866 d 1875. They had been introduced to conquer the rapid spread infectious diseases, to build up a reservoir of skilled workers combat foreign competition, to reduce the increasing poor tes and to neutralise the growing organisations of the workers. ie Liberal reforms extending Government activities to the rsonal medical services were introduced to counteract the

growing industrial and political organisation of the people and especially the birth and growth of socialism.

This period showed a considerable development and progress in environmental health and hygiene, and the birth of Government interest in the development of the personal medical services.

CHAPTER VIII

HEALTH SERVICES IN TRANSITION: 1919–48

THE PERIOD BETWEEN THE two world wars was not marked by any great prosperity. There were many economic crises. The first was in 1921, with 2 million unemployed, but the severe began in America in 1929, spread all over the world and lasted until 1935. In this crisis, official figures of unemployment in Great Britain topped the 3 million and skilled workers and black-coated workers drifted into pauperism. This had a profound effect upon the treatment of the population.

Previously, the poor had been considered as a class apart—the unemployables, not to be confused with the willing, industrious worker. These "down-and-outs" had succumbed to pauperism through their own failure in life and had to be treated as inferior social beings. Their needs were relieved because it was difficult to condone obvious starvation and because it was necessary to prevent a situation which would encourage the spread of dangerous infectious diseases. The relief of their needs was not to be so generous as to encourage the "ne'er-do-wells."

This attitude was not confirmed by the fact that in both wars even the casuals, "the most inveterate work-shy," were absorbed into industry—some, of course, into the armed forces. The number of casuals in London, during the War of 1914–18, dropped from a daily average of 1,200 to only thirty-seven, while, during the Second World War, in the country as a whole the number dropped from 9,124 in 1938 to 199 in August, 1944.

The authorities proceeded to adopt the old and tried measures in the treatment of the needy population, but the new destitute, the skilled and black-coated workers, who had been accustomed to higher standards of living, demanded better treatment. This influenced official policy, and in many instances the people were better treated as a result of their reaction to Government orders. The Government's general policy, however, was to dispense just enough relief to prevent starvation or to tide the needy over difficult periods until they were able to fend for themselves.

Unemployment insurance became part of a system of public relief, to which the employed subscribed substantial sums. As soon as this fund became insolvent, the main task of the Government was to cut down expenses as much as possible. This policy resulted in the "household means test" of the 1934 Act. Some of the unemployed were then transferred to the Public Assistance Committees or in effect to the Poor Law administration. In January, 1936, there were 2,131,000 unemployed, 330,000 of whom were receiving relief through Public Assistance, apart from those relieved in institutions.

Institutions had to be prepared for the acceptance of the new type of patients who required assistance, especially with the new development in the science of medical diagnosis and treatment. These patients came from the artisan classes, requiring more attention than they could get at home, and from the new poor, who were accustomed to better treatment than that provided at the infirmaries, the scandals of which had already been exposed.

A Royal Commission on Local Government was set up in 1923 and collected evidence for six years. The problems described above were studied by the Commission and the serious weaknesses of the local authorities in dealing with them were exposed. The reports of the medical officers of health of some eighty of the small local authorities revealed the fact that there had been no progress in the shocking insanitary conditions in their districts for the past sixty years.

The report of this Commission led to the passing of the Local Government Act of 1929, which transferred the functions of the boards of guardians to the county and county borough councils, thus eliminating some of the smaller ineffectual authorities. The county and county borough councils were given the opportunity to make available the facilities of the infirmaries and the hospitals to the poor, without the stigma of pauperism. The more progressive authorities accepted this opportunity, but in most areas the conditions remained almost unchanged. This new procedure widened the gulf between the aged and infirm, the chronic sick, children, and many thousands of others who were transferred, and those who through no fault of their own were not.

The Local Government Act of 1929 superficially appeared a much greater advance than it actually was. The General Circular

which introduced the Act was presented with the optimism which is so prevalent at the beginning of any Act. It said: "A clear direction is thereby given that the process known for the last twenty years as the 'break-up of the Poor Law' shall be put in hand in a practical manner and carried so far as the existing law and the prevailing circumstances allow."

The Minority Report of the Royal Commission on the Poor Laws had recommended a total break-up of the Poor Law, while the Majority Report had preferred the transfer of the administration of the Poor Law from the boards of guardians to the county councils and the county borough councils. This latter suggestion was not a new one, for Neville Chamberlain, in introducing the 1929 Bill in Parliament, reminded his listeners that his father had advocated the transfer of the Poor Law to the local authorities in the debate on the Local Government Act of 1888.

The main reason for the Act was to deal with the increasing numbers of unemployed who had to be given relief under the Poor Law. Another reason was that the Ministry of Health had considerable difficulty in altering the policy of boards of guardians which had workers' representatives (e.g. Poplar and West Ham) who were giving too generous forms of relief. The Act merely provided for a mechanical transfer of the Poor Law administration from the board of guardians to the local authorities. A proportion of the members of the new public assistance committees were chosen from the members of the boards, so that their experience should not be wasted and so that there should be no break in the continuity of treatment. The century-old spirit of the Poor Law ruled as before, and apart from a few progressive authorities, the majority of the new committees carried on the old well-tried inhuman methods of the past. Most authorities continued to deal with the needy patient and the mentally defective under the Poor Law and the public assistance committees, and they failed to make provision for them through either the public health or education committee, as had been suggested.

The Act, however, promoted important local government changes. By abolishing the boards of guardians, it removed the anomaly of the differences in the boundaries between the boards and the local authorities. The functions of vaccination, infant life protection and the collection of the fundamental vital

statistics were transferred to the public health committees of the county councils and county borough councils. The Act also altered the method of the Government's grant of financial aid to the local authorities. Ostensibly designed to assist the authorities who were financially weak, it had little effect in practice.

The Report of the Chief Medical Officer of the Ministry of Health seven years later (1936), while not so optimistic as the General Circular accompanying the Act, still tended to exaggerate the results of the Act. He wrote: "The Poor Law is not abolished by the Act, but a way is made for its abolition. The newly constituted local authorities are empowered to administer as many as possible of the medical services 'otherwise than by way of the Poor Law' and to make full use of other Acts of Parliament relevant for this purpose. The Act contains the germ from which will spring up a complete system of health services."

As already mentioned, few authorities availed themselves of the opportunities presented by the Act. It is interesting to note that the Minister of National Insurance to-day refers to the aim of the new series of Health, Insurance and Assistance Acts (1946–8) as being "to accomplish the break-up of the Poor Law." For sixty years there has been considerable discussion and Acts passed to "break up" the Poor Law and the spirit of its administration. Whether the new Acts will achieve this purpose where their predecessors have failed will depend upon the interest the people take in the carrying out of them.

The other important public health measures passed after the Local Government Act of 1929 were the Public Health Act of 1936, the Housing Acts of 1930 to 1935, the Local Government Act of 1933 and the Poor Law Act of 1930. The Public Health Act of 1936 consolidated the old public health Acts, but introduced no important new reforms; but the Housing Acts laid a new emphasis on the removal of insanitary conditions and overcrowding.

Charities during this period still played a large part in the treatment of the poor. To-day there are many charitable societies. Some have a short-lived existence; others manage to do very useful work but are relatively unknown. There is, unfortunately, no method of supervision of these many charities, and, as there is little co-ordination, there is overlapping and waste of energy and money. Some charities are run in an uneconomic way, and the final sum obtained hardly merits the

cost and effort of the collection. The methods of collection with flag days, ceremonies and functions are hardly worthy of the causes which they support. With the increasing cost of medical provision, it becomes more difficult to obtain sufficient funds from charity alone for efficient treatment.

The fact that voluntary hospitals were dependent upon subscriptions and donations encouraged a good deal of self-advertisement. In order to attract sums of money, the numbers of patients attending the hospital were artificially stimulated, with a consequent lowering in the standards of treatment. In the nineteenth century, as a result of this factor, there was overcrowding of the in-patients in the wards, while in the twentieth century there has been unnecessary overcrowding of the out-patient departments of the hospitals. The unhealthy financial rivalry of the hospitals prevented the effective co-operation between the various hospitals.

The conditions of living of the people improved but little in this period, although factory legislation and housing Acts with slum clearance helped to ameliorate the worst faults of the last century. Nevertheless, many people still lived in unsuitable primitive conditions. In spite of the sanitary reforms, insanitary privies and privy middens abounded in the country. Even in the large towns water-closets were not general, and when present were often some distance from the dwelling and shared by two or three families. A piped water supply was a rarity in many parts of the country, the water being supplied from wells, often enough polluted.

The Chief Medical Officer of the Ministry of Health, in his Annual Report of 1937, reviewed the number of outbreaks of diseases conveyed by polluted drinking water. He referred to twenty-seven outbreaks occurring from 1911 to 1937 which affected altogether thousands of people with typhoid, para-typhoid fever and dysentery. Several of the outbreaks occurred in the 1930's.

In the large towns one water tap often served several families who had no facilities for washing. The general state of repair of these houses was very poor—dampness, vermin and rats were common features. The homes were frequently badly lit and ventilated. Overcrowding has been an important factor in the spread of disease, and even the Ministry of Health's ungenerous standards for gauging overcrowding showed 853,000 overcrowded families in the overcrowding survey of England and Wales in 1936.

Dame Janet Campbell, in her investigation of the high

maternal mortality in industrial towns in the West Riding of Yorkshire in 1932, described the living conditions as follows: in Dewsbury, "much of the work is unskilled and wages are low. There is much unemployment and the standard of living is not good. Housing is bad. There are many long rows of back-to-back houses, 'one down and two up,' the type of house is bad in itself, and there is also overcrowding. Water is laid on, but sanitary conveniences are outside and shared with other families. About 40 per cent. of the total houses are said to be of the worst type. Externally the houses often look clean and neat, but ventilation is very unsatisfactory, many are damp, and the accommodation is grossly inadequate." Halifax is similarly described, and in Sheffield "housing conditions are often unsatisfactory. There are still about 16,000 back-to-back houses, mostly built in blocks of about twenty dwellings with one common yard. A usual type is the 'single' house, which contains a house-place, a bedroom and a garret, each house above the other. New housing estates are being developed, but 'overcrowding in the city is still deplorable.' "

The Chief Medical Officer of the Ministry of Health reported in 1934 that one in every five of the *infectious* cases of tuberculosis in Sheffield shared a *bed* with another person. The Medical Officer of Health of Northamptonshire introduced a Housing Supplement to his Annual Report of 1932 which gave a graphic description of the insanitary conditions and overcrowding prevalent in the districts of the county. He gave a picture of the incredible state of disrepair and dilapidation of the houses and cottages. Rooms were often too small, dark and ill-ventilated. He referred to a recently married couple who had to sleep in a space under rotten thatch and rafters in which one could not stand erect. "In this so-called room they have literally to 'crawl into bed.' " He described the floors as being generally in a bad condition, badly broken or in a shocking state of decay, and roofs crumbling with bad universal leaks: "paper is stuffed here and there between the rafters to keep out adventitious draughts and leaks"; walls were broken and crumbling, ceilings sagging with plaster falling down; they showed a complete absence of pantries and sanitary conveniences, no windows at the back, staircases steep and narrow "no better than a ladder." "The housewife has an impossible task to keep [the house] in any sort of order."

After the description of many such houses, he concluded with a recommendation which recurred regularly throughout the report: "I recommend demolition and clearance."

In 1936 the Medical Officer of Health of Northamptonshire presented a more selective and intensive report of housing in the rural districts of the county. The conditions he found were, if anything, worse than those he had discovered in his previous survey. He described the housing in the three areas of Towcester, Wellingborough and Thrapston as follows: "The 'mass' type of construction . . . predominates . . . closets, barns, and dwellings are mixed up in inextricable confusion, so that Mrs. A's closet may be just underneath Mrs. B's bedroom window. . . . There is a . . . uniformity in the interior. . . . The living-room has a rough, broken quarry floor, on which linoleum cannot be laid because it quickly cracks on the edges of the bricks and gradually rots on account of the damp underneath. The outside (front) wall is invariably damp and the paper peels off a few months after the room has been decorated. . . . There is no lack of ventilation in the living-room, because the front door seldom fits its frame." He referred to cottages where rain was pouring in through a visible gap, not only into the upstairs bedroom, but through holes and cracks on to the living-room beneath. "The window frames in these cottages are usually decayed beyond description. As it is unsafe to move them on their hinges, they are kept shut day and night—but ventilation is secured through the holes where the panes are missing."

A section headed "Illustrative Descriptions" began with a survey of Brackley rural district, which proceeded as follows: "Entering the village [King Sutton] along Station Road, one comes to a row of five apparently well-built brick cottages with slate roofs. The first three are subject to flooding in winter, when the river overflows. The wells in the very small gardens become unusable, and water has to be obtained from the 'Town Well' some three or four hundred yards away. A grossly polluted ditch runs along the bottom of the so-called gardens, which are really nothing more than small unpaved backyards. This ditch becomes nauseating in summer. These houses are in a bad state of repair. The walls and floors of the living-rooms are badly affected with rising damp, while the bedrooms are damp owing to defective roofs, eaves guttering and pointing."

This dismal description was duplicated in practically every

village, and in some instances reached even lower depths of degradation. The following is an example: "This row provides three 'horrible examples' of the unfit house. . . . The back walls especially in the pantries are not *damp*, but positively soaking wet, and the smell in the pantries is 'something horrible.' The gable end in the third house is falling out, causing a great rift in the roof through which the rain pours, the chimney and wall tottering outwards. . . . There is no through ventilation, the stairs are broken and dangerous, the floors are bad, and huge cracks in walls and ceiling have been pathetically plugged with rags and paper or boarded up with pieces of wood."

Village after village told the same dreary tale of neglected dilapidation and disrepair, and in more than one village the same report could be made as of Harpole: "I have made several reports upon the bad housing conditions in Harpole, but up to the present no action appears to have been taken. . . . Several cottages are in a really dangerous condition. . . . The fact that these structures find favour in the sight of those who love rural England cannot justify our action in permitting their tenants to live under slum conditions."

These slum conditions are not peculiar to the County of Northamptonshire. They are prevalent in practically every village and town in England and Wales.

Infectious diseases, respiratory diseases, tuberculosis, rheumatism, children's diseases are all more prevalent in the insanitary, overcrowded slum areas. Conditions have deteriorated since the war owing to loss of houses through bombing and the fact that no new dwellings have been built during the war.

The Report of the Medical Officer of Health of the rural district of Brackley for the year 1946 indicated that the housing conditions in Northamptonshire had not improved in the last ten to fifteen years. Of 1,215 houses investigated, at least eight out of every ten required major repairs and at least half of these were in such a bad state that they were not worth repairing, i.e. they were only fit for demolition. Only three out of ten houses had water-closet accommodation and approximately two out of every ten still had the old insanitary privy. Six out of ten of the water samples tested were unsatisfactory and many of these contaminated samples were taken from the water supply of schools. Only three out of ten dwellings had a water tap inside the house.

The effects of war conditions on overcrowding are shown by the reports on housing in 1945–6 of the Medical Officer of Health of Tottenham. A description is given of the conditions of living of some of the applicants for "temporary" housing. "In most cases the one room is used for sleeping purposes; there is no spare room, and the family lives, eats and entertains in a kitchen or scullery . . . the majority were living under most appalling sub-human conditions. When the husband comes home on leave he has to share a bed with his wife and one or two children. In some instances he has to sleep on the floor in the kitchen. . . . In a few cases members of the family were sleeping in the kitchen, and one in a Morrison shelter. An outside w.c. had to be shared in many instances, resulting in the tenants having to go through another tenant's living-room to use same. In one or two instances owing to difficulties of sharing cooking arrangements, families had most of their meals out." These living conditions must have been breeding grounds for infection, illnesses and mental disturbances. It must be very difficult in circumstances such as these to live decently and respectably as human beings.

The Medical Officer of Health of Pretoria, in a paper read at the South African Health Officials' Conference in Johannesburg on November 28th, 1944, clearly described the living conditions of the slum-dweller. He first produced figures which showed that the general death-rate and infant mortality rate among the coloured peoples who generally inhabited the slums was three times, and the tuberculosis death-rate more than thirteen times, that of the white Europeans. He continued: "The literature is full of similar statistical proof of ill-health and high mortality rate of the poor. Figures, unfortunately, cannot register the misery, unhappiness and wretchedness of squalor, cold, and hunger—the lot of the slum-dweller.

"Think of the discomfort of leaking roofs, absence of adequate bathing facilities, sharing common dirty w.cs. for whose cleanliness no one seems responsible, the lack of proper cooking facilities and, more often than not, nothing to cook, anyway; and then sitting down in overcrowded hovels to a meal with the smell of cooking, with dirty plates and cooking utensils staring you in the face, and the noise of the neighbours coming from all sides. . . ."

He referred to the high accident rate due to the overcrowded

buildings, the lack of open spaces, lack of playing fields and too narrow streets; all of which created "favourable circumstances for the spread of disease, particularly because such areas are always inhabited by the poorer section of the community, whose vitality is already lowered through the lack of sufficient protective foods, cold, sheer hunger, and all the misery associated with poverty."

Referring to the mental condition of the slum-dwellers, he said: "The rich have their animosities and hatreds born and bred in greed and selfishness, and the poor have their minds warped by squalor, hunger and suffering. Strife and bitterness can surely never end until we 'liquidate' these factors; and on their liquidation depend the future peace and well-being of the whole world.

"These, then, are the inescapable and undeniable physical and mental havocs wreaked upon the slum-dweller, written in the figures which register life and death, and in the incalculable suffering of poverty and misery which can only be measured in terms of drudgery, depression, and mental anguish."

The Factory Acts (1901–37), paved the way to better factory conditions. There has been a general reduction in working hours, but, apart from the large newly-built factories, the conditions of work in the majority of industries remain unsatisfactory. The Amalgamated Engineering Union in 1944 conducted an inquiry into ventilation, heating, lighting, overcrowding, sanitary arrangements, cloakroom facilities and general cleanliness in 1,000 factories with 1,000,000 employees. The number of complaints was very high, rising in some instances to over 90 per cent. of the factories. The replies showed that the employees generally worked under bad conditions which must sooner or later undermine their resistance to disease and make them more liable to accidents.

The diet of the people did not improve much during this period. During the slump period, many medical officers of health testified to the serious degree of malnutrition in their areas. Sir John Boyd Orr estimated that only half the population were receiving a diet completely adequate for health and well-being, and that one in four children were receiving a diet inadequate in all respects.

Dr. M'Gonigle of Stockton-on-Tees, in 1935, investigated the living conditions of 716 transferred slum-dwellers and demonstrated the importance of an adequate diet. The standardised

death-rate in this sample was increased by 46 per cent. because the higher rents left less money for food.

Dame Janet Campbell found that tenants in Halifax in 1932 appreciated this fact from their experience in the harsh school of practice, for "tenants in the new housing estates find that the increased rent, together with the less convenient facilities for cheap shopping and the cost of tram fares, more than counterbalance the advantages of good housing, and not a few have returned to their slum homes." She described the diet of the inhabitants of Barnsley as: "Inadequate and ill balanced, too much carbohydrate food, tinned food and tea, too little butter, milk and vegetables—there is over-eating on Sunday and short commons for the rest of the week." Referring to the diet of the people of Sheffield, she wrote: "There is a large consumption of fish and chips and tinned food, very little milk and not many fresh vegetables."

Malnutrition was found even in the rural areas, where food was produced in abundance. Dr. Dilys M. Jones in 1932 referred to the fact that in Wales "the practically unanimous opinion of the county medical officers of health in the rural areas is that the mothers live far too exclusively on tea and white bread and butter."

They do not have this unsatisfactory diet from choice, for "fresh farm or garden produce, such as milk, eggs and fresh vegetables, is sold and the amount of these articles consumed at home is reduced to a minimum."

The Government's attitude in the provision of free meals to undernourished children was not very generous. In 1934, the School Medical Officer of Smethwick described it thus: "You must stop having free meals. You do not need them yet. When you have starved sufficiently to show signs of actual malnutrition, 'however slight,' come back for meals. Then you may have meals until malnutrition is cured, but only until then. After that you must have another period of trial starvation!" He discribed this system as "brutal, inhuman and a relic of barbarism."

School feeding at the beginning of the 1914–18 War had been encouraged and almost half a million children received meals in the first year of the war. Towards the end of the war the Minister of Food discouraged school feeding and only one in ten of those who had previously received school meals were being fed in the schools.

In 1922 the Geddes axe aimed another dangerous blow at the scheme. Sir Eric Geddes, in reply to protests, said: "We have

been accused of starving the minds, and indeed of endeavouring to starve the bodies also of the children. We are passing through a period of extreme difficulty and of great financial stringency. This is not the time for a vast increase in educational expenditure like this, when trade and industry are being strangled by heavy taxation. The only thing that matters in this country is to get down taxation or we die."

The number of children supplied with school meals was reduced by half, and the scheme between the wars never recovered from this mortal blow. At times only one in fifty schoolchildren were receiving meals at school. The atmosphere of the Poor Law still pervaded the schools' meals service, and the dining halls were generally lacking in comfort and the meals unattractive. The Chief Medical Officer, in his Report of 1935, said: "The fact that halls have usually to be hired in the poorest quarters of the town results often in their being in poor decorative condition; they are often dark, badly ventilated, and with no facilities for lavatory or cloakroom use." He referred to the serious faults in the diet supplied, such as "inadequacy, monotony or sloppiness." There was "a certain monotony in hash, stew and soup meals." In some cases in addition the diet "is ill-balanced and deficient even in calorie value." Examples are given of such meals: "The meal provided is much the same as when I reported seven years ago. On three days a week it consists of soup made from bones (the same bones used throughout the week) with some peas or beans put in—into this the children press two or three slices of bread. In addition they have a small mug of milk and a piece of bread and jam. One day potato pie replaces the soup and another day potato hash."

The economy campaign extended to the diets of children in the Public Assistance institutions. The Chief Medical Officer in 1937 described an investigation into the dietary of children in twelve institutions where "generally speaking the diets were not satisfactory." There was a deficiency in some institutions of milk, eggs, fish and fruit and "in one institution the midday meal was highly unsatisfactory—it consisted of nothing but bread and a *proprietary meat extract* as a beverage."

Mr. B. Seebohm Rowntree, in *The Human Needs of Labour* (1937), wrote: "The basic fact is, that to-day millions of working-class people in this country are inadequately provided with the necessaries of life," and in his *Poverty and Progress* (1941) he

showed that even in 1936 almost half of the children in the working-class families in York lived below the minimum economic conditions laid down by him.

Finally, F. Le Gros Clarke and R. M. Titmus, in *Our Food Problem*, wrote: "Army recruiting returns, 1928–37, show an unduly high percentage of ailments that should have been preventable, and this period compares unfavourably with the period 1901–11, although Army medical standards had been reduced since that time."

The widespread malnutrition was not the proof in practice of the Malthusian theory. The advance of scientific agricultural production had increased considerably the amount of food produced. By the use of tractors and fertilisers and the science of genetics and nutrition, the production of eggs, wheat and meat had been improved to such an extent that there was more than sufficient for the world's increasing population.

The distribution of the supplies, however, had not improved, and while millions of people were starved of food, millions of tons of food were being destroyed. Those in control of the production of food became terror-stricken as their stocks mounted, and stern measures were taken to solve this problem, not by feeding the hungry, but by restricting and limiting supplies to maintain high prices.

In America, millions of dollars were spent on the emergency slaughtering of animals and in restricting wheat-production. In Denmark special incinerators were constructed to deal with 5,000 cattle per week. In the Argentine and in Chile thousands of sheep were slaughtered and their carcasses burned. In Brazil thousands of sacks of coffee were burned, and in the Argentine wheat was used as a substitute for fuel. Thousands of cases of Spanish oranges and hundreds of tons of onions were dumped into the sea. Even this country, which has to import food, destroyed quantities of foodstuffs. Brussels sprouts were left on the fields to rot, cabbages and potatoes were ploughed back into the soil, and fish were thrown back into the sea.

In this situation there would appear to be sufficient grounds for alarm on the part of the authorities, and a natural desire and urge to take action to solve the problems of malnutrition. The Ministry of Health appreciated that there were problems bristling with difficulties. But the maintenance of "healthy and complete nutrition" was rather complicated.

"*It needs a clean alimentary tract*" (Chief Medical Officer of the Ministry of Health, 1930). "There is still much apathy and ignorance in the choice of foods, often associated with deplorable inaptitude in cookery." There was no mention of the low wages or unemployment, or the wholesale destruction of foods which, in addition, may have affected the people's choice of food.

Action was taken, however, by the Ministry of Health. A Committee was set up, including professors whose task was "to advise on the practical application of modern advances in the knowledge of nutrition." Their functions were to include "the tendering of advice to the Ministry of Health on physiological aspects of nutrition and its relation to food, with special reference to dietaries for use in public institutions and to the issue of information directed to improving the nutrition of the people."

One Government department was educating and advising the public to make a wise and wide choice of foods, while another was restricting the production and entry of these foods in the country.

The drive for profits in the supply of foods was not restricted to reducing the quantities of food which caused widespread malnutrition. It was extended to reducing the quality of the foods supplied by the manufacturer who sharpened his weapons in the battle with the public analyst on the field of food adulteration.

The main difficulty confronting the analyst is the fact that the Ministry of Health has not provided standards for most foods. As the Chief Medical Officer wrote in 1934: "It is notoriously difficult for the purchaser to judge of the quality of food which has been skilfully prepared, packed and advertised for sale. The working mother is perhaps induced to pay more for a certain brand of margarine by the vendor's statement that it is blended with butter, whereas in reality it contains only 0·5 per cent. of butter." He referred to the fact that the descriptions "prime," "choice" and "select," with the prefixes "extra" and "super" to provide a wider range, were not suited to official standards and had become "so debased as to have hardly any significance."

The Annual Reports of the Ministry of Health on the control of pure food give a sad and dismal record of the fraudulent practices of food traders. The following examples of adulteration and contamination are given, and many recur with unfailing

regularity: sugar adulterated with salt, ground rice, desiccated coconut or lard or even with sand; mixtures of coffee and chicory (in one case 76·7 per cent. of chicory) sold as pure coffee; bread and margarine sold as bread and butter; semolina infested with maggots, soup powder with an excessive amount of living fungus, dried beans infected with insects, and raisins with residual matter from insects—all these were found and condemned. There is no record of the many similar varieties of contaminated food which remained undiscovered and were sold to the unsuspecting public.

The following examples of fraudulent misrepresentation were given: steak-and-kidney pudding with no kidney; egg baking powder with no egg; pure butter cake and mixed fruit with less than one-tenth fat; butter fat; fruit pudding powder labelled "delightfully flavoured with ripe fruit juice" completely devoid of fruit juice; fish: cod sold as hake; witch as lemon sole and lemon sole as Dover sole; chocolate cake which contained no chocolate, but was coloured with a brown dye which alarmed parents by causing the children's urine to turn red; and "pure chocolate-cream Easter eggs" where the chocolate had to be removed by scraping and amounted to little more than one-twentieth of the sample.

Examples are given of the nauseating methods of some food-traders. In March, 1938, the Ministry discovered a firm in the Midlands manufacturing "chicken paste" filling for pies made from dead one-day-old chicks or dead unhatched chicks. The premises were indescribably filthy. The report concluded: "It is clear that the use of dead day-old chicks or chicks dead in shell for the preparation of food for human consumption is not only æsthetically revolting, but also hygienically indefensible." The report of the same year indicated that as many as 50 per cent. of poultry in the poultry markets had avian tuberculosis.

The report of 1935 dealt with the salesmanship of some public-house managers. Waste beer was allowed to stand in open tubs and pails in the cellar exposed to dust and cobwebs and filtered through dirty cloths. "Definite evidence was obtained that leavings from customers' glasses were thrown into the drip-sink behind the counter and mixed with the rest of the beer for resale."

The methods of certain fishmongers were exposed in the Report of 1937. The poorer fish were dyed and kippered to resemble the better oily fish. Artificial colouring was used to

disguise blemishes or defects in the fish. Poor-quality or stale haddocks and smoked fish fillets were dyed to make them "more acceptable" to the customer.

The Second World War, producing food shortages, was the heyday of the fraudulent food-trader and his food substitutes. The Report of the Chief Medical Officer for the period of the war (1939–45) gave a picture of this, as follows: "Shortages of all kinds led to the appearance of innumerable substitutes, many of them fraudulent and sold at exorbitant prices." The "everlasting see-saw of attack and defence" between the authorities and the fraudulent food-trader was intensified. The Chief Medical Officer continued his report by describing the battle of the substitutes: "Among the first to appear were egg substitutes, consisting mostly of baking powder coloured yellow, and milk substitutes, consisting mostly of flour. These were followed by a large variety of so-called fruit drinks, lemon essences and tonic wines, widely advertised by misleading statements of their value in preventing vitamin deficiencies. . . . After consultation with the Ministry of Health, the Ministry of Food issued an Order in 1942 licensing and controlling food substitutes. Although the more notorious of these frauds disappeared, such as small packets of citric acid bearing pictures of succulent oranges and the words 'rich in ascorbic acid' (i.e. vitamin C), many avoided the Regulation by merely withdrawing the claim of being a substitute."

Another example of the dangers to the public was given in the manufacture of gelatine. Gelatine was found to contain large quantities of lead, arsenic or zinc, because raw material "of doubtful quality" was being used even by the old firms. When the sale of cream was prohibited in 1940, artificial cream was manufactured in large quantities under conditions which were not very satisfactory. There was a suspicion that paratyphoid fever was spread by the sale of some of this cream.

The farcical but serious nature of the food-traders' fraudulent practices is that in peacetime, when good, fresh food was being destroyed in large quantities, inferior samples were foisted on people who were economically hard hit and were already suffering from malnutrition. In wartime the position was doubly serious, for when vital foods were scarce and the maintenance of the nutrition of the people was an important defence measure, inferior substitutes were undermining the health and strength of the nation.

While it has been difficult to separate the effects of malnutrition from that of overcrowding, etc., there is ample evidence to show the high correlation of poverty with disease, especially with infectious diseases, tuberculosis, infant mortality and respiratory diseases.

The Chief Medical Officer of the Ministry of Health, in his Report of 1933, referred to the effect of the slump in increasing poverty and thus causing the deterioration in the health of the nation. He wrote: "Not less than 2 million homes were stricken by death or disease during the year; there was distress and deprivation, physical and mental, in areas severely depressed by unemployment; and there was the burden of anxiety for physical risks and losses incurred in a mass of readily preventable sickness and accident which had been unprevented." An atmosphere of pessimism appeared to pervade the Ministry. He continued: "Unemployment, undernourishment and preventable malady and accident seem to be the unavoidable concomitant of current civilisation in Western Europe in the present day."

Although the medical treatment of the population improved during this period, there was very little difference from that of the previous years. Charity still played an important role, but owing to the more general application of scientific medicine the cost of the services increased and the State had to take a larger burden than in the past.

The more progressive authorities began to recognise the general principle that prevention is better than cure and pays dividends in the long run. This trend of municipal and State interest in medicine was further encouraged by the views taken by the members of the Labour Party who were being elected as representatives of the people to the authorities. Insurance or self-help commenced with the National Health Insurance Act, but was not developed officially, although voluntary hospital saving schemes grew in number and importance.

The services as they exist to-day will now be discussed. The various sections of the services will be described as they were prior to the operation of the National Health Service Act, 1946 (i.e. prior to July 5th, 1948). Attention will be drawn to the improvements which are considered necessary, and they will then be compared with the probable effects of the new social services Acts.

Part Two

THE PRESENT HEALTH SERVICES

CHAPTER IX

THE MATERNITY SERVICES

THE BIRTH OF A BABY is a normal physiological function of the mother. Skilled supervision is, however, necessary if the life and health of the mother and child are to be safeguarded. The first essential for normal, healthy childbirth is a healthy mother.

Care in childhood, girlhood and adolescence is necessary for the development of a normal, healthy woman capable of having a normal, healthy child. Infantile rickets may produce a narrow pelvis which impedes the passage of the child, tuberculosis may damage the reserve power of the lungs, rheumatic fever that of the heart, scarlet fever and nephritis that of the kidney, and general debility that of the whole body, thus undermining the capacity of the mother to withstand the additional strain of childbearing. General debility is often caused by an unfavourable environment—slums, overcrowding, insanitary living conditions, and especially malnutrition. All these handicaps are present at the beginning of pregnancy and play an important part in producing death and disabilities among mothers and babies. However, steps can be taken to prevent their potential evil effects if they are discovered early in the pregnancy.

In addition there are conditions which arise directly from pregnancy which may menace the life and health of mother and child. These are mainly the toxæmias (poisons) of pregnancy, the causes of which are unknown; the malpresentations (bad positioning of the child); and obstructions in the birth canal (contracted, small pelvis, tumours, etc.). Here again the evil results of these conditions can be prevented and guarded against if they are discovered early enough.

Ante-natal clinics are centres where investigations can be made for any of these conditions, so that proper precautionary measures can be taken or treatment instituted at once. An early general medical examination, regular testing of the mother's urine and blood pressure, and regular examinations of the position and activity of the child are all important functions of

these clinics. They also perform work which, though not spectacular, is very important.

General advice on the conduct of the pregnancy, advice on general hygiene, diet, clothing, sleep, exercise, etc., the treatment of minor ailments, e.g. nausea, constipation, indigestion, varicose veins and anæmia, and, above all, adequate psychological preparation and training for the delivery, are all necessary. These latter duties call for the giving of individual attention to each mother and the expenditure of a fair amount of time on the part of midwife, health visitor and doctor, working in unison. Mothercraft classes at the clinics help considerably in training, as they bring the mothers together in groups where general difficulties can be discussed and general advice given.

Although it is important and necessary to have routine tests in ante-natal care, regard must be given to the particular needs of the individual mother. The routine must not develop into an automatic ritual. The routine tests are devised to cover most of the difficulties likely to arise in pregnancy and labour. As the routine tests cannot embrace all the possible complications of pregnancy, it is essential that the doctor's approach to the mother should be an individual one.

This approach is necessary also to build up one of the greatest assets of the mother when the time of labour arrives—confidence in herself and in the doctor. The main aim of ante-natal care is to help the mother to appreciate that childbearing is a normal process which she can achieve by her own natural functions. At the same time, steps must be taken without fuss or anxiety to ensure that the labour is not attended by unexpected complications. It is also necessary to provide ante-natal beds in hospitals, for in some of the complications of pregnancy it is advisable to have the mother resting in bed under expert supervision. Operative or active interference to hasten the onset of labour may become necessary to save the life of the mother or child. Ante-natal supervision is also conducted at clinics in hospitals and in the mothers' homes. But wherever it may be conducted, it is essential that it should be expert and thorough, and gain the confidence of the mother.

Next comes the delivery of the mother and the birth of the child: that short dramatic event for which there has been the nine long months of preparation. The birth of a baby in normal

circumstances is relatively a simple matter. Unexpected complications or difficulties may produce insoluble medical problems and tragic results. Whether the confinement takes place in the mother's home or in the hospital, skilled attention must be available to deal with the many difficult problems which may arise. Skilled manipulations may be required to deal with obstructions to the free passage of the baby as a result of bad positioning or narrowing of the birth canal. Operative treatment may occasionally become necessary, and shock or hæmorrhage may call for blood transfusion and specialised treatment. The application of instruments such as forceps to assist in the delivery of the child is usually a simple procedure which can be carried out in the home of the mother. Often, however, their use requires fine judgment and skill, otherwise difficult labour with an exhausted mother may result, with the added dangers of infection.

The puerperium is the period of recovery of the mother from the effort of labour. It is also the period for introducing the baby to breast-feeding and the other routines of life. Post-natal care and attention are required to ensure that there is no infection of the birth canal and that any injury caused by the birth heals normally. The health of the baby must also be safeguarded and measures must be taken to deal with any abnormality. A post-natal examination within six weeks of labour is required because, although the minor difficulties of the puerperium will have disappeared, the more serious late results of labour, such as anæmia, tendency to prolapse, infection of the cervix and the late results of toxæmias or general diseases, will have become manifest.

In conclusion, an efficient midwifery service must pay attention to the ante-natal, natal and post-natal care of the mother and the child. In order to inspire confidence, the responsibility of the care of the mother throughout this period must be in the hands of one person who has at his fingertips all the skilled attention which he may require. He must of necessity be skilled in determining when he requires this additional assistance, and it must be made readily available to him. These general principles are the basis of an efficient midwifery service.

As we have seen, the British health service, like Topsy, "just growed." We must not, therefore, expect a planned service aiming at perfection. In discussing the present services, its

various deficiencies will be described as depicted in official reports. The necessary improvements based on the principles outlined above will then be discussed in relationship to the changes of the National Health Service Act of 1946.

The reports referred to will be as follows: Final Report of the Departmental Committee of Maternal Mortality and Morbidity (Ministry of Health, 1932); Report on Maternal Morbidity and Mortality in Scotland (Department of Health for Scotland, 1935); Report on an Investigation into Maternal Mortality (Ministry of Health, 1937); Report on a National Maternity Service (Royal College of Obstetricians and Gynæcologists, 1944); and Maternity in Great Britain (A Survey of Social and Economic Aspects of Pregnancy and Childbirth undertaken by a Joint Committee of the Royal College of Obstetricians and Gynæcologists and the Population Investigation Committee, 1948). These reports will be identified and referred to in the text by their date of appearance.

The present maternity services are based mainly on three Acts: the Midwives Act (1902, as amended and extended in 1918 and 1936); the Maternity and Child Welfare Act of 1918; and the Public Health Act of 1936. The Midwives Act of 1902 established the Central Midwives Board to organise the training and certification of qualified midwives. The midwives would replace the illiterate women—the "Gamps"—whose sole claim to knowledge of the art of midwifery was gained in practice.

The Maternity and Child Welfare Act of 1918 confirmed and extended the permissive powers of local authorities to establish ante-natal clinics, educational classes, dental treatment and home visiting for expectant mothers. It also empowered local authorities to provide food and milk, free or at reduced price, for those in need of it during pregnancy. The Public Health Act of 1936 was a consolidating Act, and, while the setting up of a maternity and child welfare committee by every welfare authority was compulsory (it could form part of the public health committee), permissive powers were given for the establishment of the services. In the words of Section 204 of the Act, "a welfare authority *may* [N.B.—Not *shall*] make arrangements for the care of expectant and nursing mothers and of children who have not attained the age of five years."

In 1915 the first ante-natal centre was established by voluntary efforts in Edinburgh, followed closely by a centre set up by the

local authority in the Metropolitan Borough of Woolwich. The 1918 Act stimulated the development of ante-natal centres and the number expanded from 120 in 1918 to approximately 2,000 in 1948. Some ante-natal care is arranged from private sources, and practically every mother comes under supervision at *some time* during her pregnancy.

The estimates of the number of mothers who attend the municipal clinics vary, but approximately six out of ten mothers do so. There has been an increase in the numbers in recent years which may be partly accounted for by the fact that during the war additional grants of food and clothing coupons were at first distributed by the maternity and child welfare departments. Attendances vary with the district, and in rural areas the percentages are often only one-third of those in the towns. One of the basic principles indicated above was the necessity for an early medical examination in pregnancy. Yet even in the most favourable circumstances less than half the mothers attended in the vital first three months of pregnancy—this in spite of the fact that the shortage of hospital beds and midwives encouraged mothers to attend early in order to obtain a booking. The report of 1948 said: "Few local authorities make efforts to publicise their ante-natal services or to emphasise the need for women to seek advice as soon as they realise they are pregnant." Other factors are that women may be actively discouraged by unsuitable, badly sited premises, and by the lack of an appointments system, which makes a visit awkward for a mother who has to find someone to mind her other children.

The various official reports give a good insight into the standards of ante-natal care and supervision. The report of the Committee of 1932 said: "There is too little ante-natal supervision by general practitioners and midwives, and what there is is often too perfunctory to deserve the name." The Committee recorded the fact that it felt "it necessary to emphasise that if the heavy annual toll of life and health incident to the toxæmias of pregnancy is to be diminished, more attention must be given to early diagnosis and adequate treatment." The Committee also referred to the non-recognition of the warning ante-partum hæmorrhage and the fact that "in the absence of a general medical examination many cases of serious systemic diseases are not recognised during pregnancy." The Scottish report of 1935 said: "It is obvious from the mortality reports

that ante-natal care falls short of what might reasonably be expected both in quality and amount. In many cases the attendant allowed matters to drift until too late. In other cases the advice given was so perfunctory or so inadequate that the emergency condition was present before its existence was recognised."

The report of 1937 repeated these criticisms, as little had been done in the meantime to remedy them. The report said: "The ante-natal supervision of women in whom symptoms of toxæmia were present was too often inadequate, and the unsuitability of attempting to treat such patients in their homes does not appear to be sufficiently appreciated. . . . The records show that some of the women were physically unfitted for childbearing, and from their condition when admitted to hospital as recorded in the clinical and post-mortem reports it was evident that they were suffering from chronic disease at the time of confinement." The report of 1944 commented on the fact that one of the chief mistakes was that many local authorities regarded ante-natal care as an end in itself, isolated from the labour room, whereas the truth is that pregnancy and labour are all of a piece and should have continuity of supervision from the same doctor. The inadequate provision of ante-natal beds even in modern maternity hospitals was deplored; they should be at least one-third of the total bed complement.

The 1948 report referred to clinics held in unsuitable premises—church halls, town halls, National Fire Service huts and corrugated iron sheds. These buildings are often "very draughty," "unbearably cold," noisy, with no adequate privacy. The waiting-rooms are often furnished with hard wooden benches, and after a long period of waiting only a cursory examination is given by the doctor.

At one clinic visited the doctor had seen twenty-nine women in just over an hour, and at another clinic he was over an hour late. "The doctor in charge of an ordinary ante-natal clinic is usually a member of the public health department *with no practical experience of obstetrics*." General practitioners who deal with the difficult cases in the homes, and the midwives who conduct the confinements, are generally excluded from the clinics. Yet "the most satisfactory ante-natal supervision is given at the clinics," i.e. by the people who do not attend the confinement. The conduct of the ante-natal clinics by

doctors "tends to hurried and inadequate consultations." There is often a lack of co-operation on the part of the mother. This could be remedied by a more effective follow-up by health visitors and by better education of the mother, preferably at an early stage, e.g. by teaching parent-craft at school.

The supply of supplements to the mother's diet, with milk free or at a reduced price and meals at dining centres, is probably one of the most important functions of the ante-natal centres. The report of 1944 in the summary and conclusions stated: "In the *social and economic section* we have stated the evidence that poverty—with its accompanying deficient nutrition, bad housing and overcrowding—contributes greatly to stillbirth and neo-natal mortality, and is not without effect on maternal mortality and morbidity. Moreover, it is very necessary to remember that when poverty and its accompaniments exist the technical service cannot function effectively."

The report referred to the fact that before the war many of the population suffered from deficiencies in the quality of their diet, and evidence has now been adduced to show that malnutrition is associated with increased abortion rate and premature birth rate. Moreover, malnutrition may profoundly influence the skeletal development of the foetus *in utero*, leading on to a rickety pelvis which twenty years or so later may affect the safety during childbirth of a new generation of mothers.

The effect of supplements to the diet in reducing the number of maternal and infants deaths is illustrated by many trials, particularly those carried out in the Rhondda, London, Boston and Toronto. In 1934 the Rhondda Urban District Council improved its maternity services by providing ante-natal centres, etc., but the maternal mortality continued to rise. The Council then provided additional food for certain expectant mothers and the number of deaths was reduced considerably. The maternal mortality rate among the 10,384 expectant mothers receiving the additional food for two and a half years (from January 1st, 1935 to July 30th, 1937) was only one-quarter that of the other 18,854 other mothers in the same area (1·64 per 1,000 total births as compared with 6·15 per 1,000 total births). There were also fewer deaths among the babies born to mothers who received the additional food. The number of children born dead, or dying within one month of birth, was reduced by half. This result was also borne out by a similar experiment in Toronto

in recent years. The diets of a selected group of expectant mothers were supplemented by the addition of milk, eggs, fruit, wheat germ and vitamin D. These women had a much better record of pregnancy, confinement and convalescence and their children were healthier than those who remained on poor diets.

During the Second World War the general provision of additional food for mothers was begun. Mothers were included in the priority classes for eggs and milk, and in addition received vitamin supplements, although only four in ten took up the latter in 1946. The number of deaths of mothers in childbirth has been halved since the war (1·24 per 1,000 in 1946 as compared with 2·70 in 1938). Part of this improvement was due to the more prevalent use of blood and plasma transfusion, the use of the sulphonamide drugs and the recent bacteriological technique in the preventing and tracing infection. The reduction in the maternal mortality rate from infection during this period was, however, quite small (0·36 per 1,000).

The war brought no general improvement in the maternity services. Doctors were called up for military service, specialised training in midwifery diminished in extent, and the building of new centres and hospitals ceased. There is therefore strong evidence to infer that the improvement in the maternal mortality rate during the war was due to the better diets of the majority of the mothers.

This is confirmed in the report, *On the State of the Public Health during Six Years of War*, published by the Ministry of Health in 1946, which said: "The national provision of milk and vitamin supplements to the priority groups *has probably done more than any other single factor* to promote the health of expectant mothers and young children during the war, and the scheme, together with rationing and the greatly improved nutritional qualities of the national loaf, has contributed to the gradual decline in the neo-natal and infant mortality and stillbirth rates, so noteworthy in the last five years. The scheme has resulted in the consumption of more milk per head by these priority groups to whom milk is of vital importance, particularly 'those underprivileged classes' who, before the war, could not afford enough milk."

The old controversy of whether home or institution is the best place for the conduct of the delivery is often based on artificial arguments. So much depends upon the condition of the

home and the provision of hospital beds in a particular area. Generally speaking, a normal uncomplicated confinement can with advantage take place at home, provided the home is suitable. As the 1948 report said: "Many women would prefer a good domiciliary service, provided that some domestic help was available and housing conditions were improved." Provision must also be made for dealing with the complications in the confinement.

Institutional treatment is necessary if the expectant mother is living in an overcrowded or unsuitable home or if obstetric complications are anticipated. In 1927 only one in seven mothers had their babies in institutions. In 1933 the proportion rose to one in four, while in 1946 it was one in two. These statistics give a false impression of the use of hospital beds in various parts of the country, for in London eight out of ten mothers had their babies in institutions, whereas in Anglesey it was fewer than one in fifty, in Norfolk one in ten, and even in towns as large as Wolverhampton and Plymouth, with no problems of sparse population and bad transport, only one in four mothers were confined in hospital. The report of 1944 suggested that the future should be planned so that seven out of ten mothers have their confinements in institutions. As indicated, however, the controversy will be determined in the future by the extent of the improvement in the home conditions, the domiciliary midwifery services and the quantity and quality of hospital provision.

Most confinements in the home (over six out of ten) are conducted by midwives and the remainder by general practitioners. Home delivery seems to carry a low risk of still-birth and neo-natal death but appearances are deceptive because some of those originally booked for home delivery are admitted as unbooked cases to hospital; among these, stillbirth and neo-natal deaths are very high.

Such unbooked cases should be regarded as domiciliary risks, because some result from mishandling by doctors or domiciliary midwives, and others from abnormalities undiagnosed during the ante-natal period (1948 report).

The major difficulties in home confinements are the unsuitable conditions in many of the homes. The Committee of 1948 reported that "many confinements take place in appalling conditions of overcrowding. Midwives interviewed in the local

inquiries spoke of women who slept during their confinements in the same bed with mothers, female relatives or husbands." Examples are given of a woman who during her confinement shared a bed with her mother and sister and of a woman delivered in a room which she shared with her husband and three older children.

The practice of midwifery in the homes has improved considerably since the handywoman has been displaced from practice. The improvement in transport facilities, including the provision of better roads, and the great extension of the telephone service have done much to make available the service of midwives in remote districts. Yet the report of 1937 could still refer to handywomen as follows: "The practice of handywomen is still extensive in some areas, particularly in rural districts in which midwives are lacking. With a few exceptions, the number of handywomen who are employed in the county boroughs appeared to be small or negligible. In some of the towns in which their services are still utilised, there is not a shortage of midwives."

The standards of the midwives vary a good deal. Some lack a knowledge of up-to-date methods, but this should improve with the refresher courses which have now been instituted. In 1937 the training of students was extended by six months if the student was a State registered nurse, otherwise by a year.

The report of 1937 referred to the work of midwives in the home as follows: "The standard practice of midwives in some cases was unsatisfactory, the ante-natal supervision exercised was perfunctory, medical assistance was sought too late, and procedures inconsistent with competent midwifery were occasionally adopted. The importance of sympathetic and skilled supervision of midwives cannot be over-emphasised, yet it formed one of the least satisfactory features in several of the maternity schemes surveyed."

General practitioners are in charge of approximately three out of ten home confinements. In addition, they are called out by midwives in about one in twenty-five cases because some abnormality has occurred or is suspected. Even though a doctor is booked for the confinement, he carries out the delivery in only about half of these cases. The same applies when the doctor is called in by the midwife to deal with emergencies. "In some cases the difficulty may have been surmounted before he

arrives, and in others the midwife may well be able to deal with the emergency under his direction. Usually he in unacquainted with the history of the case and may not be conducting a midwifery practice. Consequently, he may prefer that the midwife herself should carry on under his guidance" (report of 1948). The number of cases conducted by doctors has been reduced because of the increasing number delivered in hospitals and by midwives in the home.

The number, however, varies from district to district, whether residential, industrial or rural. In many instances a general practitioner's practice is restricted to a few cases per year and to the calls made upon him by midwives. His experience is therefore limited. Many have no special training in midwifery and are very busy in their general practice. As the Ministry of Health's report of an investigation into maternal mortality (1937) says, "the general practitioner is often called to an emergency in the patient's home, and may have to cope without the adequate assistance and in unfavourable surroundings with critical situations which would challenge the skill of an obstetric specialist. His experience of midwifery may be, and in particular of complicated labours often is, of necessity limited. Other calls upon his time may be pressing. . . . The history of many of the maternal deaths indicate . . . the woman's chance of recovery would often have been enhanced had a practitioner experienced in midwifery been in attendance, had the doctor been assisted by an obstetric expert, or had the patient been admitted sufficiently early to hospital."

The main fault with general practitioner midwifery lies in the attempts made by the doctors to hasten the process of birth by the injudicious and too frequent applications of forceps. A *Report on High Maternal Mortality in Certain Areas*, published by the Ministry of Health in 1932, said: "There is evidence that in some cases considerable and serious mismanagement of labour occurs, that forceps are applied prematurely and that aseptic precautions are neglected." The report of the departmental committee of 1932 referred to the fact that "there is too great a tendency to intervene in the normal case and to perform obstetric manipulations under unsuitable conditions."

The Scottish report of 1935 said: "There is no doubt that one of the most disquieting features of present-day obstetric practice in hurried and unnecessarily meddlesome midwifery. 'Failed

forceps' is a convenient term of obstetrical jargon, used here to denote a series of cases in which the doctor, without allowing due time for the essential process of dilation of the cervix and moulding of the head, had applied forceps and used forcible traction in an attempt to hasten delivery, but had failed to deliver and had then sent the patient to a maternity institution as a 'failed forceps.' "

Lists of doctors have been compiled in some areas for the use of midwives in an emergency, but this problem will not be solved until the recommendation of the 1937 report is implemented, i.e. "Those general practitioners who undertake obstetric work should be interested, experienced and actively engaged in the practice of midwifery, and have sufficient time for unhurried work. Practitioners rendering medical aid should form an integral part of the local maternity service and should freely avail themselves of the consultant and other facilities provided by the Local Authority."

Consultants are available in most of the districts but their value is variable. The 1937 report said: "While most of the authorities visited had made some arrangements for the services of consultants, the qualifications and experience of the latter varied greatly, as did also the purposes for which they were appointed. Even where consultant facilities were available they were too seldom utilised."

Occasionally emergencies occur in the home which require more than the attention of a consultant and the mother's condition is too serious to withstand the strain of transport to hospital. "Flying squads"—mobile obstetric units—are available in some areas to deal with this situation. The unit is staffed by a doctor and nurse skilled in obstetrics, and equipped to deal with cases of hæmorrhage, shock, difficult labour or retention of placenta. This service was first inaugurated in Newcastle in 1935 and should be extended to all districts. The need for it will ultimately diminish when ante-natal supervision, home conditions and the obstetric skill of doctors improve.

Pregnancy and the confinement incapacitate the mother for her work in the home. It is therefore essential to provide domestic help for the mother to give her a chance of resting in the last weeks of pregnancy and after the confinement. The report of 1948 suggests that all mothers should have domestic help, irrespective of the place of the confinement, for one month

before and one month after the delivery. In the first month the mother could also initiate the home help into the ways of the home. In addition, this service would encourage mothers to have their babies in institutions without worrying about the care of the home and would generally give them a well-earned rest from household responsibilities.

In the majority of homes (eight out of ten) domestic help was given by relatives and only one in seventy received assistance from the official municipal home help services. As the 1948 report said, "the total absence of any help, or the provision of assistance for only a limited period, must have caused great strain and worry at the time of childbirth, and may have had an adverse influence on the mother's subsequent health. Mothers whose need was greatest obtained the least assistance. Housewives in the poorer social groups often have large families to look after, and they are likely to live in old and overcrowded houses lacking modern labour-saving conveniences. Many of these women have to spend much time in daily shopping because tradesmen do not deliver. Moreover, their husbands may work long hours, occasionally on shifts, requiring meals at unusual times. But housewives living in these conditions received much less domestic help at childbirth than those whose household demands were not so great. . . . Mothers often resumed domestic work a few days after delivery."

Some municipal authorities have a well-developed home help service, with a domestic home help supervisor and special training for the domestic helps. But even in the best areas, such as Croydon, Aberdeen and Lewisham, the supply of home helps is far from satisfying the demand, and in several cases the mother "would not engage a home help in the future because of the expense involved."

The use of day and residential nurseries for the care of older children during the confinement would be a useful supplement to the domestic help service. The report of 1948 said: "Attempts to give priority for hospital beds to those whose homes are overcrowded or otherwise unsuitable for delivery are largely frustrated by shortages of home helps and residential nurseries."

As has already been indicated, there has been a general increase in the demand of mothers for hospital confinements. This demand has been inadequately met and the type of hospital bed provision varies from district to district. Some of the wards

in the former municipal hospitals have been specially built for the practice of midwifery, and are modern, well-equipped and adequately staffed. Many, however, fall far below this standard. As the report of 1937 commented, "in some of the areas visited the only available accommodation for complicated cases was in hospitals lacking adequate facilities for obstetric work; the conduct of difficult confinements was sometimes entrusted to junior resident officers with little, if any, post-graduate experience of midwifery. In such circumstances the condition of women, admitted in emergency with obstetric complications which had baffled older and more experienced practitioners outside, had reached a stage when treatment was far more difficult and when the patient's strength was failing."

The Committee referred to the disadvantages of adapting general wards for maternity purposes as follows: "The lying-in wards contain too many beds. The number of small or single-bed wards is insufficient and the labour-room facilities are often inadequate and unsuitable. In some institutions the excess of maternity patients is accommodated in general wards.

"In some Public Assistance institutions, particularly those in the counties, the maternity accommodation leaves much to be desired. The lying-in wards may consist of small rooms in close proximity to or even open off wards in which chronic sick or female surgical patients are treated. Labour-room arrangements are primitive, or may be lacking, and the sluice-room and lavatory provision is often inadequate, or may be used in common with wards in which there are patients who are liable to be a source of infection."

Several of the former voluntary hospitals suffered from the same failings, and in some towns mothers had to be admitted to voluntary general hospitals which had no maternity department and no obstetric staff. The 1937 committee described some of these hospitals as follows: "Much of the maternity accommodation in the hospitals visited was not designed for the purpose and many of the maternity homes are adapted dwelling-houses, in some of which the work is carried on under conditions of difficulty. Although the services of obstetric specialists were frequently available, the treatment of the maternity patients was too seldom under their clinical supervision. In a number of districts complicated maternity cases had to be admitted in emergency to voluntary general hospitals,

in some of which obstetric practice was not regarded as within the scope of their normal activities and the services of obstetric specialists were not always available. The routine nursing of maternity patients may be entrusted to junior nurses and probationers who have had neither midwifery training nor experience. Maternity patients have to be treated in medical or surgical wards with other patients."

During the war the Government was faced with the difficulty of dealing with confinements in front-line areas where bombing was heavy. This problem was solved by the establishment of evacuation maternity hostels in safe areas in the country. One hundred and thirty large houses with accommodation for 3,500 beds were converted into maternity homes and by March, 1945, 150,000 births had taken place in them. Although there was a marked shortage of maternity bed accommodation after the war, especially in 1947, when the birth-rate was high, these hostels were gradually closed and at the end of 1947 only twelve homes with a total of 365 beds remained. The mothers spent more time in these homes than in the ordinary maternity hospitals and therefore had a longer period of rest. The Chief Medical Officer of the Ministry of Health, in his report of 1939–45, referred to the effects of the additional rest as follows: "It was generally considered that the mothers benefited by the enforced rest during the last weeks of pregnancy, so that the confinements were easier; uterine inertia was practically unknown and less interference was required."

One general result of the war which particularly affected maternity hospitals was staff shortages. This gave rise to many women making "legitimate complaints of wearisome waiting, unnecessarily early hours (wakened at 4.30 a.m. in one hospital), lack of individual attention and limitation of visiting" (1948 report). One woman referred to the lack of individual attention as "awful. They leave you in a room to get on with it. At home you can have someone with you."

As the 1948 Committee discovered, "in visits to hospitals the impression was gained that the comfort of the mothers sometimes comes second to hospital routine." The Committee referred to the fact that "the existing maternity hospitals are not always well designed, and, in particular, labour-rooms are often insufficiently isolated from each other and from the lying-in wards." One hospital in a town was described by the Committee

of 1948 as follows: "The large wards are very noisy because there is no nursery, and consequently the babies are left in the wards night and day. Ante-natal and confinement cases are admitted to the same ward, and here the expectant mothers remain during the whole of the first stage of labour. Clearly, these are not the sort of conditions which would increase the popularity of hospital confinement."

Every mother would welcome relief from the pains of child-bearing. Minnitt's gas-and-air apparatus brings to mothers in a convenient and safe form the benefit of a childbirth which is painless in most cases. Yet only one in five had relief in their home confinements and, in spite of the additional facilities available, only half the mothers confined in hospitals had analgesia in childbirth.

There is a general shortage of the apparatus and of midwives trained to use it. In some areas there is little encouragement for the midwives to use it, for although it is bulky and heavy, no facilities are provided for transportation. The long-term solution of the problem of the relief of pain in childbirth lies in the discovery of a more effective form of apparatus in a more convenient, portable form.

During the war the number of illegitimate children doubled, showing 93 per 1,000 live births in 1945 as compared with 42 per 1,000 in 1939. Although the mother of the illegitimate child requires additional care because of the home and economic difficulties, "the resources available to unmarried women were most inadequate" (report of 1948).

Many of these women (nine out of ten) have to work to support themselves. They receive little encouragement to attend the ante-natal centres early, particularly as they have a genuine feeling that they will be subject to unfair discrimination. Unfortunately, "discrimination was occasionally shown against unmarried women, and some of them were unwilling to use their local municipal services because of the possibility of adverse comment" (report of 1948). In one case the woman attended once only, on the day before confinement. She then left work, had the baby, and returned to work two weeks later. One in twenty had no ante-natal supervision at all, and one in four gave birth to the baby alone in the absence of any attendant. Some of the mothers are confined in hospital, and in the past their delivery was entrusted to pupil midwives. Others are

confined in Public Assistance institutions "under most unsuitable conditions" (report of 1948). A few are admitted to homes supported by charitable funds and contributions from local authorities. "Adequate nursing and medical facilities were rarely available in the special homes" (report of 1948). They are often kept there for several months under these bad conditions in order to train the mother for employment. In cases where the mother cannot look after the child, arrangements are made for a foster-mother, but their selection and supervision have not been satisfactory.

Some of the homes for mothers are much too rigorous and impose unreasonable discipline and too heavy work, while the diet, heating and sanitary arrangements may be of too low a standard for a woman in advanced pregnancy. In many there is much "spit and polish," and little attempt is made to cultivate a homely and cheerful atmosphere. Some hostels cater specially for mothers with venereal disease, as their admission to the ordinary venereal disease wards subjects them to demoralising influences. Voluntary hostels seldom admit second cases and therefore a local authority hostel is desirable. When these cases were sent to Public Assistance committee institutions, they remained for months or even years. Some escaped in most unsuitable circumstances.

The care of the unmarried mother presents many problems. For the solution of these problems there is a need for co-operation between all the agencies which cater for motherhood—the health visitors, the midwives, the doctors, the local authorities, the hospital management committees, the probation officers and the moral welfare workers.

The importance of post-natal examinations has already been emphasised. It has been estimated that one in ten of all mothers is more or less crippled by conditions resulting from or aggravated by pregnancy. The number of mothers who have post-natal examinations varies from district to district, ranging from two to four out of every ten. There is little encouragement for mothers to attend centres where there is overcrowding and staff is short. The conditions in the clinics themselves are not attractive, as already described, and the importance of post-natal examinations is rarely explained to the mothers.

Voluntary committees usually organise birth-control clinics, and the extension of these, in addition to general education,

would assist in reducing the number of abortions, which is estimated at 150,000 per year and produces its quota of 14 per cent. of the maternal mortality rate.

National Health Insurance did not provide medical attention for the confinement, but supplied a maternity grant, the amount of which varied according to the approved society to which the woman or her husband belonged. It was at least £2 when only the husband was insured and £4 when both were insured. The woman was also usually considered as "not available for employment" during the last eight weeks of her pregnancy. Most of this sum was spent on the fees of the midwife and doctor and did not cover all the additional expense involved in the birth of a baby.

Before discussing the possible effects on the maternity services of the National Health Service Act, 1946, an analysis will be given of the background to the present services and the improvements necessary to them.

The official reports paint a gloomy and depressing picture of the maternity services. Their description and criticism of the defects in the system point the way clearly, logically and simply to the necessary reforms. They all suggest similar remedies for improvements. All their recommendations are based on the same foundations—the abolition of poverty, the planning and integration of the various services, more and better centres and hospitals, more and better trained midwives and doctors, and improved health education.

A typical example of a complete maternity and child welfare scheme is as follows:

(1) Arrangements for the local supervision of midwives.

(2) Arrangements for

(*a*) An ante-natal clinic for expectant mothers.

(*b*) The home visiting of expectant mothers.

(*c*) A maternity hospital or beds at a hospital in which complicated cases of pregnancy can receive treatment.

(3) Arrangements for—

(*a*) Such assistance as may be needed to ensure the mother having skilled and prompt attendance during confinement at home.

(*b*) The confinement at a hospital of sick women, including women having contracted pelves or suffering from any other condition involving danger to the mother or infant.

(4) Arrangements for—

(*a*) The treatment in a hospital of complications arising after parturition, whether in the mother or in the infant.

(*b*) The provision of systematic advice and treatment for infants at a baby clinic or infant dispensary.

(*c*) The continuance of these clinics and dispensaries to be available for children up to the age when they are entered on the school register.

(*d*) The systematic home visitation of infants and children not on the school register.

There is no local authority in the whole country which has a service for all the mothers in their district as complete as the one described above. The mothers and children everywhere in the country would benefit by the introduction of such a scheme by the local authorities in their area.

This scheme was prepared by the Local Government Board and first saw the light of day in July, 1914. Thirty-four years have passed and, because most authorities have failed to carry out essential reforms, committees investigating the maternity services to-day have to suggest similar schemes for improving the services.

Earlier in this work striking examples of this process were given. The Royal Commission on the Poor Law in 1909 (following Joseph Chamberlain's advice of 1888) recommended the "break-up" of the Poor Law. The Minister of National Insurance can still speak in 1948 of the need to break up the Poor Law. The famous Public Health Act of 1875, followed by the Housing Acts of 1875–1936, were passed to eradicate slum conditions. The annual reports of medical officers of health still refer to the slum conditions which exist in every town and village in the country. The Food and Drugs Acts (1875–1938) were enacted to eliminate the sale of unsound or adulterated food. The annual reports of the Chief Medical Officer still refer to the seizure of unsound or adulterated foods. The Factories Acts (1901–37) were passed to improve working conditions. The annual report of the Chief Inspector of Factories still refers to the "slum" conditions in many factories.

At every stage vested interests have operated: firstly, to oppose the passing of the Acts by Parliament and then to restrict their implementation, and, secondly to hinder or delay the

carrying out of the Acts after they were passed. For example, the vested interests who opposed the "break-up" of the Poor Law were the industrialists and landowners. They were afraid that higher wages and taxes would then have to be paid, resulting in a reduction in profits and rents. The slum landlords fought against any expenditure on repairs to their slum properties, for this would lead to a reduction in their net rents. The food-purveyors opposed measures for the introduction of food standards or for improved hygienic food production, for these would result in increased costs and reduced profits. The factory-owners opposed measures for the improvement of health conditions in their factories, for these would tend to increase costs and might reduce profits.

The same forces operate in the development of the social services. The social services provide a welcome addition to the workers' conditions of living and thus indirectly to his pay. Their introduction or extension is therefore resisted by those interested in profits and rents, as their income is threatened with a reduction.

It is generally agreed that medical services should be allocated according to the needs of the patient. The best medical skill and attention should be devoted to the most difficult and complicated cases. In practice, however, the best medical skill and attention are usually distributed according to the mother's ability to pay. The Committee of 1948 clearly emphasises this point. The report states: "In all aspects of maternity care, well-to-do mothers get better attention than those of the poor. They come under ante-natal supervision earlier, can afford a nursing-home bed if no hospital one is available and are more often given analgesia." The well-to-do can choose the place of their confinement with absolute confidence. Their home is suitable and they can afford to pay for domestic help in the house. Alternatively, if they prefer institutional confinement and no hospital bed is available, they can always afford to pay the fees of a nursing home. "The poorer groups, on the other hand, are restricted in their choice by the present shortage of hospital beds, by the high fees of nursing-homes, and by the rarity of home helps."

Wives of the well-to-do "are three times as likely to be given analgesia as wives of manual workers." Three times the number of doctors are booked for the confinements of the well-to-do

as compared with the manual workers. "Even in hospital, better-off mothers were more often delivered by doctors than poorer ones."

Examples are given of the money spent on the confinement. One-third of the well-to-do mothers spent over £60. Several spent over £150, employing both a doctor and a specialist whose combined fees were £40 or more. It takes a good five years of post-graduate training to make an obstetric specialist. There are at present less than 500 Fellows and Members of the Royal College of Obstetricians and Gynæcologists, and "even if these were uniformly spread they would scarcely suffice."

The reports have indicated that in some of the hospitals "the services of obstetric specialists were not available," and that in some of the maternal deaths "the woman's chance of recovery would have been enhanced had a practitioner experienced in midwifery been in attendance or had the doctor been assisted by an obstetric expert." At the same time the skill and energy of doctors and obstetric specialists were being expended on normal cases, not because they were specially needed, but merely because there was a favourable financial return. Both specialists and doctors are thus encouraged to attend normal cases and neglect cases where their services are required.

The general recommendations for a complete maternity service have been indicated in the official reports and in the scheme outlined by the Local Government Board in 1914. The principles upon which they are based are indicated in the programme for *A National Service for Health*, published by the Labour Party in 1943. "The Service should be: (1) Planned as a whole. (2) Preventive as well as curative. (3) Complete: there should be made available to every citizen whatever medical treatment he requires. (4) Open to all, irrespective of means or social position. Poverty must be no bar to health, no bar to a man's right to life. (5) Efficient and up to date: in particular, provision should be made for 'team-work' by the doctors, and for bringing together the resources of modern medicine in conveniently distributed centres. (6) Accessible to the public. With specialists available at centres or in the patient's home. (7) Preserve confidence between doctor and patient. (8) Equitable for the medical profession."

The above principles are agreed generally as being the aims of the health services. The Act can therefore be judged on how

far it carries out these principles. Principle No. 4 is probably the most important—that the medical needs and not the financial status should be the determining factor in the distribution of medical skill and attention. The medical services should be available to all and not the privilege of those who can pay.

The Act, in making the medical services free to every citizen irrespective of his means, has made a considerable advance in this direction. In addition, there is a maternity grant of £4, intended to help the general expenses of the confinement, buying clothes for the baby, etc., and an attendance allowance of 20*s*. a week for four weeks immediately after the confinement. This allowance is intended to help pay for domestic assistance for the mother after her confinement. If the mother is at work, she may obtain a maternity allowance of 36*s*. a week, paid normally for thirteen weeks, to begin six weeks before confinement. This allowance is intended to make it easier for the women, in their own interests and those of their babies, to give up work in good time before confinement and not to return to work too soon afterwards. Another great advance is the ending of permissive legislation whereby an authority was allowed to provide certain services, but in practice many failed to do so. The new Act makes it a specific duty of all authorities to provide the health services as laid down in the Act, i.e. the health centres and the provisions for maternity and child welfare, etc.

The Committee of 1948 reported that "in all aspects of maternity care well-to-do mothers get better attention than those of the poor." There is a marked shortage of clinics, hospital beds and skilled health workers in the health services to-day. There will therefore be an interim period while health buildings are being erected and health workers are being trained, when the existing services will be inadequate. The services should be so organised that those who require them most should receive them.

This policy requires careful planning. Unfortunately, the Act, for reasons to be given later, has not adhered strictly to principle No. 1—that the services should be "planned as a whole." All the reports emphasise the importance of the integration and planning of the maternity services. Pregnancy, confinement and the puerperium form one continuous process and should be supervised in all their phases by the same authority. Under the Act, the domiciliary midwives, the home helps and

the assistant medical officers of health (who are responsible for the ante-natal care in the clinics) are under the supervision and control of the local health authorities. The general practitioners who are responsible for the ante-natal care and the confinement of the mother in the home are under the supervision of executive councils, the successors of the insurance committees. The hospitals and some of the domiciliary midwives are under the control of the regional hospital boards and, finally, the nursing-homes are under private control.

These administrative organs will be described in detail later, but at this stage it must be appreciated that these three bodies are separate and, except for occasional joint representation, have no connexion with each other.

While the medical services are limited and restricted, they should be distributed according to need in strict priority. In any area there will be a number of midwives, a number of doctors more or less skilled in midwifery, a number of obstetric specialists, some clinics and hospital beds. The available beds in hospitals and institutions should be reserved exclusively for expectant mothers living in overcrowded or unsuitable homes or for cases in which obstetric complications are anticipated. There should be no private beds for normal confinements until adequate provision has been made for every mother with a difficult labour. In this respect it is interesting to note that almost one in four of the institutional confinements takes place in nursing homes and private wards of hospitals. The hospitals where "labour-room facilities are often inadequate and unsuitable," the institutions where "labour-rooms are primitive," and the hospitals where "the comfort of the mothers comes second to hospital routine" should receive immediate attention.

Obstetric specialists could be more evenly distributed, especially to the hospitals receiving complicated cases and where "the services of obstetric specialists are not always available" and where "the conduct of difficult confinements is sometimes entrusted to junior resident officers with little, if any, post-graduate experience of midwifery."

The National Health Service (Pay-Bed Accommodation in Hospitals, etc.) Regulations, 1948, provides for a fee of 50 guineas to be paid by a private patient in a State hospital to the obstetric specialist in attendance, whether the case is *normal* or abnormal. Every private normal case which an obstetric specialist attends

means one more difficult labour conducted without the necessary obstetric skill. The financial inducement which attracts the obstetric specialist to normal cases could be given by the Government to encourage them to attend to the cases which actually require their skill. There would consequently be a saving of the lives and health of mothers who are crippled as a result of blundering midwifery.

At the same time, domestic helps and day and residential accommodation for the care of older children during the confinement could be made available, otherwise "attempts to give priority for hospital beds to those whose homes are overcrowded or otherwise unsuitable for delivery are largely frustrated by shortages of home-helps and residential nurseries." As the report of 1948 said with regard to the provision of home helps, "mothers whose need was greatest obtained the least assistance." Until the home help service is fully developed, "the housewives of the poorer social groups often with large families" should have absolute priority.

The dangers of general practice midwifery have already been emphasised in the reports. Unless midwifery in the home is restricted to "those general practitioners who are interested, experienced and actively engaged in the practice of midwifery, and have sufficient time for unhurried work," maternal deaths will still occur where "the woman's chance of recovery would often have been enhanced had a practitioner experienced in midwifery been in attendance." Until sufficient general practitioner obstetricians are available, midwives could quite readily deal with the normal cases under the supervision and guidance of experienced doctors. The number of these skilled doctors, as indicated in the famous Circular 118/47 (July 10th, 1947) could be supplemented by assistant medical officers from the clinics. Those particularly interested in obstetrics could be assigned to obstetric teams and gain the knowledge which they now so sorely lack—a knowledge of practical midwifery. The general practitioner obstetrician could at the same time be encouraged to conduct ante-natal clinics at the local authority centres, where he would find better facilities and greater assistance than he has in his private surgery or in the home of the mother. Some authorities have organised ante-natal clinics for midwives, who regularly refer the mothers to the assistant medical officers.

The above arrangements would considerably improve the ante-natal services and would ensure that the same team of midwife, doctor and health visitor and, if required, obstetric consultant was supervising the mother throughout the pregnancy and confinement. The doctors could then attend the home confinements where they were most needed. The midwives could safely deal with the other cases, with the knowledge that, if they required assistance a reliable doctor could be sent for and not one who "is unacquainted with the history of the case and may not be conducting a midwifery practice."

The success of the maternity services depends to a large extent upon the role assigned to the general practitioner. The problem of developing "general practitioners who are interested, experienced and actively engaged in midwifery, and have sufficient time for unhurried work" must be solved. The methods adopted by the Ministry of Health to this end are described in detail, not merely because of the importance of the subject, but mainly as an example of the Ministry's vacillating policy and its retreat in the face of resistance.

The Ministry began with a good, workable policy. As indicated, in Circular 118/47 the Minister of Health has set up local professional *ad hoc* committees whose task is to draw up lists of approved doctors who are experienced and competent in the practice of midwifery. A payment of seven guineas is made to the doctors on the obstetric list who are booked for a confinement. No standards for estimating the skill and experience of these doctors were laid down, and the selection of doctors for the list in many areas was very liberal. Nevertheless, the stage was set for the elimination from obstetric practice of those practitioners whose "experience of midwifery may be, and in particular of complicated labours often is, of necessity, limited."

Pressure was, however, put on the Ministry by the British Medical Association on behalf of the doctors who either did not elect to do midwifery or were not deemed sufficiently competent to be placed on the obstetric list. It was represented to the Minister that, as they could not charge fees to their own public patients within the scheme, they might be undertaking midwifery in some cases without either private fee or public remuneration for it.

This was a specious argument, for if these doctors wanted to practise midwifery they could apply to be placed on the obstetric

list. If they were competent, they would be accepted. If they had insufficient experience, they could attend post-graduate courses or receive training and gain experience at a hospital or centre. No financial inducement should, of course, have been held out to those doctors who were not competent and were unwilling to undergo a course of training. Nevertheless, the Ministry of Health yielded to pressure, and in a letter sent to the British Medical Association on May 26th, 1948, granted a payment of five guineas to doctors who were not on the obstetric list but "booked" cases for delivery. This payment is made even though the doctor does not carry out the delivery himself, which is the present position with regard to half the doctors' booked cases. The stage is set again for a continuation of the present-day practice of "unnecessarily meddlesome midwifery."

This measure has caused a considerable amount of uneasiness among midwives. As the service is free to every mother, they fear that every mother will choose a doctor for her confinement irrespective of his competence, and the midwife will therefore be relegated to the position of maternity nurse, lacking any real responsibility or interest in her work.

The Goodenough Report of the Inter-departmental Committee on Medical Schools said: "The conduct of a normal confinement is the primary and essential obligation of the midwife to the community. The medical practitioner has many others which may be both urgent and exacting." The President of the Royal College of Midwives commented on this statement and the effects of the new regulations as follows: "Our anxiety rises from the fact that to-day in some areas there has been a tendency to transfer this responsibility for normal midwifery from the midwife to the medical practitioner, in spite of his many other obligations. If this became general, the status of the midwife would be affected; many practising midwives would be tempted to leave the profession for more remunerative and, above all, less arduous branches of the Health Service. The loss to the maternity service of this country would be incalculable, and the mothers would be the chief sufferers. All hope of our ideal, a skilled attendant with the mother during the whole period of her labour, would disappear, for even if he or she were trained for the job a medical practitioner could never spare the time in view of other 'urgent and exacting' duties."

The Working Party on Midwives (1949) reviewed the historically changing relationship of the doctor and the midwife and then discussed their relative positions to-day in the maternity services. The report said: "The British system is the result of the midwifery and medical professions having evolved side by side and often in competition, and we cannot ignore the fact that the circumstances of its growth have led to a class distinction whereby the well-to-do tend to employ a doctor and the less affluent a midwife."

Those women who could afford to pay a doctor engaged him for their confinement; the remainder had the services of a midwife or a handy-woman. As a result of this, the general conception grew that pregnancy had to be treated like a disease and the confinement like a surgical operation. The midwife was therefore from the very beginning considered as a handmaid to the doctor, and in his absence a very poor and inefficient substitute. As the report remarked: "It is still true that many who have been debarred for financial reasons from having a doctor feel that they are missing something: something medically and socially important."

The profession of midwifery has been struggling to free itself from the prejudices which surrounded its origin. It was gradually succeeding in this important task when the National Health Service Act struck it a severe blow. The Working Party referred to the new development in a postscript to the introduction of their report. They said: "When this Report was actually in the Press our attention was drawn to many complaints both from medical officers of Health and midwives that general practitioners are tending to take over the whole of ante-natal care as well as relegating midwives to the status of maternity nurses. In some cases midwives are not seeing patients until they go to deliver them. This is entirely contrary to the development of the maternity services as outlined to us by representatives of the Health Department and as envisaged by us. We recognise that a general practitioner should accept his full responsibility for his patient, but not that he should exclude his partner, the midwife, whose function is, we should have thought, well established and clearly recognised. Moreover, we are convinced that it is not possible for the present number of doctors to take over complete responsibility for all maternity work in addition to their other commitments, even if this were

desirable. We do not consider it in the patient's interest for either party to monopolise the case. They should work as a team.

"We hope that prompt administrative action will be taken to stop this new and unwelcome trend which could wreck the structure of the midwifery services."

In appeasing the most powerful section of the health workers, the doctors, the Minister has sown the seeds of dissension among another section of the health workers, the midwives, who in their limited sphere do the most important work in the maternity services. Their attendance at normal confinements and their taking full responsibility for the case restricts the practice of "unnecessarily meddlesome midwifery."

There is a general shortage of doctors. Since the introduction of the new Act there have been more "calls pressing on his time" than previously. Any encouragement given to busy doctors with little experience of midwifery to undertake obstetric practice can only lead to obstetric disasters. It will discourage the midwives in their work, prevent any adequate planning of the service and will hamper any attempt to institute a fair and reasonable scheme of priorities.

The short-term policy outlined above could readily be introduced to-day with profound effects on the present and future development of the health services. It would immediately create and develop a new spirit of hope and faith in the services. It would banish this sense of frustration which exists to-day in all grades of health workers.

The long-term policy for a maternity service must include the provision of a considerable number of new clinics and hospitals, and must provide for the training of health workers to staff them. Health centres, which are the "keystone of the Act," can play an important part in the planning and the development of the service. In spite of the different administrations concerned, the midwife, health visitor, doctor (assistant medical officer of health or general practitioner) and consultant can meet in the health centres on common ground, the field of practice. They can then work together to satisfy the needs of the people. As already indicated, there will be a considerable amount of opposition from vested interests to the development of an adequate building programme for the maternity services.

We have seen that the various authorities differed in their provision of hospital beds for confinements. The Metropolitan

boroughs, Liverpool, Bradford and seven other large towns provided beds in institutions for at least six mothers in every ten, while Wolverhampton and Plymouth provided beds for only four in ten, and Norfolk for only one in ten. Even in London, where there was relatively a generous provision of beds, four in ten mothers who had their babies at home preferred a hospital confinement.

There are many reasons for these variations—the number and siting of the hospitals, the preference of the mothers and the policy of the maternity and child welfare authority. The main reason, however, for the more favourable provision of maternity beds in the larger towns is that the organisations of the people, the Labour Movement, is generally stronger in these towns and they have a better representation on the councils of the authority. Similarly the provision of health centres and hospital beds in the future will, to a large extent, depend on the strength and spirit of the Labour Movement in the localities as well as nationally.

Even when the health centres and hospitals are built, the problem of organising the health services on the basis of the medical needs of the people, rather than on their financial status, will still have to be solved. The struggle for the best use of the health centres and hospital beds will then arise. It is essential to introduce a short-term policy to solve the problem of the rational distribution of the medical services in a period of shortages and restrictions, otherwise the same problems in a heightened form will face the Government when the period of scarcity has passed. Unwise and injudicious compromises in this period will seriously affect the rapidity with which the Government implements its programme of health centres and hospitals. It will also have an effect on the type and number of persons recruited to the health services and their methods of training.

We conclude this section by referring to the annual reports of the Chief Medical Officer, which show that in 1946 and 1947 of the 800 cases or so investigated in each year, 40 per cent. show an assessable avoidable factor; in other words, in four out of ten cases the death of the mother might have been avoided if there had been a more efficient maternity service.

We must prevent maternal deaths and a repetition of such reports by reorganising and planning our maternity service for the benefit of the whole community.

CHAPTER X

CARE OF THE CHILD

THE CHILD IS FATHER of the man. A nation which neglects its children neglects its future, for a nation of healthy adults can only succeed a nation of healthy children. It is impossible to maintain health in the adult if preventable illness is allowed to develop in the child. The Government first recognised this elementary fact after the Boer War, when the inter-departmental committee reported on the reasons for the rejection of 40–60 per cent. of the Army recruits. The Education Act which gave birth to the School Medical Service was a direct result of this report.

The child is a human being at his most vulnerable. The child requires special care, for in addition to the ordinary hazards of living he is subject to the stresses and strains of growth and development. It is for this reason that he is very susceptible to an adverse environment. We have already seen the general effects of environment on the infant mortality rate and on the prevalence of infectious diseases. A general improvement in environmental conditions, better housing and nutrition would do more for the preservation and maintenance of child health than any reform in the health services. Nevertheless, reforms in the health services for the care of the child are considerably overdue and their fulfilment would raise the general standards of health in the nation.

It will be convenient to examine the care of the child in four specific age groups, 0–4 weeks, 4 weeks to 2 years, 2–5 years, and 5–15 years, for, although the general problems are similar, in many respects different reforms apply to each group.

(*i*) *0–4 Weeks*

The care of the child requires to be especially intense in the first year of life. The first four weeks are particularly important for it is in this period that a child is subject to the new world outside with all its attendant dangers. His capacity to survive this critical period will depend upon whether he is sufficiently developed and capable of dealing with his new and more

complicated form of living. His development will depend upon his maturity, and his capacity upon the effects of any injuries or disabilities acquired at birth. The death-rate of children of ages up to four weeks is known as the neo-natal mortality rate and accounts for at least half the deaths in children under the age of one year. Prematurity accounts for half the deaths of the neo-natal period and is the greatest single cause of the loss of life in children.

The significance of prematurity in causing loss of life in children becomes more evident from year to year. This is because there has been an appreciable reduction in the general death-rate of infants under one year of age, whereas there has been little reduction in the death rate from prematurity, especially in the first week of life. The death-rate of children under one year of age to-day is only one-third of that of fifty years ago, but there has been no marked reduction in the death-rate from prematurity during the same period. Prematurity to-day is therefore the core of the problem of the loss of life in early childhood.

There are two major aspects to the solution of this problem. Firstly, measures must be taken to reduce the number of premature babies, and, secondly, measures must be taken to deal with babies who are nevertheless born premature.

Although we do not know all the causes of prematurity, some of the more probable causes are well known. Many of the unknown causes of prematurity are associated with poverty. The Report of a Joint Committee of the Royal College of Obstetricians and Gynæcologists and the British Pediatric Association on "Neo-natal Mortality and Morbidity" (1949) referred to the fact that the cause remains unknown in about half the cases of prematurity. The report continued: "There is, however, some reason to believe that these unknown causes will become fewer as preventive treatment of a general character is extended, e.g. improvement in economic, social and educational status of the poorer classes." The Maternity in Great Britain Report (1948) considered that malnutrition was probably an important factor in producing premature births.

The Neo-natal Mortality and Morbidity Report of 1949, after quoting the fact that the prematurity rate is "much less in the upper middle class women than in women of the 'hospital class,' " said: "Upper middle class patients are better developed and nourished than 'hospital patients' in the same area."

The report quoted investigations which showed that the stillbirth and neo-natal death-rates were higher in the lower income groups and rose with the increase in the percentage of unemployed in a district. The report continued: "Baird (1945) has shown that the main reason for the high neo-natal death-rate in Scotland, as compared with Holland, and for Social Class V of England and Wales as compared with Social Class I, is the relatively high proportion of premature births; this in turn is associated with poor social and economic conditions affecting adversely the physique, health and nutrition of the mother." The report emphasised again and again the importance of good nutrition in reducing the number of deaths in young babies. It referred also to the important factor of the improved health and nutrition of the pregnant mother in producing a fall in the stillbirth and infant mortality rates during the war, and said: "There is good reason to believe that a greater improvement in social and economic conditions with raising of nutritional standards would result in a further reduction in the stillbirth and neo-natal death-rates."

Studies are quoted which show that the death-rate in artificially-fed infants is four to five times that in breast-fed infants. The report noted that "the prospects for successful breast-feeding are much improved when the mother is adequately nourished and lives in good environmental conditions," and it summed up: "The evidence goes to show that the present neo-natal mortality and stillbirth rates could be reduced by one-third to one-half, and if they were, there would be a saving of *about 15,000 babies each year* in England and Wales alone."

Prematurity is also caused by specific obstetric abnormalities or disorders in the mother. Toxæmia, ante-partum hæmorrhage, general diseases such as chronic nephritis, syphilis and diabetes, and general anæmia may all lead to premature labour. Proper and efficient ante-natal care is therefore essential in order to detect these complications early in pregnancy, so that prompt measures may be taken to deal with them. The present inadequate ante-natal care and supervision has already been noted, together with the fact that improvements in ante-natal care would not only spare invalidism and loss of life among mothers, but among infants as well.

The report of 1949 referred as follows to the importance of efficient ante-natal and natal care: "Above all, however, the

prevention of birth injury depends upon expert medical and nursing attention during pregnancy and labour. Many cases of birth injury are undoubtedly due to lack of obstetrical skill and judgment on the part of the accoucheur, especially when delivery by the breech or by forceps has been necessary. Breech delivery in primigravidæ [first pregnancies] still causes, in many hospitals, a fœtal mortality, mainly due to intracranial injury, of 20 per cent. or more. It has been demonstrated that this figure can be lowered to 3 or 5 per cent. by good obstetric technique alone. Lack of care and skill in the application of forceps in the above circumstances is a well-known cause of fœtal injuries."

Under the heading of "Prevention and Treatment," the report of 1949 suggested that "one well-balanced meal a day in a restaurant or canteen might be provided for all pregnant mothers." Ironically, the reason given for supplying a meal to the mother in a canteen is "lest other members of the family should benefit at the expense of the mother." Yet the Report emphasised the fact that, to achieve a more complete success in the prevention of prematurity, improvement in the standards of nutrition must begin early in life. The report said: "It is unlikely, however, that even first-class nutrition during pregnancy will entirely neutralise the effect of years of faulty diet dating from early childhood." An improvement in the general standards of nutrition of all the members of the family would obviate the need for food sacrifices on the part of any member of the family.

In 1944 the Minister of Health, following the Report of the Medical and Professional Sub-committee on the Welfare of Mothers and Young Children, drew the attention of local authorities to the need for improving facilities for the care of premature infants. The Ministry of Health Circular 20/44 suggested the notification of births where the weight of the baby was $5\frac{1}{2}$ lb. or less. The circular also suggested an improvement in hospital accommodation and in the domiciliary services, especially in the supply of equipment.

The hospital is the best place for giving care and attention to the premature baby. In the hospital it is much easier to arrange for rooms with controlled temperatures and for proper aseptic precautions to be taken against infection. In addition, highly skilled staff, child specialists and specially trained nurses can be made readily available.

The famous Rotunda Maternity Hospital in Dublin has shown how planned provision for the care of premature babies can reduce the number of deaths. In 1928 twelve out of twenty premature babies died in hospital, whereas in 1943 only one-quarter of this number died. While many hospitals have special wards and staff to deal with premature babies the 1948 report remarked: "Some hospitals are, however, inadequately equipped in this respect. In one of the maternity hospitals visited, for instance, no special ward was set aside for premature babies, who were cared for in the open children's ward of an attached general hospital."

At present, however, almost half the number of premature babies are born at home. It may not always be possible to transfer the child to the hospital, for the baby's weak condition might make the risk of the journey too great. In these difficult cases special provision must be made in the home.

Before the Act, many premature babies received little care and attention in the home, for the mother could not afford the services of a doctor or a nurse. Results of this are shown in the Maternity Report of 1948, which referred to the fact that "premature babies are more frequent among the poor than the well-to-do." Deaths in the first month of life are four times greater among working-class families than among the well-to-do.

The first essential in the home care of premature babies is the provision of a specially trained nurse. Next comes the supply of special equipment for keeping the baby warm—draught-proof cots, electric blankets, pads, etc., and, for feeding the baby, supplies of breast milk and special feeding bottles. Finally, there should be made available the services of a child specialist and if necessary a flying squad specially equipped and staffed to give oxygen or to inject fluids for feeding the baby. The services as a whole should be under the general supervision of a child specialist.

To provide an efficient service for all premature babies ante-natal, hospital and domiciliary services must be planned as a whole. Difficulties will arise because of the many authorities concerned.

The ante-natal clinics, the assistant medical officers of health, some of the midwives, the health visitors, the home nurses and home helps, and the home equipment will be provided by the

local health authorities. The general practitioners will be supplied by the executive councils; the pediatricians, hospital beds and some of the midwives by the regional hospital boards; and, finally, private facilities will be available in the private wards of general hospitals and in nursing homes. While the medical services are limited and restricted, they should be distributed according to need in strict priority. At present, skilled personnel, specialists and nurses in private wards, patients' homes and nursing homes are devoting time, energy and skill to cases whose needs are not so important or urgent.

A short-term policy could be adopted to attract the skilled personnel to the care of premature babies. The hospital beds could be allocated to the worst cases or where home conditions were unsatisfactory. Arrangements could be made immediately to organise premature ward units in hospitals where there are none at present. Special facilities could be made available at little cost for dealing with premature babies in the home.

The success of the premature baby service will depend on the role assigned to the general practitioner. The general practitioner who takes an interest in child welfare can be trained to supervise the care of premature babies in the home with the assistance of a skilled nurse and the backing of a specialist.

The long-term policy, as with the maternity services, will include the provision of a considerable number of clinics and hospitals. Health centres will play a valuable role in bringing together the various agencies which deal with the problem of premature babies—the local authorities, the executive councils and the regional hospital boards. The health centres will also play a very important part in improving the ante-natal and general practitioner services.

Urgent consideration should be given to policies which would result in "the saving of about 15,000 babies a year in England and Wales alone."

(ii) 4 Weeks to 2 Years

We have already noted that there has been a considerable improvement in the infant mortality rate in the last fifty years. The rate to-day is only one-third that of fifty years ago, and in 1948 was 34 per 1,000 live births. This improvement has generally followed improvements in social conditions. The rate in England, however, still compares unfavourably with the rates in New

Zealand, New York, Australia and Holland, where the rates are not much more than half that of England.

The major causes of death in this age period are the respiratory infections, gastro-enteritis and the infectious diseases. These diseases and infections spring from two main factors. The first, adverse social conditions, has already been mentioned, and the second factor, which is often coupled with the first, is maternal ignorance and neglect in the care and management of the child. Overcrowding, bad ventilation and dampness, improper or inadequate clothing or bedclothes may all produce respiratory and infectious diseases. Insanitary conditions, badly prepared, unhygienic and ill-balanced meals may cause gastric upsets, enteritis and diarrhœa.

As with prematurity, the problem of the infant mortality rate resolves itself into two parts. First, measures must be taken to avoid disease and infection, and, secondly, measures must be adopted to deal with any disease or infection which nevertheless attacks the child. Improvement in the general sanitary environment and particularly in housing is the most important measure in the sphere of prevention. Improvements in the health services can also achieve satisfactory results in reducing the infant mortality rate.

The mother is the key person in any scheme of infant care and welfare. The mother must be trained in the best methods of nursing and rearing the child. It is difficult to teach the practice of mothercraft to mothers who live in conditions of bad housing, overcrowding, defective sanitation and poverty. Nevertheless, even in these adverse circumstances a high standard of education in mothercraft can be reached.

The training of the school child in mothercraft can be followed up in later years in the ante-natal and infant welfare centres. The ante-natal centres not only play an important part in the prevention of prematurity and congenital abnormalities, e.g. in the investigation of the inheritance of the rhesus factor, congenital syphilis, etc., but also in teaching the mother the importance and value of breast feeding.

The breast-fed baby is healthier than the bottle-fed baby and suffers less from infantile diarrhœa and infectious diseases. Nevertheless, in some areas as many as seven babies out of ten are bottle-fed at the age of eight weeks. The 1948 Maternity in Great Britain Report investigated all the possible factors for failure

in breast feeding and concluded that "ante-natal supervision stands out as more important than any other factor, biological, social or economic."

The general education of the mother must be conceived in the broader practical sense, taking into consideration the actual conditions in which the mother has to work. The education must include the general care and management of the child, the protection of the child from avoidable disease and infection, and the general nursing of the sick child. The spearhead of the attack on maternal ignorance and neglect is therefore the health visitor. In her visits to the home she can learn all the relevant details of the family and the conditions under which they live. On the basis of this knowledge she can educate and train the particular mother in the best methods of rearing the child. She can become a valued and trusted friend of the family, so that they will always turn to her in any medical or social difficulty. She can inspire the mother to gain confidence in the general management of the child and to trust the health visitor, who can assist her in solving the family's social problems.

The advice given by the health visitor in the home is supplemented by advice given to the mother on her visits to the infant welfare centre. The centre is staffed by health visitors and infant welfare doctors, and occasionally by specialists as well. The primary function of such centres is to provide for the systematic supervision of the health of children up to the age of five years, although they concentrate on the age-group 4 weeks to 2 years. They serve as educational centres for the training of the mother in the care and management of the child. Personal advice is given by the doctor in his consultations and systematic instruction is carried out by means of lectures and informal talks. The health visitor assists the doctor, carries out his instructions, weighs the babies and generally gives advice and encouragement to the mother. Special attention is given to the prevention and treatment of minor ailments, such as dental caries, defective vision, enlarged tonsils and adenoids, chronic catarrhal conditions and skin complaints. When additional treatment is required or the illness is more severe, the case is referred to the general practitioner, the specialist clinics or the hospital. Continuing their original functions, the infant welfare centres distribute milk and vitamin products.

In the poorer districts many infant welfare medical officers

prescribed treatment for illnesses and thus encroached on the province of the general medical practitioner. Before the National Health Service Act, 1946, the mother had to pay a consultation fee to the general practitioner which she often could not afford. Her only alternative was to consult the Public Assistance ("parish") doctor. This she was loath to do because she objected to the stigma of pauperism.

The first infant welfare centres were opened almost fifty years ago and they have already been described. They were first organised by voluntary agencies to provide food and clothing for the mothers in the poor districts. The local authorities, especially when they became welfare authorities, extended this service in order to reduce the high infant mortality rate. They introduced education to the mother in the care and management of the child, and in addition provided nutritional supplements. To-day the service has expanded considerably and there are nearly 4,000 centres in the country attended by seven out of ten mothers. Two in ten of the centres are still run by voluntary agencies.

The centres, like the ante-natal clinics, vary in their standards. The best centres are attached to general health centres which also serve the purpose of school clinics, ante-natal and post-natal clinics, etc. Some of these centres are modern in construction, well equipped and staffed with specialists as well as assistant medical officers of health. The modern Health Centres are unfortunately in a very small minority. Most centres are held in improvised buildings, understaffed, overcrowded and deficient in up-to-date equipment.

The Maternity in Great Britain Report of 1948 gave a very sorry and depressing description of our present infant welfare centres. It referred to the buildings and their internal arrangement as follows: "The structure of the halls varies greatly. Some are temporary corrugated iron huts, while others are mission halls built of iron and stone. Some local authorities have acquired small halls or temporary huts, or converted residential or shop property for full-time public health use. These premises are by no means ideal."

Apart from the buildings being unattractive in appearance, "the premises now available are not always conveniently sited in relation to local shopping centres, schools and other amenities. For example, one mother could not use the centre because

'taking baby to the clinic wastes a whole shopping afternoon, as the clinic is in a different direction to the shops.' "

The heating in the centre is often unsatisfactory. "The smaller rooms used by the doctor are not always adequately heated; at one Aberdeen centre the doctor could only keep warm by sitting near a lighted gas oven in the 'consulting-room,' a small kitchen behind the hall. Several of the mothers refused to go to the centres because they said it was too cold there." Many halls are as unattractive inside as outside. "The caretaker is usually responsible for cleaning the hall, and standards vary greatly. Many of the church halls are badly lighted, and the paintwork is often dark, giving the rooms a dingy appearance. There is usually a cold-water tap somewhere on the premises, often in a back kitchen where water can be boiled and instruments sterilised."

The clinics are often held at awkward times. The report referred to the fact that "some mothers complained of inconvenient hours." The clinics are frequently grossly overcrowded and understaffed. "In urban areas visited, attendance of seventy mothers at each two-hour session were common, and occasionally more than a hundred attended. Only a very few minutes could be devoted to each child when such large numbers had to be dealt with, and many mothers were therefore unwilling to attend. Appointment systems were not usually in operation, and mothers tend to come at the beginning of the session in the hope of having their babies weighed and examined early. As a result many waited with their babies for as much as one hour, and sometimes longer if a doctor's consultation was also required. Some mothers would not use the centres because of the waiting involved, e.g. one woman complained bitterly that 'mothers are kept waiting too long at a session and are herded together like cattle.' "

The Report on the British Health Services by P.E.P. (Political and Economic Planning, 1936) made the following comments on the infant welfare centres: "There is no doubt that some infant welfare centres are doing very good work, but that in some cases the doctors do not possess the necessary specialised knowledge. Inadequate facilities for treatment outside, and the reluctance of the mothers to consult the family doctor, also impede the work of the centres, while the overcrowding at many of them means that the medical examination may be largely perfunctory and

the health visitors are often too harassed to give the necessary individual attention."

The voluntary centres are, if anything, more unsatisfactory than the municipal centres. The 1948 report said: "Welfare centres run by voluntary committees suffer from serious faults. The committees receive a substantial grant from the local authority . . . the health department provides freely the services of the doctors and the health visitors for consultations. But the organisation of all other activities is entirely at the discretion of the voluntary committee, which sometimes organises an extensive business for the sale of proprietary foods, clothing, and medicines, and the building up of a large bank balance seems to become the main object of the centre. Municipal health officers believe that educational and supervisory functions are often ignored, the work of the doctor and health visitor is minimised, and the centres become little more than 'shops.' "

In these circumstances it is not surprising that the report referred to the failure of the centres to perform efficiently their important work of education: "Infant welfare centres have always been officially regarded as 'primarily educational institutions.' But the educational and advisory work which can be done there is limited by the inconvenience of makeshift premises and by staff shortages."

There can be no marked improvement in the education of the mother in the unsatisfactory infant welfare centres of to-day. The extension of facilities for the education and training of the mother can only take place in efficient, well-organised centres. In this respect the building of comprehensive health centres is fundamental to the success of the services. The comprehensive health centres can also make a big contribution in helping to bring together and co-ordinate the services which deal with the treatment of the sick child. At present the treatment of the sick child is completely divorced from the preventive services.

The main weaknesses in the services for treatment of the sick child are lack of co-ordination between the various agencies providing treatment, lack of sufficient skilled home nurses to attend to minor and major maladies of infants in the home, and, finally, the fact that, although there is a shortage of skilled medical personnel, those available are not distributed according to the medical needs of the children.

The main emphasis in the prevention and treatment of

illnesses in children of this-age group must be laid on the improvement of social conditions, the building of new health centres, the extension of nursing facilities in the home and the organisation of priority admissions to hospital. These priorities should be arranged on medical grounds, and on social grounds where there are difficulties and dangers of treating the child at home.

(iii) 2–5 Years

The mortality rate in this age-group is comparatively low. The rate has fallen considerably in the last fifty years largely as a result of the marked decrease in the number of deaths from respiratory and infectious diseases. In this respect the improvements in social conditions have played an important part. Nevertheless, medical supervision of the group is necessary to detect and treat abnormalities and illnesses at an early stage and thus avoid serious disabilities and disorders in the future.

The child in this age-group is known as the pre-school child. An examination of 3,000 children between the ages of two and six years showed that approximately three out of ten suffered from some disability which required treatment. These disabilities included chronic catarrh, bronchitis, heart trouble, rheumatism, anæmia and ear discharges. Seven out of ten children required dental treatment. Medical supervision is therefore essential to detect and deal with ailments early, otherwise the child will reach school with well-developed physical or mental abnormalities which are much more resistant to treatment.

We may agree or disagree with the psychologists and Jesuits, who say that the experiences of the first few years of the child's life determine the pattern and character of the remainder of his life. There is, however, general agreement on the fact that failure to preserve a sound physical and mental constitution will render the child incapable of serving a full and interesting life as a useful citizen when he grows up.

The child during this period is still growing rather rapidly and is therefore still sensitive and very susceptible to the effects of even mild illnesses or malnutrition. Considerable damage can thus be caused by undetected or untreated minor illnesses or unrecognised developing abnormalities, with a consequent increased expenditure of time and money later on when the more marked disabilities are discovered. A joint circular issued

by the Board of Education and the Ministry of Health in 1929 recognised this fact. It reported that hundreds of thousands of children before reaching school age "have no help, direction or succour from public sources however much they need it." The view was expressed that "it is grossly uneconomic to allow the health and stamina of infants to deteriorate till five years old and then to spend large sums of money in trying to cure them between the ages of five and fifteen."

A new cause of disabilities and deaths arises as an important factor in this age-group. This is the adventurous stage in the life of the child. As a toddler his territory for exploration is considerably widened, with a marked increase in the types of danger he can encounter. As a result, accidents cause the largest percentage of deaths at this stage and their consideration is essential in any plan for reduction in deaths and disabilities.

The problem of the care of the child in this age-group resolves itself into two parts. Firstly, prevention of illnesses, accidents and infections and secondly, treatment of the ravages of these misfortunes.

There are two complementary methods of organising the medical supervision of this age-group. The first method is a continuation of the medical supervision of the baby, i.e. home visits by health visitors and attendance at the health centres by the mothers. The second method is similar to the system of medical supervision of the old school child; i.e. organised medical supervision of groups of children in day nurseries and nursery schools. This is supplemented by observation and treatment in clinics at health centres. The architects of a comprehensive child health service should concentrate their efforts on the second method, by which attention to education and training can be focused directly on the child.

The role of the mother is still very important, but by this time she should have acquired a considerable fund of knowledge in the care and management of the child. The emphasis on education and training begins to shift logically to the child. The child now reaches the stage where he can consciously derive benefit from training. He can also acquire useful habits in the practice of hygiene and learn that in addition to being a free individual he is also a young budding social being. It is for these reasons that living and playing with other children in a pleasant atmosphere, with expert training, supervision and

affection, is preferable to any individual training or supervision.

The supervision of children as individuals in the infant welfare clinic is not very satisfactory. The infant welfare clinics are overcrowded and understaffed, and therefore the young babies receive most of the limited attention available.

Officially, it is assumed that the mother in rearing the baby acquires sufficient knowledge to be proficient in the care of the infant. Less attention, therefore, is paid to this age-group in the infant welfare centres. The mothers are encouraged to lengthen the intervals between their visits to the centres and the health visitor pays fewer visits to the homes. As the 1937 P.E.P. Report remarked, "many of the centres are so fully occupied attending to the babies that they have no time to deal with the older infants. Also many mothers cease to think it necessary to take their children after they are one year old. This conviction is strengthened by the fact that the difficulty of carrying them to the centre then becomes noticeable."

The medical supervision of these children expands with the extension of the provision of day nurseries and nursery schools. The Ministry of Health has the responsibility of the establishment and administration of day nurseries, and the Ministry of Education is responsible for the nursery schools. Although both these institutions concern themselves with the health and the education of the child, the day nursery tends to lay the emphasis on health and the nursery school has a bias towards education. The main difference, however, lies in the fact that the day nursery cares for the children for a longer period in the day and accepts children under the age of two years. It thus fulfils one of its main original functions: the release of the mother from some of her home duties to enable her to enter factory or other employment.

The nurseries serve very useful purposes in respect of the child—in his feeding, education, recreation and medical supervision. The child is served with three wholesome meals a day, together with vitamin supplements, which thus help to prevent malnutrition. He is trained to acquire useful hygienic habits, cleanliness of body, adequate rest and sleep, and civilised methods of feeding and recreation, so that any general or mental disturbances are combated. He is allowed to use his initiative in organised games both indoors and outdoors, which, together with planned excursions, compensates for overcrowding in the

home. Finally, the nurseries are visited regularly by doctors and health visitors so that any deviation from the normal can be detected and rectified as soon as possible.

The first nursery school was founded by Robert Owen in Lanark in 1816: "All the children above one year old were, if the parents were willing, to be sent to school." The Government favours the establishment of nursery schools rather than day nurseries. A consultative committee of the Board of Education reported on this matter and said: (*a*) that the proper place for a child aged three to five years was at home with his mother, provided the home conditions were satisfactory; (*b*) that the home surroundings of large numbers of children were not satisfactory; and (*c*) that the best place for such children is a nursery school.

The Government has had many opportunities for carrying out the committee's recommendations, for this report was issued in 1908. In 1939, 123 years after the Lanark experiment and thirty-one years after the Board of Education's report, there were still many districts where "the home surroundings of large numbers of children were not satisfactory." The Government had provided "the best place" for these children, a total of 8,000 places (in 110 nursery schools) for a pre-school population of 1¾ millions.

The nursery schools' premises and equipment do not always reach a high standard. The Central Advisory Council for Education, in their booklet *School and Life* (1947), referred to the accommodation of the child in school as follows: "The schools that the little ones attend are too often housed in old buildings with high-up windows, bad ventilation and scarcely any playground.

"Cloakroom and sanitary arrangements are out-of-date, and sometimes the schools, especially those in crowded areas, are large, and the nursery classes seem lost in them. Much idealism and humanitarian sentiment is bestowed on little children; but let anyone look at the schools in which infants and still younger children are brought up, in urban and rural areas alike, and they will find much to disturb them."

The provision of day nurseries fared little better. Before the Second World War in 1939, there were 104 day nurseries (eighty-three organised by voluntary bodies) with accommodation for 4,291 children. A large industrial city like Birmingham

had no day nursery before the war. The standards in many of the day nurseries was low because the voluntary organisations had financial difficulties. The Government, with the aid of voluntary efforts over a period of nearly fifty years, succeeded in providing for children (aged four weeks to five years) the sum total of 12,000 places for a child population of 2 million—one place for approximately every 200 children.

The Government's policy of providing accommodation only for those children whose environmental conditions are unsatisfactory is not universally accepted. There is a large body of opinion which holds the point of view that the provision of nursery schools and day nurseries should be extended to all children, because they have valuable social and educational functions to fulfil. One criticism of this approach has been that the child's absence from home for a portion of the day would break up family life and in addition would encourage the parents to throw the responsibility of the children upon other shoulders. Practice has proved the opposite. There is a marked relief from stresses and strains in overcrowded families or where there is a self-centred only child. This has had an effect in harmonising family relations and in strengthening family bonds. In many instances, parents who had a tendency to neglect their children took a new interest in them when they attended a day nursery or school.

The Government's policy with regard to the provision of day nurseries is given in some detail, for many lessons can be learned from it. The policy is an example of the predominant influence of political considerations made with a complete disregard of the real needs of the people.

During the war there was a considerable expansion in the provision of day and residential nurseries, both to encourage mothers to enter industry and to care for children in evacuation areas. As there were large numbers of men in the Forces, there was a shortage of manpower. It became essential to attract women into industry in order to maintain and expand production. Day nurseries were therefore established to relieve the mothers of some of their responsibilities in the home. It is unusual for the Government to extend social service during a war, although in order to sustain the morale of the people it is often the occasion for promises of future improvements in social services. In this instance, practical considerations in waging the

war of production were the main factors. The main concern of the Government was the increase in production, not the long-overdue increase in facilities for the child aged four weeks to five years. The Government paid the full cost of these nurseries. Within a very short period the number of day nurseries increased more than tenfold. The peak was reached in 1944, when there were 1,555 day nurseries (compared with 104 in 1939) accommodating 72,120 children, with additional provision for 13,000 in 400 residential nurseries.

The war ended in 1945 but the social need for day nurseries was enhanced. Bombing had destroyed many houses. Many more had become slums during the war because, owing to the shortage of building materials and labour, no repairs had been executed. Day nurseries could give the children in these homes some relief from their adverse home surroundings. In addition, in the post-war period of food rationing and queueing, day nurseries could provide the children with the necessary additional wholesome food and relieve the mother of the heavy responsibility of looking after young children all day. There were many mothers in the community who urgently needed a day nursery to care for their children during the day, so that they could go out to work—mothers with illegitimate children, widows, separated wives, and those who, because of the illness of the father, had had the burden of the breadwinner shifted to them.

Unfortunately, these matters were not taken into consideration. The Government, with the prospective return of the men from the Forces, feared the onset of unemployment. Their policy was therefore to encourage the mothers to return to their homes and thus leave jobs vacant for their returning men-folk. Propaganda was used to suggest that day nurseries spread infection and that the best place for the child was in the home.

More practical steps were taken to discourage day nurseries, despite the fact that they had helped in winning the war. Almost immediately the war was over, the Government gave the local authorities warning that the 100 per cent. grant for day nurseries would be withdrawn and the responsibility of half the cost would pass to the local authorities. The reaction of the local authorities was to close many nurseries. At the beginning of 1946 the number had already been reduced to 1,358, but by the end of the year only 915 remained open. One hundred and

sixty-seven were permanently closed and the remainder were converted into nursery classes or schools. Residential nurseries were drastically reduced from 400 to twenty-eight. The Government adopted a policy of reducing the number of day nurseries at a time when a policy of expansion was necessary. The criticism and outcry from the public was met by the local authorities by putting the blame on the Ministry of Health for withdrawing the full subsidy, while the Ministry blamed the local authorities for their lack of initiative.

In the meantime, the war crisis was followed by the peace crisis. The number of men in the armed forces far exceeded the 1939 figures and therefore the drive for export production required the further recruitment of women into industry. The factory-owners were faced with a shortage of manpower and a prospect of no assistance from the local authorities.

In some districts the numbers on the waiting lists for day nursery admission rose to 1,000, whilst the authorities continued their policy of closing existing nurseries. The employers therefore began to open day nurseries attached to the factories. Their main object was to recruit mothers into industry; the care of the children was a secondary consideration. They had little technical assistance and their arrangements for training the children and for their medical supervision were very primitive.

The annual report of the Chief Medical Officer of the Ministry of Health in 1946 referred to the conditions in some of these nurseries as "being far from satisfactory." There was even harsher criticism in the House of Commons. Members of Parliament referred to "cases of bad overcrowding . . . premises deficient in ventilation or sanitary accommodation . . . staff completely untrained and unsuited for the work." In the north-west region alone there were over 100 day nurseries established by the employers—more than the whole country possessed before the war.

In the factory day nurseries the production motive is predominant. The child is often discharged when the mother is off sick and, from a welfare point of view, most in need of the kind of help given by a day nursery. There is a distinct place in child welfare for the factory day nursery. There is probably an advantage in the proximity of an efficient day nursery to a factory, for it stimulates the formation of a social community of mothers.

burden which is involved in the support of untrained children for the rest of their lives.

We have already seen how the school medical service emerged from the Report of the Inter-departmental Committee on Physical Deterioration in 1904, following the Boer War. The Committee produced evidence to show that there was a marked degree of physical unfitness in large sections of the population. They concluded that "there is need of a much more complete system of medical inspection in schools than has yet been attempted." This Committee, together with the Inter-departmental Committee on Medical Inspection and Feeding of Children attending Elementary Schools (1905), recommended a general system of medical inspection and supervision with the power to provide medical treatment and school feeding. The main declared object was to make the health of the child such that he could profit by the instruction provided for him in a public elementary school.

The Education (Administrative Provisions) Act of 1907 placed a new responsibility on the shoulders of the local authorities. They were given the power to arrange medical inspections and to supervise schoolchildren. Dr. George Newman, Chief Medical Officer of the Board of Education (1907–35) commented on one of the effects of this duty as follows: it "opened a vista of reform, not to say revolution, which filled the mind of the ratepayer with something akin to alarm." The new system of inspection and supervision soon met insuperable obstacles. After the medical inspection, the affected child was referred to the general practitioner or the hospital. The parents in many cases could not afford the doctor's fees, and the number who required treatment far exceeded the general practitioners' capacity of dealing with them.

The local authorities were therefore compelled to provide their own treatment for many of the disabilities, such as defects of vision, dental decay, infected tonsils and adenoids, discharging ears and malnutrition. The school clinic was developed in order to deal with such of these conditions as remained untreated and were affecting the child's schooling.

The present-day school medical service lacks the facilities, staff, equipment and opportunities which are required for work of a high standard. In some of the schools suitable rooms, properly warmed and lighted and with adequate equipment,

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The factory-owner has answered the criticism of those who maintain that the staffs of day nurseries absorb more women from industry than they supply to the factories. In spite of the absorption of a number of young girls and women into the staffs of the day nurseries, the employer considers he gains heavily on balance, especially if he can obtain skilled labour. In such cases the employer will, contrary to the general practice, accept two or even three children into the day nursery rather than lose the labour of one mother who is a skilled operator.

The Government answered the criticism of the unsatisfactory factory and private day nurseries, but not with the obvious action of providing more standard day nurseries to satisfy the enormous demand. Instead, they passed the Nurseries and Child Minders Regulation Act, 1948, to overcome some of the abuses in these day nurseries. This long-overdue Act was essential to regulate the day nurseries, which were springing up like mushrooms. It applies especially to some of the private day nurseries, whose main purpose was to make a profit. It was particularly in these that the premises were unsuitable, the staff inadequate and the medical supervision non-existent. The Act, however, only touched the fringe of this important problem. The Government should assist the employers to improve their day nursery premises and to recruit an adequate number of suitably trained staff. The only satisfactory solution is the further provision of day nurseries of a standard approved by the local authorities, subsidised, if necessary, by a special financial charge on the factories in the area served.

There are many lessons to be learned from the Government's attitude to the provision of day nurseries. Regarding them as a social service which appears rather expensive, official quarters in normal times have never shown any great enthusiasm for them. There has always appeared to be a hard core of resistance, for the well-to-do overlooked the eventual financial saving on illnesses, disabilities and delinquents. In a typically short-sighted fashion, they saw only the immediate expenditure and resisted the present financial burden, which they assumed was theirs only.

The well-to-do have the facilities of the day nursery or nursery school in their own homes. Their homes do not lack the material for training in hygienic habits. Their homes are equipped with bathrooms, airy playrooms and gardens, with adequate dining

are made available for the doctor and nurse for medical inspections. In most of the schools, however, the facilities are very primitive. An improvised classroom is often used for this purpose. This frequently causes antagonism between the teaching and medical staff, as it encroaches on the already sorely-tried accommodation of the school. There is almost invariably an absence of hot water, adequate heating arrangements or any provision for special medical examinations. The doctor often has to work behind screens in the same room as the nurse, who at the same time is testing the children's vision or asking the parents questions concerning their children's medical history.

There is rarely adequate accommodation for waiting parents and, apart from a letter advising them of the appointment, little effort is made to encourage parents to attend. In the older age-groups the number who do so is very small. The children are generally examined only four times in their school career, at the ages of five, eight, eleven and fifteen.

The doctor at the inspection usually does not know either the child or the parents, and very few medical officers maintain close contact with the health visitors, teachers and parents of particular schools. The examinations are usually very hurried, taking on an average five to eight minutes, and are therefore not very thorough.

The school medical officer has little or no contact with the pediatric and hospital services, and therefore he has had little opportunity to keep abreast of new developments in the diagnosis and treatment of many of the defects in children with which he is directly concerned. He is rarely a genuine health adviser to the school, for he does not know all the children and teachers, the school's organisation, its defects in building, lighting and heating, its meals service, its desks and equipment, its sanitation and hygiene, and the opportunities it offers for sport, leisure and future employment. In these circumstances, it is impossible to maintain a close and adequate supervision of the health of schoolchildren. It is impossible by these meagre inspections alone to detect every ailing child and all the children with incipient defects.

The National Union of Teachers, in their booklet on the review of *The School Health Services* (October, 1938) referred to the inadequate school medical inspection service in the following words: "The lack of accommodation for medical inspection and

the following after-care work of the health visitors in the schools is a serious menace both to the efficacy of the work of the doctors in the primary schools and to the health of the teachers and children alike." Almost every year at their annual conferences they made the recommendation: that "medical inspection rooms, with necessary equipment, should be provided instead of teachers' rooms being used for medical inspection purposes."

The health education of the child suffers from the same disadvantages as the welfare education of the mother. It is difficult to teach the practice of hygiene in unhygienic surroundings. The Chief Medical Officer of the Ministry of Education, in his report (1939–45), referred to this point in the following words: "In many infant schools health education is made difficult by premises being dingy, insanitary and long out of date—premises where there is not a quickly accessible water supply, where the lavatory, closet and cloakroom facilities are inadequate, where the classrooms have insufficient natural lighting and poor ventilation and where, the site being in a densely populated urban area, there is no possibility of even a small plot of ground for a garden. Even in rural areas some schools are without gardens. As in the towns, so, too, in the country, school premises are often much below modern standards of hygiene. Many small rural schools, of course, have no separate infant department."

He made the following recommendations: "In every area in the country there is a need for new schools to meet advancing educational requirements and to replace old, and often long out-worn, existing buildings. There is need, too, for the modernising of many school buildings that are much below present standards of hygiene. And there is an equal need for modern furniture both for new schools and for replacing out-of-date equipment in existing schools."

The Central Advisory Council for Education in 1947 referred to the defects of teaching hygiene in schools as follows: " Schools that are overcrowded, poorly ventilated, dimly lit and without washing facilities, up-to-date sanitary arrangements, dining-halls, gymnasia or adequate space for outdoor recreation, wherever they remain, do not teach children by example that the basis of health is organised living, with attention to cleanliness of the body, clothing and surroundings. Poor conditions in the school suggest rather that the way of living seen by many in their own homes is the better way."

School feeding in the period 1914–38 has already been described. The Second World War at first dealt a serious blow to the snail-like progress in school feeding. As the war progressed, the Government was faced with the problems of feeding evacuee children and the general population in the difficult periods of bombing. It was essential to extend facilities for communal feeding in order to maintain the morale of the population and relieve the housewife of some of her household burdens. This was especially the case with regard to housewives who were recruited into industry.

The Government raised the grants to the local authorities for "communal feeding arrangements for children whose needs are not fully met by the normal provision of food at their homes." The arrangements were to be regarded "as a nucleus which could, if necessary, be expanded if circumstances should arise, in which the normal distribution becomes difficult and impracticable." Once the Government began to extend the school canteens to provide for all children, the "Poor Law" stigma had to be removed from school feeding. At the beginning of the war only one child in forty was being fed in the schools. By the end of the war one child in three was having school meals, an increase of 1,250 per cent.

The meals are not elaborate and are not always of a high standard. A common custom has developed for the meals to be cooked at a central kitchen and then transported in hot containers to the various schools. This method of preparation destroys the vitamins in the food and reduces the palatability of the meals. In the same war period there was an increase of approximately 50 per cent. in the number of children who were supplied with milk in the schools.

The Government's policy to-day is to provide school meals free of charge as part of the plan for family allowances. Milk has been supplied free since August, 1946. The Government originally intended waiving the charges for school meals in 1946. They deferred action on this matter, however, until the facilities for the supply of meals to all schoolchildren have been completed. The grounds for this decision appear to be that if meals were declared free at a time when only part of the school population could be catered for, the parents of the children who could not obtain school meals might claim compensation. This problem could be solved by giving special priority for the provision

of canteen equipment to schools over hotels and restaurants.

There are many difficulties in the present school medical treatment service. There are three main channels for obtaining medical treatment—the local authority, the general practitioner and the hospital services. The local authorities who organised treatment for some of the defects often included treatment for minor ailments, ear discharges, dental caries, tonsillar infection and defects of vision. The facilities for treatment vary from authority to authority. Some have modern up-to-date clinics with adequate staff and equipment. These clinics make provision for the treatment of a wide variety of complaints, including all those mentioned above plus speech and orthopædic defects, and clinics for ultra-violet light, rheumatism, nutrition and child guidance. Many authorities, however, have very few facilities for treatment, which is therefore restricted to minor ailments and defects of eyes, ears and teeth. The only clinics which were extended during the war were the Child Guidance Clinics, and this was because of the marked increase in child delinquency due to the break-up of family life and the unsettling conditions of war. By the end of 1945 there were 115 child guidance clinics, an increase of more than 150 per cent.

Many of the local authority school clinics are housed in unsuitable premises with inadequate equipment and staff. Their main disadvantage is their general isolation from the general practitioner and hospital services.

The British Medical Association's Interim Report on Health Centres (1948) referred to the clinics as follows: "[The clinics] have no organised contact with the general practitioner and their work overlaps with his considerably." The report gave reasons for the isolation of the general practitioner: "In many cases co-operation was prevented by a definite antagonism between the general practitioners and the clinics, which they regarded as encroachments on their preserves. It must be said, though, that many practitioners made no attempt to provide what they resented others providing in their place."

The general practitioner service will be described in detail in the next section, but we can note here one of its most serious weaknesses, the treatment of children. Most parents could not afford to pay the doctor's fee, and when the mother was referred by the "clinic" doctor to the "family" doctor, she usually went to the chemist's shop and bought proprietary drugs. In some

cases treatment was delayed and serious complications set it. It was rare for the school doctor to give the general practitioner details of the child's school medical history, and it was almost unknown for the general practitioner to inform the school doctor of the child's treatment at home. The general practitioner, who should be the first line of attack in the diagnosis and treatment of illnesses, had practically no contact with the school medical service, the school environment or the educational problems of the child.

If the child was treated in a hospital, there was little co-ordination of the services and little or no co-operation with the medical personnel outside the hospital. The specialist in the hospital concentrates largely on the sick child, and neither he nor the family doctor has much experience of the normal child or the educational needs of the handicapped child. Generally speaking, in the large towns there is an adequate number of beds for children with acute illnesses. In many parts of the country, however, there is an acute shortage of children's beds and specialists. In many cases children with long illnesses suffer from lack of education, and there are far too few hospital schools or other facilities for dealing with them. The major deficiency, however, is in the treatment of the child in the home. There is an acute shortage of home nurses for this skilled task and there is no organised consultant service for home treatment.

Children who are referred for treatment by the school doctor or the school clinic are followed up by health visitors, and in London by voluntary workers. The important work of follow-up could be improved if the teachers and parents were encouraged to take a greater interest in the medical aspects of schooling.

(*v*) *The Handicapped Child*

Under the Education Act, 1944, local authorities have the duty of ascertaining and making provision for the care of all handicapped children in their area. Arrangements must be made so that the children can receive education suited to their age, ability and aptitude. Owing to the heavy expenditure involved in providing for these children, authorities in the past have co-operated in the organisation of special schools. Children with serious disabilities are thus catered for, while those with milder disabilities can be educated in ordinary schools, provided suitable arrangements are made.

Handicapped children are divided into several categories. These include the blind, the deaf, the educationally subnormal, and delicate pupils, etc. The famous cases of Laura Bridgeman and Helen Keller, who were blind deaf-mutes, are illustrations of the results which can be attained with efficient education. Helen Keller learned to speak at ten years of age and became a scholar and a university graduate. Not all handicapped children have the same potentialities as she, but there are thousands to-day who are not being educated or trained to their full capacity.

The largest number of children fall into the categories of the educationally subnormal and the "delicate." It is in these two groups that there is the most serious shortage of places for special educational treatment. The educationally subnormal were previously known as the "mentally defective." Many children who are educationally subnormal are not ascertained, as there is little provision for them in special schools and the waiting time for admission is in many cases two years. The special schools for the educationally subnormal should cater for children who can be trained to earn their own living.

Owing to the lack of residential schools and the inadequate provision for the mentally defective, many children who are not capable of being trained are placed in the special day schools. There is no alternative at present for dealing with many of these cases. At the same time, many retarded children who could be dealt with in the normal schools cannot receive adequate education and special training because the classes are too big and the teachers too few. Even the inadequate provision of day schools is therefore not utilised to the fullest advantage.

Dr. E. O. Lewis, in his investigations for the Wood Report in 1929, estimated that there were 35,000 educationally subnormal children in the country. In 1945 the accommodation for educationally subnormal children who required residential care was estimated by the Ministry of Education as "hardly exceeding 3,000 places in the future." Together with the 15,000 places in day schools, the supply of places barely covers half the actual demand.

The Curtis Report of 1946 on Care of Children described some of the homes for educable mentally subnormal children: "The whole 'school' [a voluntary home] of twenty or thirty

children was crowded into one comparatively small room, seated round a table. . . . Some of them were occupied with a few toys, but most of them were just passing the time in general hubbub. . . . A local authority home for fourteen educable mentally deficient children seemed unnecessarily cramped in its accommodation. The living-rooms were few and dark, the bedrooms rather better, the kitchen dark and neglected, with ragged oilcloth on the table. There was only one bath for fourteen boys in a home in which the frequency of bathing is obviously desirable. There was no sign of comfort, little decoration and no pictures in the playroom."

There is a great need for residential hostels for the new category of "maladjusted children," for there has been a considerable increase in their numbers during and since the war. As many of these children are potentially delinquent, their supervision and training become an urgent necessity. The Ministry of Education, in the same circular which dealt with educationally subnormal children, referred to 150 places for maladjusted children for the whole country.

There are ten groups of children in the category of the "delicate" child, ranging from the convalescent and the nervous and highly strung to those with tuberculosis of the glands of the neck and certain types of cripple. There are thousands of children who require the benefits of education in an open-air residential school, but there are less than 5,000 places for them in such schools. The Chief Medical Officer to the Board of Education, in his annual report of 1947, said: "There is great need for more open-air school accommodation, particularly of the residential type in the Midlands and North."

The Curtis Report described one of the children's sanatorium schools as follows: "We found the twenty-two children housed in decayed wooden huts which had been condemned before the war. The sanatorium and the conditions prevailing in it at the time of our visit was no less than shocking. It had been virtually uninspected for years. . . . The [medical] report made in 1943 stated that the accommodation had been twice condemned: it was described as 'rat-ridden and unsafe.' . . . The heating provided (a central stove in a large ward) and the lighting (which shone from the centre into the eyes of the children in their beds) were altogether out of date. There were holes in the floor boards, the decoration was dreary and the surrounding

overgrown vegetation depressing. . . . The children seemed to have few toys and little or no materials for play or handwork; they were bored and listless. It was clear to us that the nursing staff and the teacher were struggling with almost impossible conditions."

It is estimated that more than half the partially-sighted children are unascertained and there is insufficient provision for those who are known to be partially-sighted. Although the blind child is easier to discover, the National Institute of the Blind could comment in 1945 on the inadequate facilities for the ascertainment of the blind in the following words: "That 12 per cent. of the physically and mentally sound blind children of this country can slip through the meshes of an educational net now more than a century old needs more explanation than the rather too facile one of 'wartime conditions.' "

The same dearth of accommodation affects the deaf, the crippled, the epileptic and children with rheumatism or heart disease, etc.

Over half the residential accommodation for these groups of children is provided by voluntary organisations. As many as eighty voluntary societies deal with the deaf and dumb. The voluntary organisations receive payments from the local authorities in addition to the income they receive from appeals and bequests. The Curtis Report described two voluntary institutions for deaf and dumb children as follows: "Both these institutions were large and barrack-like in appearance and old-fashioned in furnishings, though both were set in beautiful grounds. The rooms at the first were very comfortless and bare, with forms for seats and little in the way of decoration. . . . We regretted that this group of children, already so isolated from other children and from the world, could not be housed in more modern buildings with a more homelike and comfortable appearance."

The Curtis Report illustrated the lack of educational provisions for crippled children in orthopædic hospitals in these words: "We called at about four o'clock in the afternoon. The children were lying on their beds, mostly awake. One or two had picture books or dolls, but others had nothing and looked bored. A young nurse was in charge and did not seem much interested in discussing the welfare or occupation of the children. It seemed that these children had little of occupational or social interest

after the teacher left at three o'clock in the afternoon, though most of them appeared well enough to need this."

A study of the provisions for handicapped children proves them to be woefully inadequate both in numbers and in quality. The contribution made to war production by the crippled and the mentally subnormal demonstrated that handicapped children can become useful members of society if they are given adequate training, supervision and protection.

The schools and workshops at the orthopædic hospital at Stanmore, Middlesex, succeeded in training crippled children with severe deformities for various useful jobs, e.g. upholstery, watch-making, shoe-repairing, etc. A period of manpower shortage clearly revealed the vast potentialities and capabilities of handicapped children. This experience and knowledge should not be lost. There could be a considerable extension of the facilities for the training, care and supervision of all handicapped children. Expenditure on their training and supervision to-day will repay handsome dividends in the future.

(vi) The Future of the School Medical Service

The future development of the school health service is governed by two Acts, the Education Act of 1944 and the National Health Service Act of 1946. The Education Act of 1944 extended the scope of the school medical service to cover all children in primary and secondary schools. Previously the local authorities had the option, which they need not have exercised, of extending treatment facilities to children in secondary schools. When county colleges are established for young people for part-time education after leaving school, the school health service will be responsible for their care and supervision. This will be a considerable advance in the provision of preventive health services, for the adolescent has not had the advantages of regular medical inspection and advice in the past. Eventually all medical treatment will be provided through the comprehensive National Health Service, which will be organised under the provisions of the 1946 Health Act. Until this stage is reached, the education authorities will remain responsible for their present health services and may even be required to extend them.

As with the other services, the well-to-do have a different kind of service from that which we have described. The Central

Advisory Council in its booklet, *School for Life* (1947), referred to this in the following way. After describing the unsatisfactory conditions in the elementary schools the report said: "To put all this right will be a costly business, but we shall not get good citizenship at the school-leaving age *if in the early stages of education we deny the children in these schools the advantages which the more privileged children accept as a natural state of things.* Parents who sent their children to private schools are often accused of snobbery, but it seems to us doubtful whether this is the only, or even the predominant, motive. When the conditions under which public education is given are unwholesome, parents who can afford it naturally seek an alternative."

There are still too many differences in the provisions for public and private education. There were similar differences in the measures adopted for medical treatment—differences which have not yet been removed. The sick child of the well-to-do could always have the services of a doctor, a specialist or a skilled nurse. If he required hospital treatment, admission to a nursing home or a private ward could be readily arranged, irrespective of the severity of the illness or defect.

In the general consideration of the health of the child to-day there is a tendency, especially marked in public health circles, to make a comparison with the past and point with complete satisfaction to a considerable improvement. Some medical officers of health have even suggested that we are now reaching the peak of the potential improvement in child welfare and that the public health services should direct their attention almost entirely to the ills and disabilities of old age. While it is necessary to make comparisons with the past, it must be realised that with the modern advances in the science of medicine our standards of health have risen. If the health of the child population to-day is matched against these new standards, a large proportion will be found to be in need of additional medical care and attention.

The Central Advisory Council in 1947 made the following remarks on this subject: "The gain [in health] has certainly been considerable; but it must be realised that standards change, and that, in terms of positive health, the health and physique of children to-day is quite as far removed from the present ideal as the state of affairs in the last century was from that of to-day." We can only greet the future of child health with optimism if

we strive *now* to improve the health services for the care of the child.

A short-term policy for the improvement of the school medical service can be planned, involving no new additional buildings in the first instance. The linking of the curative with the preventive services would immediately enhance the general standards of school medical work. The general practitioner could be encouraged to take an interest in school life and health, and could then work closely with the school medical officers. The specialist could visit the special schools for handicapped children and assist and instruct the school medical officers in dealing with the medical problems of the children. At the same time, he could obtain an insight into educational problems. He could also assist the school medical officer in the school clinic, whilst the school medical officer could assist him in the hospital. The school medical service could provide health visitors and clerical and administrative staff who could assist in the co-ordination of the various services.

The long-term policy must include a considerable increase in the recruitment of medical staff. There is particularly a shortage of child specialists, mainly due to the fact that in the past there was not enough work to support financially a sufficient number of child specialists. The medical need for specialists is still present. There are thousands of children requiring skilled care and attention who are not receiving it.

There has been an insufficient number of well-to-do who required the services of a child specialist, and therefore the supply of child specialists in the country is small and inadequate. Special financial encouragement and attractive posts will have to be organised for doctors entering the child health services in order to redress the balance among the specialists. The long-term programme must include the building of health centres, new school buildings and the renovation of the old, insanitary schools.

Unfortunately, economy cuts in capital expenditure seriously affect this essential policy. It is well to recall the experiences of the last post-war period in 1920–1, when economy cuts crippled the development of the social services for a whole generation, a blow from which we have not yet recovered. The Central Advisory Council (1947) referred to the effects of Government retrenchment on expenditure in the following words: "Between

the wars, whenever there was an economic crisis, education suffered through *lack of popular support*; it is essential that interest in the work of the schools should be stimulated, *so that people do at least know what damage is done when cuts are suddenly imposed. . . .* Our evidence shows also that *popular apathy* has not only acted as a brake upon carrying out what the Acts laid down, but has helped to make education an easy target for economy drives. The Association of Directors and Secretaries for Education says that the delay in carrying out the Fisher Act programmes began with the depression after the First World War and was intensified by the effects of the Geddes axe and the economies demanded as a result of the financial crisis of 1930–1.

"Apart from schools for new housing estates, little building work was undertaken until the ban on building was lifted in 1936. The purchase of many projected sites had also to be abandoned. Development plans are being prepared under the 1944 Act, and it is important to see that they do not suffer a set-back of this kind."

Unfortunately popular apathy has already allowed serious setbacks to be imposed on the development plans in the education services.

Nemesis is overtaking the Government, however. They are faced with an increase of nearly 1 million in the school population as a result of the increase of the birth-rate in recent years. As the circular of the Ministry of Education (Circular 191, December, 1948) said, "authorities will be faced with large building commitments to provide even for the minimum essential needs of children of statutory school age for important developments in technical education."

Popular support for an adequate public educational system must see that these projected large building projects are not restricted to the "*minimum* essential needs of children of statutory school age."

(*vii*) *The Deprived Child*

The real test of a Government's general policy towards the population is its attitude to the most helpless sections of the community. Children deprived of a normal family life are the most vulnerable. Orphans, homeless children, "Poor Law" children and delinquent children—all require special care and attention. They belong to the section of the community which is

least able to voice its needs and demands, and least capable of exerting pressure in the proper quarters to remedy wrongs.

We have already seen how deprived children were treated in the last century. The care of children in workhouses and various types of homes was "one of the worst features of the administration of the Destitution Authorities." The Curtis Report (1946) described the present-day conditions of many of these deprived children (estimated total number, 125,000) in the Public Assistance institutions, the grouped and scattered homes, the foster homes and the special residential and approved schools. There have been improvements in the past fifty years, but they lag far behind the general progress made in child care.

The conditions of children in the workhouses have improved least of all. "Members of the public assistance committees, some of whom had survived as committee members from the old boards of guardians, still held old-fashioned views about what was suitable for a destitute child." These old-fashioned views were mirrored in the institutions provided for these children. "For the most part the children are housed in large gaunt-looking buildings with dark stairways and corridors, high windows and unadapted baths and lavatories . . . traditional chocolate and buff paint, with bare boards and draughts, and a continual smell of mass cooking, soft soap and disinfectant."

Fifty years ago the major criticisms of the workhouses were the inadequate unqualified staff and the "mixed" character of the inmates. Both these factors operate most unfavourably with regard to children. The same criticisms can be levelled to-day against the present-day accommodation of children in public assistance institutions. The Curtis Report referred to the staff problems as follows: "It was clear that in some areas the workhouse served as a dumping ground for children who could not readily be disposed of elsewhere. . . . This caused embarrassment to an already overworked and unsuitable staff. . . . There were some institutions in which, because of shortage of staff, children were being minded by aged inmates and by cleaners, or were simply placed in a ward with senile old men or women to be looked after by the nurse on duty."

The evils of the "mixed" workhouse are being perpetuated to-day, and the Curtis Report gave many examples: "In the same room in which these children [twelve infants up to the age of eighteen months] were being cared for was a Mongol

its effective use. The average general practitioner has no encouragement to spend either the time or the money on the necessary special equipment. His surgery is therefore ill-equipped for anything but the simplest forms of medical attention.

The doctor's waiting-rooms are often unhygienic and overcrowded. The complete mixing of patients with many diseases in unsatisfactory conditions increases the risks of the spread of infection. The doctor rarely has an efficient appointment system, as he has little clerical assistance. In some practices the doctor has no assistance at all. The time of skilled medical men is thus wasted on tasks which could be more efficiently performed by lay staff. The British Medical Association's Report on Health Centres (1948) commented on this matter as follows: "As a rule, there is less help than might usefully be employed with economy of professional time. . . . Some doctors' surgeries are ill-suited to their purpose; few have ideal labour-saving premises or as much secretarial, dispensing and nursing help as they could profitably use."

The older doctor and his patients in particular suffered as a result of these conditions. As the B.M.A. reported: "Many doctors work too much in isolation. . . . It is not infrequently observed that in old age a single-handed doctor has carried on too long, or with too big a list of patients, before retiring or curtailing his work. Frequent indisposition, unfitness for night work, and even failing judgment may then cause his patients to receive bad service."

Because of the various calls on his time, the doctor has very little time to spare for post-graduate studies or for reading medical journals and books to keep abreast with the modern developments in medicines. He therefore becomes resigned to the simple and easily prescribed bottle-of-medicine habit of his patients.

This is the era of the consultant. As new methods and modern aids to diagnosis develop, the specialist finds his field becomes narrower and narrower until we have a specialist in one type of operation only or in the use of one intricate instrument of diagnosis, e.g. the electroencephalograph. The specialist generally receives his introduction to the patient through the general practitioner. The specialist's reputation and popularity depend upon his appointments on the various hospitals' staffs and the spectacular work he performs.

Preventive medicine or medical administration is rarely spectacular. The specialist is therefore encouraged to restrict his activities to a narrow field of medicine, for it is easier to display consummate skill in one particular operation or treatment. This concentration on the obscure, relatively uncommon, diseases is reflected in the training of the medical student and subsequently in his practice as a doctor. These diseases are elevated to the category of the "interesting" illnesses and emphasis is laid on the treatment of established diseases rather than on the methods of preventing illness. Specialisation has therefore developed in an unplanned and unco-ordinated way, with little consideration given to the medical needs of society as a whole.

As specialists' fees were rather high, their private practice was restricted mainly to the well-to-do. This growth in the spectacular diagnosis and treatment of disease has resulted in an exaltation of the role of the specialist in medicine, with a consequent relegation of the general practitioner to the background. The general practitioner is now in the position of certificate- and form-filler, and his most important instrument is now the fountain-pen. Many frustrated general practitioners have migrated into the realm of the specialists, but without the necessary long training and experience.

The origin and development of the local authority clinics have already been described. The general practitioners at first were not interested in these clinics, as they dealt mainly with the poorer sections of the community. Their provisions were extended to other classes, however, and modern methods of preventive medicine were brought, without fee, to wider sections of the community.

The medical attention provided at the clinics was at the same time extended to include advice and treatment for the ailments and disabilities discovered. The general practitioner, however, still remained separate from the organisation of the clinics. He viewed their growth with considerable apprehension, for he feared their encroachment on his practice, especially as the service was free. Although, as the B.M.A. report says "[these clinics] have undoubtedly been the chief and most effective source of health education available to the community," they "have no organised contact with the general practitioner." The doctor who should command the key position in the medical

services was isolated from key medical work, the health education of the people. This lack of co-operation between the clinic doctors and the general practitioners results in an enormous waste of the health workers' time, and occasionally leads to disasters. The B.M.A. report (1948) gave several examples of the dangers of this lack of co-operation, the following being representative:

"(1) A child is found by his schoolteacher to have impetigo and is sent to the education committee's minor ailments clinic for treatment. His mother is due to give birth to another child at home. The family doctor who is attending her knows nothing of this source of septic infection in the house, and no special precautions are taken to prevent contact, with the result that the mother runs a risk of contracting puerperal fever.

"(2) The clinic medical officers do no home visiting. Therefore if a patient (adult, child or infant) attending a clinic needs medical attention between sessions or becomes unfit to go outdoors, it is necessary to call in the general practitioner and 'swap horses in mid-stream.' An actual case is that of a child who was treated at a school clinic for some days for a gastro-intestinal upset with a medicine containing full doses of belladonna. While under treatment, she became more severely ill during the night, and a general practitioner was sent for. He also supplied a medicine which contained belladonna, not knowing that the child was already taking this drug. Next day the child was found to be suffering from belladonna poisoning and had to be admitted to hospital."

The most marked contrast in the treatment of sections of the community was in the medical attention provided for the destitute poor. These comprised quite a large section of the population. The number of men, women and children in receipt of poor relief at January 1st, 1948, was almost half a million (469,556), according to the final return of the Ministry of Health, before "the final remnants of the Poor Law system have been swept away by the National Assistance Act." The children in this group numbered more than one in every four (137,442) and the total numbers were only slightly lower than those of 100 years ago (893,743). The Public Assistance committees of the local authorities made arrangements for the medical attention of the destitute poor. There had been no marked improvement

in the service as compared with that provided by the Poor Law authorities of fifty years ago.

The district medical officer was usually a general practitioner who gave his services part-time to the authority. The doctors were generally underpaid and their salaries ranged from £100 to £350 per annum. The motives for the doctor accepting the post were often similar to those of fifty years ago, which were to keep out the competition of other doctors in the area and to obtain an introduction to prospective patients. Busy general practitioners with large panel lists and with many private patients tended to devote the least possible amount of time to their Poor Law patients. This was especially so in the districts where the doctor received a fixed salary irrespective of the number of patients he saw. The doctor often passed the responsibility for the medical care of his patients to the hospital or other authorities on the slightest and flimsiest grounds.

The medical service provided by the public assistance committees was not very popular, especially among old people. They made strenuous efforts to provide a doctor for themselves either by paying a small regular subscription to a club or by paying the doctor as the occasion arose. This expenditure on medical care often left the old people short of other necessities as the public assistance committees were precluded by law from making up the deficiencies. There is no doubt that, generally speaking, the section of the population on poor relief received the worst medical attention.

There is one person who benefits considerably from the unsatisfactory nature of general medical practice. This is the patent medicine vendor. He attracts patients by skilful advertisements costing £3,000,000 per year, and by the quick service which can thus be obtained in chemists' shops. The patients prefer the service they get in the chemists' shops to the long wait in the doctor's waiting-room.

The public spend over £30,000,000 per annum on patent medicines, a sum which they can ill afford. In the meantime, their ailments, which often require special investigations and treatment, are neglected. The capital investment in patent medicine manufacture is very extensive. Many patent medicines contain no substance of therapeutic value, and when they do they are priced far beyond a reasonable return on the cost of manufacture. Their greatest danger from the medical point of

view, however, is that they persuade people to treat themselves without an accurate diagnosis, and this delay in the application of the appropriate remedy can be very serious. The best examples are given in early cases of cancer, particularly of the stomach and bowel, where early treatment can result in cure, whereas any delay may mean certain death. The libel laws and the influence of the manufacturers with the Press generally prevent any criticism of patent medicines by name. The best way of combating this menace is to improve the health services so that the patient can freely and without difficulty receive medical care in which he has gained confidence.

We have now examined the various reasons why the general practitioner is not in the key position of the family doctor. It is essential for the success of the health services that the necessary reforms are introduced to place him in that position. The reforms must bring the family doctor to every citizen, and the specialists, auxiliary health workers and preventive health services to the family doctor. Above all, the health services must be reformed to give at least as good a service to the majority of the people as it provides for the well-to-do. The situation where there is a first-rate service for the few and a fifth-rate service for the multitude must be ended.

The National Health Service Act, 1946, affords the people many opportunities for the introduction of the necessary reforms in the health services. The first great advantage of the Act is that it brings the services of a general medical practitioner to every citizen of the country, man, woman and child. Secondly, there has been a considerable extension in the medical services, and they now include the provision of specialists, hospital beds, spectacles, dental treatment, etc. Thirdly, the provision of health centres gives the general practitioner an opportunity to work in harmony and close co-operation with the preventive health services and the hospital specialists.

Every citizen is entitled to a doctor without the payment of a fee. The abolition of the sale and purchase of practices, with adequate compensation for those already in practice, relieves many doctors of a considerable financial burden. It gives the younger doctor the opportunity of entering practice without having to overcome the initial obstacle of raising a loan for the purchase of a practice. Where he is unable to make a living at the beginning of the establishment of a practice, he is allowed a

basic salary of £300 per year. Even though many areas in the country are considered to be under-doctored, he may, however, find difficulty in entering or starting a practice because the old-established general practitioners are more fully represented on the committees which regulate general practice in the area. The erection of health centres would solve this problem because the younger doctors would welcome the opportunity of beginning general practice in them.

The main drawback, however, is the fact that the payment of the doctor is by a capitation fee, according to the number of persons on his list. This method of payment incites the growth of competition among the doctors, and the doctor is tempted to devote as little time as possible to each patient in order to be able to deal with larger numbers. The fact that the income is paid by the State means that the whole amount is disclosed for income tax purposes. This gives an added stimulus to the doctor to try to attract private patients. Although every citizen is entitled to the same treatment for his weekly contribution, there have been several instances where private patients have been encouraged on the grounds that they could obtain special consideration if they paid for it. If the policy which inspires the Act succeeds, there will be a reduction in the extent of private practice, which will result in a better distribution of doctors in the country.

The extension of medical benefits has been a great boon for the majority of people. The great demand for spectacles and dental treatment at the inception of the service indicated that there was a large accumulation of medical needs which were not being satisfied.

The main advance which the Act promotes is in the building of health centres. These have been described by the Minister of Health as the keystone of the health services. It is through these health centres that the general practitioner can maintain his position as the family doctor, but at a much higher level, as he will now have the additional advantages of modern scientific medicine.

Section 21 of the National Health Service Act is the most important section, and reads as follows:

"It shall be the duty of every local health authority to provide, equip, and maintain to the satisfaction of the Minister premises, which shall be called 'health centres,' at which facilities shall

be available for all or any of the following purposes: Specialist, general practitioner, dental and pharmaceutical services, any of the local authority's own services, and for the purposes of health education, 'the publication of information on questions relating to health or disease, and for the delivery of lectures and the display of pictures or cinematograph films in which such questions are dealt with.'"

Two major advantages are immediately noticeable. Firstly, the provision of health centres is statutory. (It *shall* be the duty of every local authority, etc.) and not permissive. Secondly, the medical provisions in the health centres are comprehensive, and opportunities are given for the unification and co-ordination of the various health services. The minimum range of work in a health centre which is recommended includes:

General medical service.
Care of mothers and young children.
Care of school children.
Vaccination and immunisation.
Ante-natal and post-natal examinations.
Health visiting.
Home nursing.
Health education.

Finally, the arrangements for health education will stimulate and encourage the people's interest and co-operation in the working of the health services.

The accommodation and equipment for the various health services in the health centres will be modern and up-to-date. They will include waiting-rooms, consulting-rooms, minor operating theatres, simple laboratories, lecture halls, etc.

The advantages to the doctor working in a health centre will be that he will become the central pivot of the scheme for the medical care and attention of the citizen. He will be able to work in modern hygienic premises, fully equipped for his benefit. His records will be well kept and he will have adequate nursing and secretarial assistance. He will have the co-operation of health visitors and social workers, which will enable him to obtain a clearer and more complete picture of the patient's background and environment. His main gain, however, will be that he will be able to work together with his colleagues and in closer association with hospital specialists and the local

authority health workers. Lastly, he will have the benefits of regular hours, holidays and study leaves, and the general stimulus and inspiring spirit of working in a team.

The advantages to the patient will be that he will have the services of a *family doctor*. He will be able to place full confidence in the doctor with the knowledge that he will be able to provide the best medical care and attention which can be supplied by the health services as a whole. The doctor, with secretarial and nursing assistance, will be relieved from doing unnecessary work "with economy of professional time." He will therefore be able to devote more time and attention to the patient.

The patient would no longer require to be herded in overcrowded, unhygienic waiting-rooms, and he would save a lot of time and trouble by having special investigations and treatment at the health centre. This would spare the needless reference and travelling of patients to the out-patients' departments of hospitals. The overworked hospitals would then be free to carry on with the more complicated investigations and treatment, which they are better equipped to do.

The general practitioner would give routine health examinations and he would assist the local authority in the conduct of the ante-natal, post-natal, infant welfare and school clinics. He would also be most useful in the promotion of health education by means of talks, lectures and demonstrations. Medical research would have the opportunities of making great advances by the co-operation of all health workers and even the common ailments —chronic bronchitis, rheumatism, etc.—could be studied and conquered.

There are, however, some weaknesses in the Government's conception of health services. The fact that there are three authorities concerned in the working of the health centre is not conducive to its smooth and easy running. The local authority is responsible for the provision, maintenance and equipment of the health centre, in addition to the organisation of their local authority clinics, e.g. ante-natal, infant welfare and school clinics, in the centre. The Executive Councils are responsible for the work of the general practitioners, dentists and pharmacists employed in the health centre, and, finally, the regional hospital boards are responsible for the work of the specialists and other hospital services at the clinics. The general problems which this

division in administration produces will be discussed more fully in a later section.

The method of payment of the doctor for his work in the service is not satisfactory. The fact that he is paid on a capitation fee keeps alive the element of competition amongst the doctors. This spirit of financial competition will seriously hamper the work of co-operation in the health centres. The proposed methods of payment will, moreover, be very difficult to apply in the conditions of work in the health centres.

The B.M.A. Report (1948) comments on some of these difficulties. "The payment of the doctors will come from more than one source. For provision of general medical services under Part IV of the National Health Service Act, including maternity services, they will be paid by the executive council; for provision of services under Part III of the Act, at least some of them will be paid by the local authority; for services under Part II, whether performed in hospital or at the centre, by the regional hospital board. Also they should be entitled to receive fees for private work on the same conditions as doctors practising outside health centres. The Council foresees considerable difficulty in arranging for an equitable distribution of earnings."

To overcome these difficulties, the Council suggested "that all these salaries and fees should be pooled and distributed to the members of the staff in agreed shares." The suggestion of the B.M.A. Council is not far removed from that of graded salaries for all doctors.

Payment by graded salaries would eliminate the financial spirit of competition while retaining the spirit of medical competition. The medical work of whole-time members of the public health and municipal hospital services has clearly indicated that the drive, initiative and inspiration of doctors are not dampened by the method of payment by salaries. The spirit of medical competition will be stimulated when the doctors begin to work as a team. The group and community spirit of the health workers in the centre will do most to discourage slack or unsatisfactory work. The remainder of the staff would soon arrange that the burden of the slacker's work recoiled on his own shoulders.

The main difficulty will arise, however, in the erection of a sufficient number of health centres. The well-to-do are generously provided with medical care and attention. The redistribution

of health workers and services will mean that for a short period the general advance in the standards of the health service will take place in favour of the majority of the people rather than in favour of the well-to-do. Within the medical profession there are doctors who benefit financially from the fact that the well-to-do received special consideration in the provision of medical care. They will be opposed to the widespread erection of health centres, for an improved service of this character would undermine the suggestion that there is a need for a special service commanding a fee.

Health centres have been an ideal for many years and have captured the imagination of wide sections of the public. The opposition take this factor into consideration and are not open and forthright in their attack on them. For instance, the B.M.A. Report (1948) praises the general conception of health centres, and after describing the health centre building in detail, suggests the time is ripe for urgent *experimentation*. But the Council appreciates that "there is no possibility of their provision for some years to come," and "in most cases there will be no possibility of providing new buildings in the future."

In addition the machinery for the initiation of health centres, the publishing of proposals, their submission to all interested bodies, their suggested modifications to the Ministry of Health for approval, "will undoubtedly move very slowly." The conclusion of the Council as a result of its survey of general medical practice is that, although "it believes that the logical future development will be the provision of specially designed health centres," it "is satisfied that the most satisfactory form of practice at present and in the immediate future is partnership practice from a common surgery."

Experimentation is certainly necessary, but this must not be confused with the policy of experimentation which promotes delay. New methods of building with non-load-bearing partitions allow for flexible planning and for changes to be easily made. Architects, engineers and doctors could soon produce a sufficiency of schemes, suited to local conditions, which could be readily modified in the light of experience. It has been estimated that approximately 2,000 health centres are required for the whole country. These could be built in a five-year programme of construction at an annual cost of less than $3\frac{1}{2}$ per cent. of the total annual capital expenditure. There is no reason why

experimentation cannot be combined with speed, and arrangements made for the erection of a substantial number of health centres.

The Government, however, in Circular 3/48, issued by the Ministry of Health, discouraged local authorities from even submitting proposals for health centres. This pronouncement produced an enormous volume of protest, and the Ministry of Health immediately (April 13th, 1948) issued a letter modifying the interpretation of the circular, but in practice the position remained the same as before.

The Health Committee of the London County Council considers that a neighbourhood unit for health centre purposes should embrace a population of about 20,000, and the L.C.C. would require 162 health centres for the population they administer. It was not until January, 1949, that the L.C.C. approved the plans for the building of the first of London's health centres, incidentally the first centre to be approved by the Minister of Health. The L.C.C. propose for the present to build nine health centres for their area, which on their own reckoning requires 162. Even these centres will not be completed for some time. The large majority of local authorities have not yet produced proposals for one health centre, although many of them are proceeding with the preparation of plans.

The Government's policy of economy cuts and the British Medical Association's policy of dilatory experimentation are complementary and have the same effect. They both result in a retardation of the programme for health centres.

The provision of day nurseries, hospitals and evacuation maternity homes, together with a vast production of war weapons, showed that even in the difficult times of war it is possible to expand the social services. The Government have promised and planned a comprehensive health service for every citizen, but this is impossible without the provision of the most essential part of the plan, the health centres.

CHAPTER XII

THE HOSPITAL SERVICES

HOSPITALS PLAY A PREDOMINANT part in the present-day medical services. Their leading role has been acknowledged in the National Health Service Act, where they take pride of place at the beginning of the Act. The nature and character of the negotiations between the Minister of Health and the medical profession underlined the important role assigned to the specialists and hospitals to-day. The hospitals have not always held this favourable position. They have attained their present eminence through the uneven and unplanned development of modern medical science. The origin of the hospitals and their significant advance in the medical services have already been described.

(*i*) *The General Hospital Service*

We are now in a position to estimate the present purpose and functions of hospitals. Firstly, they should be geared and adjusted to the medical needs of the people. Wherever the ailing citizen may live and whatever special investigations or treatment he may require, there should be a hospital in his area capable of providing him with the requisite medical care and attention. The hospital will have to work in close co-operation with the general practitioner and the local authority doctors, so that the need for special investigation or treatment can be assessed with the greatest possible economy of professional skill and time.

Secondly, hospital treatment should be provided where the facilities for home nursing and treatment are unsatisfactory or inadequate. This function is a corollary to the one mentioned above. It is often impossible to provide facilities for even simple nursing care and medical attention in an overcrowded and insanitary home, and in such cases the requisite medical care and attention can only be provided in a hospital.

Thirdly, the hospital can play an important role in the organisation of medical research. In close co-operation with the general practitioners and the public health workers, medical

research could be planned to conquer the common ailments together with the "interesting" diseases.

These functions can best be achieved by having three main types of hospitals—key, district and local—working together. The teaching and special hospitals of university standing fall in the first category of key hospitals. They would raise the standard of medical practice throughout the whole region which they serve. They would be responsible for the general organisation of hospital medical training and research. Large general hospitals with specialist staffs fall in the second category of district hospitals; they would cover the main fields of medicine and would reach the standards of modern teaching hospitals. The cottage or general practitioner type would constitute the local hospitals.

The district hospitals would provide:

(1) An efficient and sufficient out-patient department for consultation, follow-up work, emergency and specialised treatment.

(2) Equipment for all reasonable forms of modern treatment for both in-patients and out-patients, with the exception of such highly specialised treatment as can be given economically only at certain special hospitals.

(3) (*a*) An adequate staff of specialists in all departments.

(*b*) A consultant service adequate to meet the requirements of the general practitioners (including dental practitioners) both in the out-patients' departments and in the homes of the patients, and in the local hospitals in the adjacent area.

(*c*) A resident staff sufficient for in-patients' needs, to deal with casualties and emergencies, and to assist in out-patient clinics.

(4) An adequate pathological service.

(5) An adequate rehabilitation standard.

(6) A training school for nurses.

(7) A sufficient bed strength to meet the above requirements.

(8) A complete and up-to-date system of case records.

(9) Easy access by road, bus or rail.

In addition, accommodation would be provided for infectious disease (except smallpox), tuberculosis and early mental disease

in special departments or blocks in the hospital. The size of a district hospital would vary according to local circumstances but the number of beds provided would be between 400 and 1,000 and they would serve a population between 100,000 and 200,000.

These, briefly, are the modern standards for hospital services. The standard of our present-day hospitals can be readily gauged from a study of the recent hospital surveys sponsored by the Ministry of Health. In October, 1941, the Minister announced his intention to institute a survey of the hospital services in London and the surrounding area, and in other areas also, as might be found desirable. Subsequently, the Nuffield Trust offered to co-operate in the work. The country was divided into ten areas for the purpose, and in each case the surveys were made by two or three eminent hospital experts. The reports of all the surveys were published in 1945 and 1946 and the report of the Ministry of Health of 1946 summarised them.

There is no hospital in this country which reaches the modern standards of a district hospital as described above; in most instances the hospitals fall very far short. The Domesday Book of the hospital services, which also summarised the conclusions of the surveys, said: "It needed no survey to establish that there is no hospital system now. There is a tendency to identify the voluntary hospital with the comparatively exceptional large teaching hospital and to assume that all reach the same high standards of work—an assumption that is unfortunately not well founded." There were over 1,000 voluntary hospitals in England and Wales, varying in size and efficiency. We have already noted that a district hospital should have at least 400 beds. Only *one in ten* of the voluntary general hospitals had more than 200 beds; *seven out of ten* had less than 100 beds and of these more than half had *less than thirty beds*.

The reports disclosed many defects in the hospital services and deplored the lack of co-ordination between the various branches of the hospital service and between the hospitals. We have already noted that one of the main functions of the hospital services is to give adequate medical care and attention to every citizen, whatever his need and wherever he may live. The first essential for fulfilling this function is the provision of a sufficient number of hospital beds. The total deficiency of hospital beds in the country at the present time has been estimated at approximately 98,000.

The Chief Medical Officer of the Ministry of Health, in his 1946 annual report, said: "The sufficiency of hospital beds varies greatly from place to place, but the reports show that there is a definite shortage in every region, though unevenly distributed within the region. The shortage is specially marked for certain classes of case, notably maternity and tuberculosis, and in the north-western report a serious lack of specialised accommodation for children is emphasised."

The general shortage of hospital beds is even worse than appears at first sight, for, as the Chief Medical Officer reports, "the general inadequacy of hospital accommodation is much greater than the number of available beds would indicate, since that number is often made available only by using unsuitable premises and by overcrowding. The East Midlands surveyors estimate the overstatement of capacity due to overcrowding at about 20 per cent.

"Further, the full measure of inadequacy is not shown by the obvious shortage of beds. In speaking of this, the North-eastern report draws attention to the fact that it is now generally accepted that when new and efficient hospitals are established they attract many patients who otherwise might not take the trouble to obtain hospital advice and treatment. Other reports also speak of a hidden shortage of beds which is only revealed when some good new service is instituted." In addition to the number of hospital beds being grossly deficient they are badly distributed, and were not used to the best advantage.

The quality of hospital buildings which house the beds is very low and provides little encouragement for the staff to do their best work. The Chief Medical Officer commented on the standards of hospital buildings as follows: "A fact which is strikingly brought out in the reports is that many hospital buildings are out of date and fall far short of modern requirements in planning and in the facilities which they provide for efficient and convenient working.

"There has been comparatively little hospital building since 1914 and a large proportion of the hospitals are more than fifty years old, though many, of course, have had additions made to them at various times.

"The following extract from the North-western survey report may be taken as representative:

"*Voluntary Hospitals*. They are usually situated in a central

and often noisy part of the town, with drab surroundings and on very restricted sites. In many cases, patchwork additions have been made at different periods and often the insufficiency of space on the site and other difficulties (especially financial) have caused these to be made in such a way that the site has become congested, and the general design formless and inconvenient. Many of these hospitals have reached a point at which they cannot expand to provide, under reasonable working conditions, the various modern facilities that would correspond even to their existing small number of beds. They are, consequently, working under great difficulties, and in conditions which are very trying to both patients and staff and which militate against efficiency. The general lack of amenity is a serious matter and is very striking; many of the hospitals are gloomy and depressing, which can hardly fail to have a discouraging effect on a patient entering them.

"*Municipal Hospitals.* The public assistance institutions tend to be even older than the voluntary hospitals. With very few exceptions, they were not originally intended to be used as acute general hospitals, and most of them are attempting to perform a function for which they were not designed and are not suited.

"They have the disadvantage of adjoining (in some cases being almost entangled among) rather forbidding and barrack-like public assistance institutions, and the 'public assistance atmosphere' (which is difficult to define but easy to recognise) tends to cling to them. . . . Sanitary accommodation is usually cramped and unsatisfactory. . . . Many are ill-provided with operating theatres and X-ray and physiotherapy departments. Modern equipment has often been obtained, but is seldom satisfactorily housed."

In the opinion of the surveyors, Liverpool hospitals, considered as premises, fall far below a satisfactory standard. The surveyors of North Wales estimated that, taking both building and staffing into account, "there is at present *no general hospital of the requisite size and quality*," while the surveyors of South Wales suggested that for their area some 7,000 new beds were needed, together with some 4,000 beds to replace those at present in *obsolete and unsuitable buildings*.

This serious situation where there is a general shortage of hospital beds, many of which are unsuitable, is aggravated by the fact that there is an insufficient number of consultants for

the beds available. The Chief Medical Officer commented on this matter as follows: "Abundant evidence is contained in the reports both of insufficiency in numbers of specialists of various kinds and of unsuitable distribution of specialist skill. The reports are agreed on the need for a much wider distribution of specialists. At present they are unduly concentrated in the medical school centres. While general surgeons, ear, nose and throat surgeons, ophthalmic surgeons and gynæcologist-obstetricians are to be found in many other towns, their distribution is uneven and haphazard; physicians and dermatologists are scarce and *pædiatricians are not to be found outside the university centres*. The need for a wider distribution as well as for increased numbers of specialists, generally, is urged."

Even the large towns are ill-provided with specialists. "In Sheffield the number of consultants is too small for the town itself," whilst in Leicester, Derby and Doncaster, long recognised as consultant centres, there is a shortage of consultants in medicine. "Nottingham is an old-established consultant centre, but the number of consultants, here again, is much too small."

The reasons for the maldistribution of specialists was given by the Chief Medical Officer in his 1946 annual report: "The distribution of specialists is dependent on economic conditions rather than on medical needs, and is determined much less by the amount of work which should be done than by the opportunities for making a satisfactory income from private practice."

In this respect, the surveyors of the West Midlands area commented on the difficulties of obtaining consultants for hospital staffs: "At present the number of consultants is limited by the economics of the area. If there is no living to be made by consulting work, then 'full' specialists are not available for the staff of the hospital, and committees of management have to get along with general practitioners of the immediate neighbourhood."

This has often resulted in general practitioners undertaking work which they cannot satisfactorily perform, with a considerable lowering in the standard of treatment in the hospital. The surveyors of the West Midlands area, speaking of the general practitioners, said: "In the past the tendency has been to drift into surgery, or whatever branch of medicine he is most interested in, and to do this as an offshoot from his general practice; he may be entirely self-taught and without proper training for the particular branch he chooses."

The surveyors of London and surrounding area said: "The large proportion of surgical cases dealt with at small 'general practitioner' hospitals has the unfortunate result that surgery is often carried out by general practitioners whose skill and experience must necessarily be limited." The East Midlands surveyors express themselves to similar effect, and added: "We do not consider it desirable that surgery should be undertaken by general practitioners who operate too infrequently to have the necessary technical capacity for more complicated work. . . . The existence of general practitioner surgeons as a class has grave drawbacks, and the hospital services should be planned to eliminate the need of them."

This tendency for hospitals to undertake work for which they are inadequately staffed or equipped is typical. The London surveyors said: "The majority of voluntary hospitals are distinguished for their independent spirit, their initiative, and their power of inspiring local loyalty. These traditions are admirable in themselves, but their fruits are not always conducive to the maintenance of a fully efficient and satisfactory hospital service. There are examples in the survey area of a tendency in the past to *adopt the course of action most likely to enhance the importance of the individual hospital rather than that most likely to produce the best facilities for the patient.*

"An example of unfortunate development in the survey area is the way in which some hospitals have attempted to undertake the treatment of malignant cases by radiotherapy without either the expert staff or the elaborate ancillary services essential for proper treatment."

On the other hand, some hospitals, as a consequence of the development of general practitioner surgeons, have more equipment than they can satisfactorily handle. There has been "a marked tendency to over-development of certain aspects of work, especially lavish expenditure on equipment in competition with neighbouring hospitals." In spite of the general shortage of modern equipment in many hospitals in the country, "elaborate operating theatres are commonly found in small cottage hospitals, even in those where operations are relatively infrequent and sometimes may be performed by unskilled hands. X-ray apparatus is usually found in cottage hospitals, although many have no visiting radiologist or *even radiographer.*"

The standard of treatment in the out-patient departments of

the hospitals are even lower than those for the in-patient. Owing to the lack of co-operation with the general practitioners the out-patient departments deal with excessive numbers of patients, many of whom could just as well be treated by their own family doctors. The voluntary hospitals were not at all averse to receiving the patients, for, by advertising the excessive work they were undertaking, they were in a better position to solicit funds for their upkeep.

The results of these methods can be seen in the reports of the surveys. The North-western survey referred to the out-patient facilities in voluntary hospitals as follows: "The general rule is that out-patient departments are much too small for the volume of work now being undertaken." The report went on to describe the out-patient provision in municipal hospitals: "They seldom have anything which could be dignified with the name of an out-patient department." The North-eastern report said: "We have been particularly impressed by the poor, inconvenient and cramped accommodation in the out-patient departments." The South Wales surveyors said: "Out-patient departments have a number of defects, which we have pointed out, and which become more apparent as their work increases, and we are satisfied that the time is ripe for their extensive reorganisation and development."

The fact that the hospitals are not always easily accessible operates particularly to the detriment of the out-patient. The North-eastern surveyors said: "A long journey to an out-patient department, especially if it has to be repeated at short intervals over a considerable period, entails hardship on the wage earner, or it may be very difficult for his wife, who not only has to look after the home, but may perhaps have several children who have to be cared for in her absence."

(ii) Care of the Chronic Sick

The lack of any system of organisation in the hospitals service reflects harshly on the chronic sick, who are least able to maintain themselves. The treatment of the chronic sick is largely a problem of the treatment of the aged, for the vast majority in this category (over two-thirds) are over sixty-five years of age. The problem is likely to increase, for it has been estimated that in 1950 there will be 5 million people in Great Britain over the age of sixty-five.

The problem has been aggravated by the change in the functions of the infirmaries. The North-western surveyors summarised the changes in these words: "Round about 1900, or a little later, a number of boards of guardians built new workhouse infirmaries, which afforded reasonably good accommodation for the type of patient for which they were intended—that is to say, for the chronic sick, with perhaps a sprinkling of acute medical cases especially pneumonia and bronchitis. The increasing demand for acute hospital beds has led to these infirmaries being more and more occupied by acute cases, both medical and surgical. The result has been that reasonably good chronic hospitals have been converted into poor acute hospitals, and the unfortunate chronic patients crowded out of the good wards that had been provided for them into what is often very inferior accommodation indeed, in the public assistance institutions."

The Chief Medical Officer referred to the results of this policy as follows: "The reports all draw particular attention to the bad conditions under which the chronic sick are housed. The description below, taken from the Yorkshire survey report, is generally applicable.

"Almost without exception, the accommodation for the chronic sick is made in public assistance institutions. In most instances, the wards do not provide either the physical or mental amenities to be found in even the most ordinary well-conducted domestic dwelling.

"The normal experience is to find long wards often placed in succession end to end, with a row of beds closely apposed to each other and with windows so high that the patients can see nothing but the sky. Sometimes there are day-rooms and, when provided, they are frequently only furnished with a row of hard wooden chairs round the walls. The sanitary arrangements are in the great majority of cases completely out of date, insufficient numerically and difficult of access."

The South Wales surveyors also referred to this problem: "In South Wales very little has been done to face this issue. . . . The worst and oldest buildings are set aside for the chronic sick. . . . These institutions are repellent to many patients who cannot be properly cared for at home and who nevertheless either refuse to enter them or take their discharge after a short stay, and it is, therefore, hard to assess the real shortage of

accommodation for the chronic sick." The London surveyors said: "Most of the 'chronic hospitals' are obsolete and should be replaced as soon as possible. In general the accommodation is poor and the arrangements are inadequate."

It is often impossible for relations to give adequate attention to the aged and infirm in the family because of overcrowded conditions in the home which are due to the present difficult housing situation. The aged persons, on the other hand, find it difficult to live on their own because of the present difficulties of queueing, rationing and the high cost of living.

To-day there are countless thousands of old people living alone. The Assistance Board estimated their number as over half a million in 1944, and at least 100,000 were over eighty years of age. Behind these figures lie innumerable stories of loneliness and hardship. In addition, there are thousands of old people who are being cared for by relations in their homes in most trying circumstances, with little assistance from official sources. Many of the younger people are suffering from the excessive strain of this work.

In contrast, the aged among the well-to-do have no difficulty in obtaining nursing care and attention, and mental and physical comfort in their own homes or, in cases of special difficulties, in nursing homes in pleasant and cheerful surroundings.

The problem of providing adequate care and attention for the chronic sick has been aggravated by general lack of interest and the consequent lack of organisation in providing facilities for such cases. As the Chief Medical Officer said in his annual report, 1946, "many otherwise healthy people have some difficulty which makes it difficult for them to live in ordinary homes without domestic assistance and some amount of nursing oversight.

"At the present time there are many beds being occupied in hospitals by patients with diseases which have become unnecessarily chronic because they have not received skilled attention in time; patients who are taken to hospital because they have no one at home to look after them; patients suffering from preventable conditions, such as accidents; and patients who have been admitted with a chronic disease, but have improved so much that they could go home if they had some care and attention available there.

"During the war elderly people were found capable of doing

useful work for the community, and anything that will tend to continue such a state of affairs is to be commended."

There are several reasons for this lack of interest in the care of the chronic sick in the community. Firstly, the simplest and cheapest solution for dealing with the old and infirm, after a lifetime of toil on inadequate wages, was to accommodate them in an infirmary. Secondly, there was no incentive to cure even the well-to-do chronic sick, for there was a vested interest in the care of the aged well-to-do. As there was therefore no need for the consultant to become proficient in the care of them, the responsibility of attending to the aged poor was left to relatively untrained and unskilled workers under difficult working conditions. As the Chief Medical Officer said, "perusal of the reports suggests that shortage of nursing staff, lack of discrimination in diagnosis, and the absence of proper day-rooms (with suitable floors, convenient offices, handrails, and appliances) lead to many patients being kept in bed. While this confinement to bed lessens the risk of accident and to some extent the need for supervision, it often results in patients becoming prematurely bedfast."

A live interest in this problem and an intensive research into many of these cases would soon reveal that with proper classification a considerable amount of treatment can be given to the aged, with excellent results. In special wards of some hospitals, notably the West Middlesex Hospital at Isleworth, special units with skilled staff have been established for dealing with the aged chronic sick. The bed-ridden patients have been taught to walk and others have developed a new interest in occupational therapy. There has been a considerable amount of rehabilitation, and the joy of living has been injected into the old "chronics" with astonishingly successful results.

As the Chief Medical Officer said, "what is needed above all is that the chronic sick should be under the care of people who are interested in them. The care of the chronic sick has tended to be regarded as uninteresting, uninspiring and depressing, but those who have taken an interest in it have been repaid by finding how much really can be done, not only to make the patients comfortable and happier, but actually to improve their condition and restore them to a greater degree of activity."

Preventive measures would include special homes and hospitals for the aged, a "Meals on Wheels" service, i.e. the transport

of hot meals to their homes; the provision of home helps and, where required, home nurses. The provision of these measures for the care of the chronic sick will be a costly business. It will, however, repay dividends in the long run, in rehabilitating the old so that they require less care and attention and in relieving the strain on younger people.

(iii) Mental Hospitals

Another section of the community which is defenceless in the struggle for care and protection is that of the mentally disordered, and recently there has been a change in the general attitude towards them. Mere custody and confinement have given way to skilled care and treatment. With modern methods of treatment, four out of ten mental patients who enter institutions can be discharged as cured and two out of ten return home much improved. Many institutions, however, have neither the facilities nor the staff to administer the proper treatment.

Mr. John Lewis, in the House of Commons on November 6th, 1945, opened a discussion on mental hospitals, and the following is a summary of his speech. He said that in 1945 there were approximately 127,000 persons suffering from mental disorders in our hospitals and homes. This large number represented only a fraction of those in need of mental treatment and attention.

He suggested that there was very little inducement for patients to enter mental hospitals voluntarily in order to receive treatment. The remoteness of the places, with high walls, bleak premises and locked doors, made clear to those able to think that anyone entering might never return. Most of the hospitals were very old and out of date. In some parts of these hospitals beds were so close together that it was impossible to stand between them. Patients were not classified according to their type of mental disease, but, as a rule, by their degree of physical infirmity, by the degree of noise they made, and by their habits —whether clean, dirty, destructive or violent. Epileptics and potential suicides were scattered throughout the whole hospital.

The staffs of these institutions worked under most difficult conditions due to lack of accommodation and understaffing. So far as the medical staff was concerned, the average was one doctor for every 300 to 700 patients. The patients in most institutions were fed from centralised kitchens and the food often arrived cold. The low standard of diet had its origin in

the fact that years ago it was believed that low feeding would keep the patient quiet.

The most terrible indictment of the system was the mortality from tuberculosis in mental institutions, which, in 1942, was fifteen times as high as in the normal population.

The *Lancet* commented on the report of the Board of Control for 1947 as follows: "[The report] hardly paints a reassuring picture. Overcrowding in public mental hospitals, though somewhat less than it has been, remains in the Board's words 'one of the main difficulties which have to be overcome.'

"At the end of 1947 there were 144,736 people under care, compared with 145,391 in 1946; 128,817 of these were in public wards and 14,668 of them were overcrowded 'on the basis of recognised standards,' compared with 16,662 at the end of 1946.

"Even 'recognised standards' are not necessarily the best that could be wished. It is a fault of our mental hospitals, built for the most part at the height of the Gothic revival, that the large wards with their gloomy narrow windows look at once crowded and bleak. The mentally ill are at present obliged to spend their days in close contemplation of others as sick as themselves; and it is a matter for speculation how much mental disorder is perpetuated by this necessity.

"Even a mentally normal person convalescing from a physical illness would find his mood and outlook affected by such surroundings; the sick mind finds in them a giant obstacle to recovery, as those who have been mentally ill can attest. Overcrowding of a mental hospital ward means, not merely that these depressing circumstances are reinforced, but also that there is a falling off in individual care, and an increase in offensive sounds and smells and even sometimes of squalor."

The contrast of the treatment of the mentally disordered among the well-to-do is striking. In spite of the notorious shortage of hospital accommodation and the considerable degree of overcrowding in mental hospitals, advertisements appear almost weekly in medical journals asking for patients, the "certified and uncertified ladies and gentlemen." Extracts from two advertisements illustrate the type of facilities provided for the well-to-do:

[1] "—— *House*. Two classes of patients are admitted: (1) *Patients for Investigation*. Much time and money can be wasted on psychotherapy from the neglect of some latent organic factor. To

meet the need of these cases a diagnostic week is arranged. For this an exclusive charge of 25 guineas will be made.

(2) *Patients for Intensive Psychotherapy.* Narcoanalysis is used when it offers prospects of curtailed treatment. Occupational therapy is available on an extended scale. Terms: 12 to 18 guineas a week, inclusive of regular specialist treatment."

[2] "—— *Hospital.* This registered hospital is situated in 130 acres of park and pleasure grounds. The private rooms with special nurses, male or female, in Hospital or in one of the numerous villas in grounds of the various branches can be provided."

"—— *House.* This is a reception hospital in detached grounds with a special entrance to which patients can be admitted. It contains special departments for hydrotherapy by various methods, including Turkish and Russian baths, the prolonged immersion bath, Vichy douche, Scotch douche, electrical baths, Plombière's treatment, etc."

"—— *Park.* Two miles from the main hospital there are several branch establishments and villas situated in a park and farm of 650 acres. Milk, meat, fruit and vegetables are supplied to the Hospital from the farm, gardens and orchards of —— Park."

"—— *Hall.* The seaside house of —— Hospital is beautifully situated in a park of 330 acres at —— among the finest scenery in ——. On the north-west side of the establishment a mile of sea coast forms the boundary. The Hospital has its own private bathing houses on the seashore. There is trout fishing in the park. At all the branches of the Hospital there are cricket grounds, football and hockey grounds, lawn tennis courts (grass and hard courts), croquet grounds, golf courses and bowling greens. Ladies and gentlemen have their own garden, and facilities are provided for handicrafts, such as carpentry, etc."

The differences between the services provided for private and public mental patients need no further emphasis.

Apart from making arrangements so that the provisions for mental treatment are available for those who need them on the basis of priority of need, many reforms can be instituted immediately without imposing a heavy financial burden.

Firstly, a considerable amount of preventive work can be done by the development of out-patient clinics and centres for the advice and treatment of early psychological disorders.

These clinics could have close contacts with schools, industry, the courts and with the public generally. They could also do useful work in following up the patients who have been discharged from the mental institutions, as trained psychiatric workers could help them to obtain jobs and to readjust themselves to the outside world.

Secondly, a better classification of the cases in mental hospitals would help to combat overcrowding. The mental hospitals accumulate cases which are dumped on them because there are no other provisions for them. These cases are called "settlers," and they prevent the entry of mental patients who have a chance of a cure.

The "settlers" include four main classes, amounting to seven out of ten of the total inmates. Of these 5 per cent. have recovered, but are homeless, 45 per cent. are chronic psychotics who are generally incurable, 10 per cent. are senile and 10 per cent. mentally defective. All but those in the last category could be accommodated in simple subsidiary homes forming an integral part of the mental hospital, while the mentally defective could best be accommodated in special institutions. The hospitals could then be reorganised to deal with cases in which there is a chance of cure.

There has been a gratifying increase in the numbers of voluntary patients, although some hospitals do not admit any but the certified. The public are still advisedly afraid of the institutions, and thus they do not come in the early stages of mental disorder, when treatment has the best chance of success. They will continue to avoid these hospitals until they are drastically reorganised.

(iv) Infectious Diseases Hospitals

The whole character of these hospitals has changed with the change in the incidence of infectious diseases. In the past, isolation hospitals were built to deal with smallpox, typhoid, scarlet fever and diphtheria. Of these diseases the only one of some importance to-day is diphtheria, and even this is waning in importance with the advance in immunisation. The small independent hospital, a relic of the old "pest" houses where the only object was to isolate the patient rather than treat him, is completely out-of-date. Yet eight out of ten infectious diseases hospitals have less than fifty beds.

The London surveyors referred to this type of hospital as

follows: "Modern opinion has come to regard the small independent isolation hospitals as an anachronism. Not only is it an uneconomic and inefficient method of providing treatment for infectious diseases; it presents almost insoluble difficulties with regard to nursing staff, and it does not justify or maintain an expert medical staff."

The Chief Medical Officer said: "Much of the accommodation for infectious diseases, especially but by no means only in rural areas, is in small hospitals without resident staff and either without a modern 'cubicle block' or at least without sufficient provision for dealing with a number of different infectious conditions simultaneously."

As already mentioned in the sections on the care of the child, more facilities for hospital beds should be made available for cases of measles, whooping cough and infantile enteritis.

The infectious disease hospitals must not remain isolated from the general hospital services. As the Chief Medical Officer said, "in recent years the emphasis has notably shifted from isolation to treatment." In this respect there should be a more extensive provision of "cubicle" beds, up to 60 per cent. of the total accommodation, to allow for adequate and efficient isolation. The infectious diseases hospital must also be linked organically or functionally with general hospitals, so that the best medical treatment can be provided for the various complications of the infectious diseases by specialists in the general hospitals.

(v) The Treatment of Tuberculosis

Tuberculosis at one time occupied first place as a cause of mortality or chronic disability. Bunyan described tuberculosis as "Captain of the men of Death."

With the general improvement in the sanitary well-being of the community, the tuberculosis death-rate has fallen. In the decade 1911–20, the number of deaths each year from all forms of tuberculosis was approximately 52,000. In the period 1938–45 the numbers were halved to approximately 26,000. But tuberculosis is still the main killer of youth in its prime and causes 50 per cent. of the deaths between the ages of fifteen and thirty. Even when it does not kill the patient, tuberculosis, being a relatively chronic disease, causes serious financial hardships, as it attacks the victim at the height of his earning power. Early diagnosis and treatment are not only necessary to prevent

the spread of the disease and its physical ravages, but also to prevent destitution. The workers are reluctant to seek advice early, because of the crippling economic effects of the disease and the unsatisfactory provisions for treatment. The disease is therefore often well-established before treatment is sought.

Mass miniature radiography has been introduced, and assists in the detection of the disease in its early stages. It has, however, placed a great strain on the already over-burdened facilities for treatment.

There has been a considerable advance in the treatment of tuberculosis in the last thirty years. The new methods of operative treatment—artificial pneumothorax, pneumoperitoneum, thoracoplasty, etc.—have completely changed our approach. Treatment is no longer restricted to general rest, with fresh air and good feeding. Every sanatorium should be equipped to deal with all the forms of modern treatment. It is more than ever essential to discover the cases early so that effective treatment can be instituted immediately, when it has the greatest chance of success.

The Medical Officer, in his annual report of 1946, referred to the general lack of facilities for treatment:

"The reports reveal a general shortage of accommodation both for pulmonary and non-pulmonary cases. Attention is drawn to the existence of too many small and unsatisfactory sanatoria or hospitals. Many of them were built during a period of stringent economy and have suffered in consequence.

"Many local authorities, having insufficient accommodation of their own, send patients to distant sanatoria, and this and other faults of organisation result in the tuberculosis officers, who look after the patients in the dispensaries and in their homes, being insufficiently associated with their treatment while in hospital. Institutional treatment of tuberculosis tends to be too much isolated from the general hospital services, of which it ought to form a part."

In his report of 1947, the Chief Medical Officer said: "During the last two years, in spite of an increase of 2,440 in the number of beds provided, the battle of the waiting list has been a losing one." The waiting list at the end of 1946 was over 7,000, and at the same time many beds were closed as a result of the shortage in nursing and domestic staff. The Chief Medical Officer commented: "It is clear that at any period in the last two years there

were enough empty but unstaffed beds to enable half the patients on the waiting list to be admitted."

Even while there is a shortage of sanatorium hospital beds, advertisements appear in the medical journals soliciting the custom of private tuberculosis patients in sanatoria situated in glorious surroundings and equipped for treatment for all forms of tuberculosis. The advertisements include one from a sanatorium in Switzerland.

Apart from the need to make sanatorium provision available on the basis of medical needs, many inexpensive, useful reforms could be instituted immediately. Consultative out-patient chest clinics could be attached to hospitals, with observation beds for doubtful cases and beds for initiating treatment in those patients who are awaiting sanatorium admission. Sanatoria could be staffed and equipped to undertake minor surgical procedures, and general laboratory facilities could be made available. Major surgical procedures could be performed in specially organised units. Convalescent treatment in seaside or country surroundings could be arranged in addition to the special colonies on the lines of Papworth and Preston Hall.

After-care, to assist the patient in obtaining suitable housing, additional food and comforts, is of fundamental importance. The rehabilitation of the patient and his reabsorption into industry would assist in preventing recurrences.

The advanced chronic case could be accommodated in selected district hospitals for the bedridden cases, and special homes and colonies could be provided for the advanced, ambulant sputum-positive cases capable of light work. Every facility should be given for the ascertainment and treatment of the early case, so that the patient may return as soon as possible to industry and a normal social life. The emphasis must, however, be placed on the individual patient in his social setting. Prevention is just as important a function of the tuberculosis services as cure.

In the past the tuberculosis officer could take an active interest in the environmental conditions of his patients as he was part of the public health service and had all the facilities of the local authorities at his command—health visitors, welfare officers, sanitary inspectors, hospitals and sanatoria. The 1946 Health Act severs many of his relations with the local authorities and thus reduces his facilities for preventive work. He is attached

for the major part of his work to the Regional Hospital Boards as a chest physician.

The only way to avoid the dangers of his isolation from the preventive health service is to engage the interest of the public in the service and to extend the general provisions for the tuberculosis patients. In tuberculosis, perhaps more than in any other disease, expenditure on measures to improve prevention, diagnosis and treatment will reap rich rewards in the general easing of financial burdens on the sufferers, their families and the community as a whole.

(*vi*) *The Human Approach to the Hospital Patient*

In the previous sections we have dealt mainly with the general medical provisions of the hospital services and the physical requirements of the patients. Just as important, if not more so, is the attention which should be given to his mental and spiritual requirements.

Mr. Parry, a consultant surgeon, in an article "The Urgent Need for Reforms in Hospitals," published in the *Lancet*, November 13th, 1947, said: "In too many hospitals an essential fact is forgotten—that they were founded not for the benefit of doctors, nurses or committees of management, but to help restore patients to health. There were traces of the old Poor Law spirit in municipal hospitals and the humiliating spirit of charity in the voluntary hospitals."

A patient in an article, "Two Hospitals," published in the *Lancet* (November 13th, 1948), gave a graphic description of how the neglect of patients' comforts in hospital affects their chances of recovery. The patient referred to the "almost unbridgeable gulf between those who occupied the beds and those who did the work." The appointments system for out-patients was almost farcical. The system appeared to be based on the principle "that a minute of the doctor's time was more valuable than an hour of the patient's." There was a general lack of privacy in the out-patients' department, and as many as three patients were called in to the doctor's consulting-room at the same time. She described her experiences as an in-patient: "My first two impressions on entering hospital were loss of personality and noise." She referred to the common annoying habits of not telling the patients anything concerning their

complaints or the investigations of the doctor, and of arousing the patients very early in the morning.

The standing complaint in most hospitals is against the food and the way it is served. A booklet recently issued by the Ministry of Health commented on hospital meals as follows: "Experience has shown that the food provided in many hospitals is unsuitable, badly cooked, and badly served, with the result that the patient's recovery is delayed. Waste, too, is common. . . . Suitable meals, well cooked and attractively served, constitute just as important a part of the treatment as careful nursing and skilled medical attention."

Considerate care and attention, peace and privacy and excellent food are the prerogatives of the private patients.

Mr. Parry considered the necessary reforms for removing the Poor Law atmosphere in the hospital. He said: "We want a much more sympathetic and understanding nursing service. Nurses should know something at least of psychology, and should recognise that a patient is a human being, living in unhappy and unusual surroundings, who is craving for kindness and sympathy. He must not be merely a case. The matron should hold modern, not antiquated, views, should be trained in human understanding and psychology as well as nursing, and should be of a nature in which sympathy, affection and kindness are predominant." It is the unsympathetic and inhuman atmosphere which pervades the public wards of hospitals which affects both patients and staff.

Dr. Cohen, in his Minority report on the "Recruitment and Training of Nurses," quoted from letters received from ex-student nurses who gave up their training. The majority referred to the "familiar cold, impersonal, disciplined atmosphere" and to the unpleasant duties and petty restrictions.

It would require no great expenditure of money to inject some humanity into the staff and into the public wards of the hospital. These measures by themselves would create a profound improvement in the hospital treatment of the nation. The previously-mentioned patient, in her article "Two Hospitals," described a second hospital where she was an in-patient. Here she was received with a "wave of warmth and friendliness the moment I entered the ward. . . . The patient was treated like a person and felt like an individual." This spirit pervaded the whole staff and all the patients with excellent results.

With a small expenditure of effort and a negligible outlay of money, the whole character of many hospitals could be transformed, with lasting benefits for the patients. A new atmosphere in the hospitals, together with increases in the nurses' salaries, would go a long way towards overcoming the present staff shortages. The Minister of Health said in Parliament on February 3rd, 1949, that there were 57,000 beds vacant and unstaffed in September, 1948, approximately one-ninth of the total beds. In addition, the beds vacant but staffed was one-eleventh, which was the normal proportion of beds due to turnover. In this period of long waiting lists and overall shortage of hospital beds "it is tantalising to reflect what could have been done to reduce the waiting list if all the beds provided had been adequately staffed" (Chief Medical Officer, Annual Report, 1947).

(vii) Present Legislation and the Future

The first reform instituted by the 1946 Act was the transfer of ownership of all voluntary and municipal hospitals to the Minister. The hospitals of the country have become a national responsibility, and it will be the duty of the Minister to provide, "to such an extent as he considers necessary to meet all reasonable requirements," hospital and specialist services, including the services of specialists at health centres, clinics, and, where medically necessary, services at the home of the patient. National ownership solves the problem of the lack of co-ordination in hospital services and the lack of public control of the voluntary hospital system. By itself it cannot solve the problems of shortages of hospitals, beds, consultants and staffs.

The country is divided into fourteen hospital regions, each of a sufficiently large area for the hospital services to be planned as a complete unit. Each region will be based on a university medical school. The hospital areas are administered by regional hospital boards, and the members of these boards are appointed by the Minister. The members are chosen for their individual suitability and not as representatives of interested groups. For a group of hospitals which forms a reasonably self-contained unit within the area, hospital management committees are appointed by the regional hospital boards on the same principles and house committees are appointed for the day-to-day administration of individual hospitals.

Teaching hospitals occupy a special position in so far as they are governed by their own board of governors and not directly by the regional hospital board. The teaching hospitals are financed by the Exchequer, but they can use their endowments for purposes not covered by the general service. They are given a greater degree of independence than other hospitals and are accorded a high degree of financial autonomy by virtue of their special position as centres of medical teaching and research.

The Act further provides that hospitals may set aside separate rooms or wards for private patients who are prepared to pay the whole cost of the service themselves, including the fees of specialists. The Minister has issued regulations which specify the maximum fees chargeable by specialists for the various items of service which they render to private patients.

The main problem is the need to eliminate the Poor Law and the "cold as charity" spirit from the hospitals. The major difficulty in this essential task is the perpetuation of two different services in the hospitals—a privileged service for the paying patients and a poorer service for the public. In order to attract specialists into the general scheme, the Minister has given them permission to charge well-to-do hospital patients special fees. He was afraid that unless he took this course of action there would be a widespread extension of private nursing homes. It is very difficult to follow the logic of this argument.

Firstly, the specialist can be just as adequately compensated for his work by the Government as by payment from private patients. This would abolish any special treatment for the privileged who can afford special fees. Secondly, the specialists cannot succeed in their private practice unless they are on the staff of a hospital. There are therefore very strong grounds for their choosing to enter the general hospital service. Thirdly, most nursing homes cannot afford all the modern expensive equipment and the specialist has to rely on the hospital to supplement the treatment of the nursing home. Fourthly, nursing homes require nursing and domestic staff as well as hospitals, and in a period of general staff shortages special priorities could be given to hospitals.

The provision of pay-beds in State hospitals must inevitably produce anomalies which will prejudice the general standards of treatment of the public as a whole.

Discussing pay-beds, Dr. Stephen Taylor, in a pamphlet in the Labour Party Discussion Series, No. 6, said: "Provided no case which needs privacy on medical grounds is denied it, there is *perhaps* little harm in the arrangement. But we shall have to be vigilant that pneumonia, typhoid or meningitis patients, patients coming round from severe operations, and those who are dying are not denied privacy, even though the specialists want the rooms for private patients." Similarly, Hilde Fitzgerald, in a Labour Party pamphlet, *A Guide to the National Health Service Act*, which has a Foreword by the Minister of Health, said: "Nevertheless, it [pay-beds] is a very considerable concession, and the general shortage of hospital beds will *no doubt* limit its application. Both pay-beds and private beds should *ultimately* become unnecessary. In the meantime, public vigilance must ensure that the public patient's claim receives priority."

These arguments and sentiments savour of sophism. The hospital surveys show widespread desperate shortages of hospitals, beds and staffs. The estimated total deficiency in beds alone is 98,000. Yet the Minister allows beds to be set aside for private paying patients provided that this does not keep out "any patient who urgently needs that accommodation on medical grounds and for whom suitable accommodation is not otherwise available" (National Health Service Act, s. 5). As all the authorities seem to agree that it will be at least fifteen years before suitable accommodation is available for all patients who urgently need it on medical grounds, it is difficult to understand the elaborate arrangements which have been set up to deal with private patients in public hospitals.

Another danger in specialists conducting private practice in addition to their hospital work was emphasised by Dr. Stephen Taylor, M.P. He said: "In the past it has been common practice for patients to see specialists privately so as to gain admission for hospitals ahead of the normal waiting lists. The real remedy for this is to provide enough beds to do away with waiting lists."

Both the Labour Party spokesmen stress the need for public vigilance. But, contrary to Labour Party policy (see the pamphlet, *A National Service for Health*, 1943, p. 15), the regional hospital boards and hospital management committees are not directly or democratically elected. The persons who are to control the hospital's policy in the provision of pay-beds are the very

persons who are interested in the extension of private wards and beds in hospitals. The Minister of Health has, in the main, appointed to serve on the boards the well-to-do and the consultants, with a mere sprinkling of representatives of the people. The fact that, in addition, the teaching hospitals are relatively autonomous augurs well for the provision of pay-beds in the teaching hospitals. In the North-western metropolitan region alone there are five teaching hospital groups with an aggregate bed strength of approximately 7,000.

The Minister has chosen the members of the board on the basis of their "individual suitability and not as representatives of interested groups." Their individual suitability has been gauged by their past hospital management experience and in most cases this has been grounded on the age-old unsatisfactory Poor Law and charity principles and the bad practices of the past. The results of their past policies have been exposed in the hospital survey reports.

Most members of the board, although they do not directly represent interested groups, spring from the well-to-do. The well-to-do were the only people in the past who could spare any time for hospital administration, and it is highly probable that their present policy, as in the past, will be determined by the interests which they indirectly represent, the interests of the well-to-do and the specialists who attend to them. The excuse that the representatives of the people have little hospital management experience is a specious argument. It results in a vicious circle, for, starting with little or no experience, the representatives of the people will never be given the opportunity to acquire this valuable asset. The logical conclusion to be drawn from this argument is that the representatives of the people are, through lack of experience, incapable of undertaking any administrative job. This principle could easily be extended to include Cabinet Ministers.

Both Dr. Stephen Taylor and Hilde Fitzgerald counselled public vigilance. They omitted one important fact: that the Minister has handicapped the public in the exercise of their vigilance.

The work of improving the hospital services does not end with the important tasks of humanising the hospital treatment of the public and organising the service on the basis of Principle 4 of the Labour Party's programme, i.e. "*open to all*, irrespective of

means and social position." There is still work to be done on the development and extension of the hospitals. We have already seen that there is a total deficiency of 98,000 beds in the country as a whole. Specific examples from the hospital surveys illustrate what this means for various parts of the country:

London. A deficiency of beds for acute general cases of approximately 20,000. "Many of the London hospitals have a high proportion of outworn or obsolescent buildings on cramped and inconvenient sites whose improvement has been hindered by the high costs of land and building."

Manchester. "The Royal Infimary, although built only in 1909, is already out of date in some respects. Sympathetic consideration should be given to the 'island-site' scheme, a 70-acre area zoned for hospital purposes by the town planning authority and approved by the Joint Hospital Advisory Board."

Nottingham. "There is an acute need for more maternity accommodation." Generally "at least 50 per cent. increase of staff all round is required."

The fulfilment of the hospital needs of all areas appears a formidable task. The mere fact that the regional hospital boards have been constituted will not automatically produce a sufficient number of hospital beds and specialists in any area. A policy, therefore, which prohibits large-scale hospital building can only leave all areas with an inadequate, unsatisfactory hospital service. Our wartime experience with the Emergency Hospital Service proves that the solution of these problems is not such an insuperable or formidable task. Under the difficult conditions of war, the Government succeeded in organising and extending the hospital services, because they had strong incentives to preserve manpower and sustain the morale of the people. They organised a system which related the hospitals to each other, and, having over-estimated the number of expected casualties, they made arrangements for a considerable expansion in the hospital services.

The Chief Medical Officer, in his report, *On the State of the Public Health during Six Years of War*, described the origin and development of the Emergency Hospital Scheme: "The outbreak of war on September 3rd occurred at a stage when the Ministry's plans for the 'long-term' policy were by no means complete, but substantial progress had been made in providing extra beds in the hospitals selected for 'crowding' and 'upgrading.'

"Of 150,000 beds with bedding which had been ordered, practically all had been distributed, while an additional 50,000 had been ordered for storage in local depots. Surgical instruments, operating theatre equipment and X-ray apparatus sufficient for 75,000 casualty beds had been delivered. The provision of 40,000 beds in hutted annexes to existing hospitals sanctioned as a first stage in the provision of 90,000 beds in this type of accommodation, was in progress."

Treatment centres, staffed and equipped to deal with patients requiring certain forms of specialised treatment, were organised. These included centres for the treatment of burns, head, chest and spine injuries, plastic surgery, rheumatism and skin complaints. General ambulance transport with hospital and bus ambulances was arranged, and country and seaside branches with recovery and convalescent homes were established. In addition, structural precautions had to be taken in hospitals against enemy activity; these included the building of shelters and the establishment of basement operating theatres.

The achievements made possible by the drive and spirit of wartime organisation indicate that peacetime problems can be solved efficiently and expeditiously.

The hospital services can only succeed if the hospital bed facilities are improved and a better spirit of democratic organisation is infused into the service.

CHAPTER XIII

REHABILITATION

AN ACCIDENT OR ILLNESS may completely alter the life of the worker. He may be left with a disability which may affect his capacity to earn his living or to pursue his previous social habits. All illnesses and accidents which cause disabilities therefore raise this important question in the patient's mind: "Shall I recover sufficiently to be able to return to work, earn my living and lead a normal life?"

This question cannot be answered unless concentrated efforts are directed to conquer the effects of any disability, and this in turn requires the establishment of a scheme of treating the disabled worker with the end result always in view—the return of the patient to work and a normal life. The success of such a scheme can only be ensured by a close link between the hospitals, the social services and industry.

The co-operation of the worker in all stages of the treatment is absolutely essential. To gain his confidence, the medical officer must make him aware of his condition, the extent of any likely disability and the measures which are being taken to overcome it. He must be convinced that all possible means are provided to help him in overcoming his disability. This entails the provision of special apparatus and trained staff to re-educate the patient, and special centres where he can recover his strength and confidence and, if necessary, learn a new job. Industry also has an important part to play in providing the disabled worker with an opportunity to earn a living in a "light" job when he is well on the road to recovery.

Before the war, there was little incentive for the Government or the authorities to introduce a rehabilitation scheme. There was always a "surplus" of workers, and one worker more or less on the scrap-heap of unemployment was of no great consequence. The hospitals had very little encouragement to introduce such schemes, as the specialists were more interested in their private practices and had very little contact with the worker in industry. The factory-owners were not much concerned, as

they could always find factory recruits from the pool of unemployment.

The Chief Medical Officer of Health, in his annual report of 1947, estimated that "in 1939 there were over 200,000 people in England and Wales unemployed on account of disability, most of whom could be placed in productive employment if *suitably treated* and guided into appropriate vocations." The hospitals were partly responsible for this appalling waste of human skill and material for in the main the disabled were not being "suitably treated." The hospital patient was not treated as a human being anxious to be restored to his normal life. The diseased organ or the injured part was treated almost in isolation from the patient, as if it were part of a machine. Little attention was therefore paid to the human needs of the patient and his desire to be restored to a normal life and occupation. In the majority of hospitals, no answer could be given to the patient's vital question concerning his return to work and a social life, for the question was not even considered.

The Government's needs under wartime conditions called for an alteration in the approach of the hospital and industry to the disabled worker. The Government, faced with a shortage of manpower, could no longer afford this enormous wastage of human skill and material. Schemes had to be introduced to conserve human strength and labour as far as possible.

The Chief Medical Officer in his report, *The State of the Public Health during Six Years of War*, said: "With the progress of the war the demand for manpower gradually increased, which necessitated every effort being made to render all military patients fit to return to duty as soon as possible. It was also necessary to accelerate the recovery of those categories of civilians engaged on essential war work."

Previous experience had shown that if fracture cases were treated in the usual hospital atmosphere thirty-seven out of 100 became permanently unfit for work, whereas if they were treated in properly organised fracture clinics only one in 100 remained unfit for work (Report of the B.M.A. Committee on Fractures). The most common injury in industry is fracture of the terminal phalanx of the big toe. In 1935 the average absence from work as a result of this injury was eighteen weeks. Ten years later, as a result of modern methods of rehabilitation, the average absence from work had been reduced to one week.

In October, 1941, the Ministry of Labour and National Service introduced a scheme for linking up the labour exchanges with the hospitals. This scheme provided for the interviewing of disabled patients in hospitals before their discharge in order to fit them into suitable employment. An interdepartmental committee, with Mr. G. Tomlinson as Chairman, was set up in the same year to report on "the rehabilitation and resettlement of all disabled persons." This Committee reported on March 10th, 1942. They recommended the extension of the rehabilitation service to "patients suffering from general medical and surgical conditions, to the tuberculous, the blind and to cases of neurosis and psychosis."

The Ministry of Health recommended the appointment of a special rehabilitation medical officer to selected hospitals, and courses on rehabilitation were organised for doctors, physiotherapists, remedial gymnasts and other auxiliary health workers. The Ministry of Health also loaned special equipment to the hospitals to assist them in promoting rehabilitation schemes. This included equipment for occupational therapy for 200 hospitals, and games and gymnasia equipment for 420 hospitals.

The authorities soon learned the obvious lesson: that to ignore the patient as a complete human being by treating only the isolated injury, made him lose confidence, sapped his morale and delayed or prevented cure. A completely different conception of treating injuries was established. The keynote of success was organised treatment from start to finish. The patient was kept interested and fully occupied, he was given to understand the nature of his complaint and treatment, and above all he was removed from the hospital atmosphere.

Centres were established in country homes or seaside resorts. The patient was taken from the grey, depressing, confining walls of the hospital and was set in the open air with open fields and open sky. He was encouraged to use the gymnasium, swim, play tennis and bowls, billiards, darts and table tennis, attend concerts and join discussions and debates in the evenings. Physical training experts and famous professional players taught him to regain the use of his muscles and limbs by organised drill, exercises and games. Massage, medical baths and electric treatment helped to loosen stiff joints and muscles.

The Ministry of Labour equipped workshops and provided

suitable apparatus to restore the disabled persons to skilled work, according to their ability. Patients were tested for their suitability for training for engineering, building, gardening, etc. Men were restored to mental and physical fitness to do a useful job of work. Industrial managers and assistants, who understood the special jobs and the special difficulties of training the disabled, were engaged. A complete change was made from past customs whereby injured workers had finished up as unemployed cripples, match-sellers, night watchmen or liftmen.

The best known rehabilitation centres were Holyake, near Loughborough, for the Royal Air Force; Egham, for "reconditioning" of war workers; and Roffey Park, near Horsham, for workers suffering from nervous strain. The new methods of treatment gave amazing results. Of 1,000 cases of fractured spine in the Royal Air Force, 856 were returned to full duty.

The Mines Medical Service was established in 1943 with the formation of eight mining regions, each employing a doctor with special experience. They extended the work of the Miners' Welfare Fund, founded in 1920. The Miners' Welfare Fund, which received 1*d.* per ton of coal and 1*s.* per £1 royalties, had an average annual revenue of £1,100,000 between 1940 and 1942. It inaugurated 1,500 schemes for X-ray installations and physiotherapeutic centres, for recreation grounds, parks, pools, pithead baths, cloakrooms and canteens. The Midland Colliery Mutual Liability Company set up a special rehabilitation centre, the first of its kind, at Berry Hill Hall, Mansfield, where miners who had suffered injuries from accidents were restored to fitness and work, mainly through recreational activities and occupational therapy.

The Miners' Welfare Fund planned a further extension to their schemes with the building of community centres, special instruction in safety precautions, general research into the cause of accidents, rehabilitation centres and convalescent homes. The extent of the problem can be gauged from the fact that from 1939 to the end of 1944 (a period of five years), 4,363 were killed in the mines, 15,420 were seriously injured and 779,260 sustained injuries necessitating absences from work of three days or more.

After years of neglect, the economic crisis and the key position of coal in the country's economy have compelled the authorities to recognise that the best returns are obtained if the miner is

treated as a human being and not as a mechanical shovel which is discarded as soon as it suffers a loss in efficiency.

The Disabled Persons (Employment) Act, 1944, followed the Tomlinson report. Provision is made for the Ministry of Labour to make arrangements for vocational training and industrial rehabilitation. A register must be kept of all disabled persons and employers are obliged to engage a proportion (3 per cent.) of disabled workers in their total staff. A special public corporation, the Disabled Persons Corporation Ltd., has been set up to organise factories where disabled persons may work under sheltered conditions. These factories would be known as "remploy" factories and it was hoped that there would soon be fifty of them, employing over 4,000 persons.

At the end of 1947 there were 800,000 names on the register of disabled persons, about half of whom were surgical cases. Disablement resettlement officers with a knowledge of local jobs were appointed to work with the hospital medical officer, who gave guidance on the extent of the man's functional capacity, and with the hospital almoner, who gave details of the man's personal background.

The carrying into effect of the scheme has already revealed some serious defects. Many employers have included on their disabled lists as many persons who were already working for them as they possibly could. They persuaded workers with mild disabilities to have their names placed on the register. This action has hampered those who really are "unable by reason of their disability to carry on normal occupation." Many of the disablement resettlement officers had little experience of their work and did not appreciate that the return to controlled work of a disabled person is a continuation of his treatment. There has been a tendency to consult the employers' interests more often than those of the disabled workers. In this respect, the district advisory panels, consisting of representatives of the local employers, trade unions and trades councils, a local general practitioner and a member of the British Legion, could play a larger part in assisting the district resettlement officer in borderline cases. They could also assist in obtaining the establishment of "remploy" factories where they are most needed.

Wartime experiences with rehabilitation have emphasised the need for its extension in peacetime. Fortunately for the policy of rehabilitation, the same incentive—that of a manpower

shortage—which spurred the Government into action during the war is still present. Faced with the problem of manpower shortages, progressive firms have introduced excellent schemes of rehabilitation for their disabled workers. The following is the outline of such a plan and is an illustration of the excellent results which can be obtained from an efficient scheme.

The firm's scheme covers 12,000 workers, and, while it is intended mainly for accidents, it also covers all cases of illness or injury.

Only three out of ten workers are actually injured on the job, and the firm have therefore allowed their methods of getting workers fit for work again to be extended to injuries occurring outside the works, over 40 per cent. of which are due to domestic, road and sports accidents. Disabled ex-Service men, medical and psychological cases are also dealt with.

The core of the scheme is a team consisting of a specialist, a whole-time rehabilitation superintendent and a special rehabilitation assistant. The doctor is brought into intimate contact with the worker in the rehabilitation workshop. The head of this department is responsible to the company medical officer and is an engineer of senior status, specially trained for this type of work.

He is a key man, and, as he is in constant touch with the visiting surgeon and the factory medical officer and works together with the factory supervisor, he can fit his men, at the appropriate time, into the general work in the main factory.

The assistant rehabilitation officer is a skilled tradesman and supervises the men on the job. He helps to fit the machine and bench work to suit each worker's type of disability.

The principle involved is first to rest the injured part and then gradually to train it by graded work and exercises.

Machines and tools are specially designed for the disabled worker to help him on the road to recovery.

The results show the excellent character of this work. In some of the cases of commoner types of broken bones, e.g. wrist, big toe, 66 per cent. lost no time off work. Apart from the importance to production, the worker is generally happier in this scheme, for he is able to get some badly needed and well-earned wages.

Unfortunately, only a few workers have the benefit of such a scheme. Most firms are too small to introduce ambitious

rehabilitation schemes. Over 50 per cent. of factory workers are employed in units of 250 or less, and it is frequently impossible to arrange for "light" or "alternative" work in the smaller factories. A scheme could be devised to embrace many small firms, or the further extension of "remploy" factories would solve the problem for a large proportion of the injured workers who are employed in small factories. The overall cost of such a scheme would not be large and would be amply repaid in increased production and in the well-being of the workers.

Arrangements could be made for centres to be established to serve smaller factories so that the advantages of this type of scheme would not be lost to those who probably require it most. The workers on the job with their skill and ingenuity can also play an important part in devising machinery to suit their injured fellows.

There is a definite need for a considerable expansion of the rehabilitation service, so that the benefit of the scheme can be shared by all injured workers. Treatment in hospitals and convalescent homes is inadequate if special rehabilitation centres are lacking and there are no arrangements for suitable employment while the worker is on the road to recovery. The Government's policy of economy cuts affects this essential service in the same way as it restricts the extension of other social services. The Chief Medical Officer, in his annual report of 1946, said: "Lack of adequate accommodation and shortage of trained staff are the chief hindrances to this development." Further, in his report of 1947, he said: "An increasing number of hospitals are establishing modern rehabilitation departments *as soon as* they are able to secure the necessary premises and the expert staff required."

The strong incentive which the Government had in wartime for extending the system of rehabilitation has been weakened in peacetime. To-day there is a greater need for rehabilitation than ever before, but the authorities are devoting less time and energy to this vital service than they did in wartime.

CHAPTER XIV

THE INDUSTRIAL MEDICAL SERVICES

A VERY IMPORTANT BRANCH of the medical services is the industrial medical service. Yet in this country it is the one which is most neglected. More than one-third of the population of 45 million are employed in industry, and they spend more than half their waking hours in factory, workshop, yard or mine. If their conditions of work are unsatisfactory, they are likely to suffer from various illnesses, diseases or accidents, some caused directly, others aggravated by the adverse working environment.

There are many diseases which are directly associated with the kind of work the worker is doing. Some are known as occupational diseases and are notifiable, e.g. poisoning from lead, phosphorus or arsenic, chrome ulceration, epitheliomatous ulcerisation, etc. Considerable headway has been made in reducing the incidence of these diseases because factory inspectors have concentrated their efforts on industries where there was a danger of the development of a notifiable industrial disease.

The fight against lead poisoning shows a typical example of the progress which has been achieved in the industrial poisonings. Lead colic, severe anæmia, wrist-drop and foot-drop were quite common in the industries using lead, e.g. white leads works, electrical accumulator factories, the potteries, etc. Preventive measures have included the use of substitute non-poisonous paints and processes, mechanical methods of handling poisonous materials, the removal of poisonous dust by local exhaust ventilation, special overalls and washing facilities for workers and regular medical inspection at intervals varying from one week to three months. As a result of these precautions there has been a considerable reduction in the number of workers suffering from lead poisoning. In 1900 there were 1,058 cases of lead poisoning with thirty-eight deaths. In 1948 there were forty-nine cases with only two deaths.

On the other hand, there has been an increase in the newer notifiable industrial diseases, such as chrome ulceration among

chrome-plating workers and epitheliomatous ulceration of the skin among workers in any process where tar, pitch bitumen, mineral oil or paraffin is used. Silicosis in the coal-mining industry, the potteries and in metal-grinding still remains a difficult problem.

Industrial dermatitis is another example of an industrial complaint which is on the increase. This is mainly due to the introduction into industry of many new chemicals which irritate the skin. The number of workers suffering from industrial dermatitis has been estimated as between 20,000 and 30,000 per year. Dermatitis is common in certain industries, where it is caused by contact with substances such as oil, paraffin, alkalis, chrome, etc. The removal of dirty oil, the provision of protective clothing, protective substances for the hands, adequate washing facilities and the education of the worker would soon reduce the number suffering from dermatitis.

The next group which seriously affects the worker and arises directly from his work is accidents.

Accidents play an important role in the life of the worker. An accident may end his life, his industrial career or his employment as a skilled worker. The Industrial Health Research Board's Emergency Report, No. 3 (1942), *The Personal Factor in Accidents*, gave a summary of the various factors which give rise to accidents. Environmental conditions were of fundamental importance. The report said: "In munition works in the war of 1914–18 the number of cuts and minor accidents was at a minimum when the shop temperature was 65–69° F., and it rose considerably when the temperature was much below or above that average. Adequate ventilation should not be regarded as a side issue, only to be attended to when complaints become too numerous to overlook. In hot weather adequate ventilation which keeps the air in circulation and the workers comfortably cool will prevent many accidents. Lighting may be a contributory cause of accidents if it is so inadequate that the worker cannot see his work clearly, or if there is glare."

Other factors are excessive speed of production and excessive hours of work which produce fatigue and therefore increase the worker's liability to accidents. Certain personal factors, such as experience, age and fitness for work, were also responsible for the causation of accidents. It has been estimated that one worker in every thirty-three has an accident each year. There are over

1,000 fatal accidents every year and over 200,000 accidents which cause a loss of three days or more from work.

In 1947 the total number of fatal accidents occurring during work among workers and seamen was over 2,000. During the war there was an increase in the number of accidents in a class which was particularly susceptible—that of the young male worker. This was largely due to the fact that more young workers were in the factories, the hours and strain were greater, safety regulations were relaxed, and the training and supervision of young workers were largely neglected.

Accidents can be greatly reduced by improving environmental conditions known to be associated with them—by the fencing of machinery, by running it at the best speeds for safety and production, by the supervision and training of the young worker and by careful regulation and control of working hours. In large factories, classes and film demonstrations have been given to young workers on the causation and prevention of accidents. In addition "works guardians," experienced workmen, have "adopted" boys entering factory life and taught them the difficulties and dangers of working conditions in the factory.

The number of illnesses which are either caused by bad working conditions or are aggravated by them are legion. The 16 million workers who were insured under the National Insurance Acts lost, through illness, an average of 30 million weeks each year (an average of eleven days for each person in every year). The illnesses include the respiratory complaints (colds, influenza and bronchitis), the neuroses, gastric disorders and rheumatism.

The causes of illnesses are numerous, but a comparison between two factories employed on the same work will show a much higher percentage of sickness absences in the factory with the worse working conditions. An improvement in factory working conditions, in methods of work and the medical supervision of the worker could reduce the number of workers suffering from various illnesses and accidents by a substantial amount.

The largest number of absences from sickness is due to the common cold, influenza and bronchitis. Ill-ventilated, draughty or overheated workrooms, long hours and excessive strain of work, and lack of protective clothing in damp working conditions predispose the worker to the respiratory infections. Damp, un-aired cloakrooms, preventing the effective drying of the

worker's outer garments, may also lower his resistance to them.

All these factors may also help in the spread of another important respiratory infection, tuberculosis. Workers in the early stages of the disease with few symptoms may spread it among other workers whose resistance may be lowered by bad factory conditions. Mass miniature radiography, which detects the disease before the worker has developed symptoms, is important in discovering early cases and in removing the source of infection.

Neurosis, or "nerves," is next on the list as a cause of sickness absenteeism. In 1945 the Industrial Health Research Board reported that working conditions played a large part in the causation of sickness absenteeism due to neurosis. Working conditions included the worker's relations with his fellows, foreman and managers and were especially important in nervous disorders. "A foreman with a badly regulated temper can cause as much discomfort as a heating plant with a badly regulated furnace." Practically all the workers got on well with their fellow workers, but at least one out of three had complaints against the foreman and supervisors. Long hours, boredom and lack of suitable holiday breaks all played a part. Additional factors outside the factory conditions were long journeys to work and, in the case of women, the difficulties of housekeeping and the care of children.

In 1947, in a study of "The Incidence of Neurosis among Factory Workers," the investigators examined 3,000 workers, a random sample of 30,000 employed in thirteen light and medium engineering factories. They found that from one-quarter to one-third of the total absences from work from illnesses were due to "nerves." It worked out to an annual loss of three working days for men and six for women for every person examined. It is important to note that one in ten of the workers suffered from a serious form of the complaint and that at least two in every ten suffered from a minor form of neurosis. Still more serious is the fact that consideration was only given to "nerves" which caused absences from work. Skilled workers and foremen suffered equally with the unskilled workers.

Certain conditions were associated with an increase in the number of those suffering from this complaint in the factories. These were excessive hours of work, restricted social contacts,

lack of recreation or leisure interests, and work which was unsatisfying or required skill inappropriate to the worker's intelligence. Another important factor was "unsatisfactory human relationships" within the factory. Here the managerial staff played a large part. In factories where the leadership was weak, there was an appreciable increase in "nerves" in the lower levels of management, which was soon reflected among the workers.

The next on the list of illnesses and often closely associated with "nerves" are stomach disorders. The question of diet can easily be related to stomach disorders. Unsuitable food, either ill-balanced or badly cooked, is the enemy of a good stomach. But the stomach does not react to food alone. The mind plays an important role in good, efficient digestion. A troubled, anxious or worried mind can easily disturb the workings of the stomach. There is nothing worse for the digestion than to have a meal in an overcrowded, badly ventilated (overheated or draughty) atmosphere, served on bare tables in a dismal room full of noise, clatter and chatter, in a terrible sense of hurry and urgency.

The meal in factory canteens is often quickly slopped on to plates which have to be gingerly balanced on the way from the queue to a hard-sought, uncomfortable seat. It is probably impossible to have in every factory canteen tablecloths and flowers on the tables, good china dishes and unstained cutlery, comfortable seats, brightly decorated rooms, and a cheerful, leisurely atmosphere, with varied food, attractively served and cooked by competent chefs. But these ideals are worth aiming for if stomach disorders are to be displaced from their high position on the sickness absenteeism list.

The Industrial Health Research Report, No. 88 (1945), showed that only one in three workers used the factory canteens and at least half of them were not satisfied with the arrangements. Complaints were made of the cooking, of "messy" service and dirty crockery, the long walk to the canteen and long queueing. Many workers preferred sandwiches because of the shortness of the meal break, which was often thirty minutes only. Night work often upset appetites and digestion, and this was made worse by the "total lack of facilities or of suitable facilities for night-shift workers" (Annual Report of the Chief Inspector of Factories, 1947). The need was for less hurried meals in more

pleasant surroundings but "the managements seemed to make little effort to encourage the workers to use the canteen."

The number of cases of food poisoning has increased because of the added dangers inherent in the more common habit of communal feeding. Food rationing has introduced more difficulties into the feeding of the family, and more and more workers have become accustomed to take their meals in factory canteens.

Good standards of hygiene and cleanliness are essential for the prevention of food infections. Yet the Chief Inspector of Factories, in his report of 1947, referred to the fact that "the standards of kitchens and storerooms leaves much room for improvement—poor concrete floors and poor finish of some equipment are wartime legacies which still cause difficulty." He also referred to canteens where "the arrangements are poor, and can only be regarded as improvisations until building or adapting is possible again." The Chief Inspector referred to justifiable workers' complaints of "poor cooking in dirty conditions."

The post-war economy has affected the quantity and quality of the workers' dietary in the factory canteens as well as its method of preparation. Owing to the cuts in the allocation of meat, bacon, milk and fats to factory canteens, it was very difficult for canteen managers "to give good, well-balanced meals and varied menus: many had to cut out such popular dishes as fried fish, fried potatoes, milk puddings and (due to the increased prices of dried egg) Yorkshire puddings."

These economies must inevitably weaken the workers' general health and strength and thus have an effect on the general level of production. In many instances he will suffer from stomach disorders as a result of the use of inadequate, unsuitable food substitutes, or attacks of food poisoning as a result of the unsatisfactory methods of preparing food.

The next illness on the list, rheumatism, has already been discussed, together with the role which unsatisfactory conditions in the factory play in its causation.

Abundant evidence has been accumulated to show that unsatisfactory working conditions have a profound effect on the rate of sickness absenteeism. The provisions for the supervision of work-places and for the improvement of their conditions of work have been in existence for over 100 years (the first factory inspectors were appointed in 1833). The arrangements

for factory inspection are still, however, in an embryonic stage. The principal Acts regulating working conditions are the Factories Acts (1901–48). The Factories Act of 1937 is the main consolidating Act. The enforcement of its provisions was almost wholly the responsibility of the Home Office. The Home Secretary's functions under the Factories Act were transferred to the Minister of Labour and National Service in 1940.

The District Councils are responsible for the supervision of factories in which mechanical power is not used, and for sanitary conveniences in all factories. The Act is fairly comprehensive and deals with the health, safety and welfare of the workers. Fifty-seven of the 160 sections of the Act enable the Secretary of State to make regulations or orders regarding seventy-five different subjects. Section 46 authorises the Secretary of State to make special regulations requiring provision to be made in respect of the following matters: arrangements for preparing, heating, and taking meals; the supply of drinking water; the supply of protective clothing; special ambulance and first-aid arrangements; rest-rooms; the supply and use of seats in work-rooms; facilities for washing; accommodation for clothing; arrangements for supervision of workers.

Although many such welfare regulations have been issued, only a few large factories have taken any action in these matters. The Act itself contains some indefinite requirements. For instance, reference is made to the necessity for maintaining a "reasonable" temperature (Section 3) and "adequate" ventilation, when neither "reasonable" nor "adequate" are clearly defined.

The main weaknesses are, however, in the implementation of the Act. The arrangements for factory inspection to enforce its provisions are inadequate, and the Act only applies to certain sections of industry. In 1939 it provided protection for only half the 16 million insured workers in Great Britain and Northern Ireland. Many industries—transport services, offices, hotels, etc.—are excluded from the Act and do not even receive the inadequate supervision of the Factories Acts.

There are over a *quarter of a million* factories and the number of factory inspectors employed to supervise them is 328 (authorised establishment, 378); only sixteen of these are doctors. The factory inspectors' visits work out on an average to one visit per factory per year. Unless there is a gross breach of the sections

of the Act or its regulations, the inspector finds it difficult to obtain the necessary improvements in working conditions.

In addition to the factory inspectors, there are approximately 2,000 appointed factory doctors (formerly known as examining surgeons), but their duties are not very extensive. These duties include the certification of young persons under eighteen for fitness of employment and the supervision of workers in dangerous or unhealthy industries. The factory doctor is appointed from among the general practitioners in the district. The general practitioners usually have little experience or knowledge of industrial medicine and rarely take an active interest in the general working conditions in the factory.

Some of the larger factories have appointed medical officers to supplement the inadequate official arrangements for supervising the health of the workers. There have been some difficulties in this connection as a result of the conflicting interests of the general practitioner, who was the "panel" doctor of the worker.

The B.M.A. have issued a list of the duties and ethical rules for industrial medical officers (Supplement to the *British Medical Journal*, April 24th, 1937). The Minister of Labour has also made a comprehensive list of the industrial medical officers' duties in a *Memorandum on the Medical Supervision in Factories* (1940).

The duties of the industrial medical officer include the immediate treatment of medical and surgical emergencies; the examination of applicants for work, of persons returning to work after an illness and of persons exposed to special hazards; responsibility for the efficiency of the nursing and first aid services; rendering advice to the management connected with the health of the workers, the hygiene of the factory and accident prevention arrangements; the continued observation of all young persons, with a recommendation where necessary for the provision of free meals and milk; the medical supervision of canteens; the rendering of advice to the works councils and welfare departments on matters connected with health; and ready accessibility to employees for medical advice upon matters relating to their work.

Where the factory has established an efficient medical service, supervised by a keen, active doctor, the results have been very gratifying. Figures from a well-known firm relating to the

incidence of sepsis showed that on the introduction of a medical service the incidence fell in one year from 3 per cent. in 1931 to approximately 0·5 per cent. and at the end of five years it had gradually declined to 0·2 per cent.

The Industrial Medical Service, however, apart from notable exceptions, has little contact with the general practitioners or with the hospital services. Some of the industrial medical officers who have worked and grown up with the service have established excellent relations with the management and the workers, and have helped to organise comprehensive health services in the factories on the principles outlined above. Others, however, particularly those who entered with the influx of inexperienced newcomers during the war (especially the part-time doctors), concentrated on cuts and injuries and paid little attention to factory conditions or the general rehabilitation of the worker after sickness or accident.

The conditions in many industries, especially in the smaller factories, reflect the unsatisfactory nature of the arrangements for factory supervision and the enforcement of the Factories Acts. This applies particularly to factories which employ women. A survey by the Industrial Health Research Board in 1943, covering 33,500 women, showed that out of every 100 days' absence from work fifty-four were due to sickness or accidents, the chief causes being colds, influenza and fatigue.

Welfare work and medical services for women in industry had reached varying standards, some good, but many very bad. General facilities were often very primitive. Washing arrangements were practically non-existent. The provision of sanitary conveniences for women in the factory was far less adequate than for the men. Many factories lacked adequate rest-room facilities for women, and the only provision many of them made was a stuffy, noisy room with no proper bed facilities. The Board suggested immediate research into the problems of certain types of illnesses and their causes. This included a study of long standing or sitting, hours of work and different shift systems. They recommended regular physical education for women in working hours, special training in the correct methods of weight-lifting and in the use of machinery. The Board also suggested special research into the hours and working conditions of pregnant women.

The shortage of manpower during the war was the incentive

which made the Government stimulate employers into improving the conditions of work in the factories. The Government had to take steps to overcome the enormous wastage of manpower caused by sickness and absenteeism due to unsatisfactory working conditions. The Industrial Health Research Board made several investigations into the problems of sickness absenteeism and produced many pamphlets on the various aspects of factory environment in its relationship to health. The lessons of the First World War, that long hours resulted in reduced production returns and increased sickness figures, had to be learned all over again in the harsh school of practice.

Apart from this general education propaganda, the Government made various orders under the Defence (General) Regulations, 1939, which were valuable measures in safeguarding the health of the workers. The first of these, the Factories (Medical and Welfare Services) Order, 1940, provided for the employment in factories of medical practitioners, nurses and supervisory officers for the medical supervision of employees; nursing and first-aid services; and the supervision of welfare. The number of whole-time medical officers in industry at the beginning of the war was fifty. The number of doctors in factory medical services rose to over 200 in whole-time and 800 in part-time employment, and the number of nurses increased to about 9,000, of whom some 5,000 were State registered.

The importance of an adequate, wholesome diet in raising efficiency and the general physical and mental well-being of the workers, and its efficacy in reducing sickness absenteeism and the number of accidents was gradually recognised. The Factories (Canteens) Order, 1940, gave the Factory Department power to require canteens to be installed in factories engaged on munitions or on work for the Crown if they employed more than 250 persons. In 1943 the Order extended these provisions to all factories of this size, irrespective of the work they were doing. As a result, approximately 5,000 factories had canteens in operation by the end of the war. In addition, smaller factories, recognising the advantages of the canteen in obtaining and retaining staff, installed canteens, even though they were not required to do so by the Orders. Approximately 7,000 of the smaller factories established a canteen service as a result of wartime conditions of labour.

It has been estimated that the factory canteens can supply

one-third of the first-class proteins, one-third of the total calories and two-thirds of the vitamins of the total days' requirements. This addition to the home dietary is especially important for the young, growing worker. In spite of the reduced charges of the meals supplied at the canteen they were still too expensive for the young workers, who therefore brought their own sandwiches. Some progressive firms have reduced the charges still further for meals supplied to young workers.

On the other hand, the war hindered the general maintenance work in the factories and the general work for improvements in factory conditions. H.M. Chief Inspector of Factories, in his annual report for the year 1944, published in November, 1945, said: "There seems to be an impression in the country that great improvements have been made in all the amenities required by the Factories Act, but this impression is largely based on the conditions found in the comparatively few factories especially built or adapted for war production. Taking the factories of the country as a whole, there is an immense amount of leeway to be made up, particularly in the provision of fencing of machinery, overhaul and upkeep of structures and plant, that may not be apparent to the untrained eye. The defects are, perhaps, most apparent to the ordinary eye in the falling off of cleanliness of w.cs., washing accommodation and the like; the fact that one large firm in the Midlands estimates that they will require eighty men for a year to bring up-to-date the cleaning required by Section I of the Act illustrates the work to be done in this direction alone."

No positive plans were prepared for the required replacements in factories in the post-war period in order to make up the leeway described in the Chief Inspector's report. The post-war crisis, with its general economy cuts and the drive for exports, prevented effective action for the improvement of working conditions in the factories.

The workers' health must inevitably suffer if they are compelled to work in a bad factory environment. A considerable expenditure of money, time and skill will then be required to restore them to normal health. Unsatisfactory working conditions will therefore increase the human toll of suffering and will cripple the lame economy of the nation. Neither the workers nor the nation can afford to have bad working conditions, and the sooner these bad conditions are eliminated, the sooner will

the nation's economy and the workers' health recover. Some of the larger firms have recognised the elementary principle that prevention is better than cure, and in spite of many difficulties have established excellent medical services in their factories.

A good industrial medical service need not be restricted to the larger firms. Small firms, unaided, cannot afford an efficient industrial service, but by combining they can organise a valuable health service for many factories. The Slough Industrial Health Service provides one solution to this important problem. The scheme is supported by the local Trades Council and is sponsored by the Nuffield Corporation, the Slough Social Fund and the various factory managements. The Service is doing excellent work and is an example of what could be done in an organised way for workers employed in the country as a whole. Industrial health centres such as those in Slough could be established at no great cost in all parts of the country, under the guidance and supervision of the Ministry of Labour or that of Health, as the beginning of a real industrial health service.

The two main essentials for an industrial health service are complementary, and include inspection and improvement in working conditions and the supervision and care of the health of the worker.

We have noted the main weaknesses in the present service. These are inadequate inspection and enforcement of Acts and regulations for the improvement of the factory environment, and an insufficient number of doctors, who work in isolation, and cannot adequately supervise the health of the workers.

It is impossible automatically to increase the number of factory inspectors, for trained men are not available. There are two ways of overcoming this difficulty, and they can be employed simultaneously. Both measures would also introduce a greater element of democracy into the system of factory inspection.

The local authorities are under democratic control. They employ sanitary inspectors, who have similar duties to the factory inspectors with regard to factories which do not employ mechanical power and certain duties with regard to all others. They could generally give more useful assistance to the factory inspectors, especially if the whole system of factory inspection came under the control of the Ministry of Health.

A still more important recruit to the system of factory inspec-

tion would be the worker himself. The fact that the worker can play an important role in factory inspection was recognised in the Chief Inspector's report in 1944. He said: "From the point of view of improving conditions the work of these [consultative] committees is of real importance because they deal with matters which though small in themselves often mean a great deal to individual workers. An extra drinking-water fountain is installed in a convenient position, lighting is improved in a particular corridor, the ventilation of a point in a workroom is dealt with or a safe means of access is provided to a certain task by a method which may only be obvious to the workers affected. *Some of these are points that are easily overlooked by the best inspector or the most scrupulous manager.* Day-to-day questions of maintenance and cleanliness of floors, clearance of gangways, and questions of safe working discipline are often too much for a safety officer to deal with single-handed."

The problem of improving the medical supervision and care of the worker cannot be achieved by an increase in the whole-time industrial medical staff, as there is not a sufficient number of qualified doctors available. It would also not be entirely satisfactory, for the doctors would be employed by the factory-owners, who are not unbiased in their approach to the problems affecting the health of the workers.

The problem can be solved by including the industrial health service in the general medical services. The general practitioners could be employed part-time in factories, and they could then take an interest in the working conditions and take them into consideration in their care and treatment of the workers. The service could also be linked with the local authority services, the health visitors and the ambulance service and, finally, with the hospital services, the specialists and the lady almoners.

The factory medical service would gain in this association with the other health services and these, in turn, would gain a deeper insight and better understanding of their patients. There would result a general improvement in factory conditions and in the health of the workers.

CHAPTER XV

THE ADMINISTRATION OF THE HEALTH SERVICES

ADMINISTRATION IS GENERALLY a dull subject. The results of its organisation, however, have profound effects on the personal lives of people. A thriving administration which stimulates local interest and local pride can only be based on the democratic influence exerted, in part by the people, so that full weight can be given to local knowledge of local requirements, and in part by the health workers, so that due regard can be given to the expert assessment of health needs and the measures for their realisation.

It is very important that the individual citizen should have easy access to his elected representatives and should have cause to feel that they are in a position to take a close and personal interest in the health services of his area. The dead hand of a centralised bureaucracy, operated by Whitehall and the technicians, can only result in a sterile administration out of touch with the real personal needs of the people. The success or failure of a scheme of administration therefore depends to a large extent on the degree of participation of the local authorities. As the present system of local government is outmoded, antiquated and unsatisfactory, it will also depend upon the future success or failure of local government.

The Government, in dealing with the administration of the health services, was faced with only two possible decisions: either to reorganise the structure and boundaries of local government so as to bring the population and resources of the major local authorities up to the requisite size or leave the present structure largely intact, making only such minor adjustments as were absolutely necessary, and transferring the functions requiring wider areas into other hands.

If the Government had chosen the first alternative—the long-overdue drastic reform of local government—the future of democracy and the satisfaction of the needs of the people would

have been assured. The Government, however, chose the second, temporary, simple and "easy" solution, which will in the future produce more difficult problems and may lead to the crippling or death of local government democracy. The solution of the crisis in local government is so important and has such widespread repercussions that a general discussion of this problem as it affects all services will be deferred until later in this chapter.

A very broad outline of the structure of the administration of the National Health Service Act, 1946, is as follows:

The provision and administration of the new service is the responsibility of the Minister of Health, but he discharges this responsibility through three main channels, each of which is concerned with a separate section of the new service:

(1) The regional hospital boards are mainly concerned with the hospital and specialist services. Local groups of hospitals are administered by hospital management committees set up by the regional hospital boards and individual hospitals by house committees set up by the hospital management committees. Teaching hospitals are not subject to the regional hospital boards, but have their own boards of governors.

(2) The major local authorities (county and county borough councils) are the new local health authorities. They are responsible for the local clinic and supplementary services, and it is their duty to provide, equip and maintain health centres, subject to the approval of the Minister of all their arrangements. The personal health services of the borough and urban district councils have been transferred to them.

(3) The local executive councils, normally one for the area of each health authority, are responsible for the organisation of the services of the general practitioners, dentists and pharmacists both in the health centres and outside.

The criticisms of this method of administration can be classified under three main headings.

Firstly, the planning and administration of the service in such distinct and separate compartments leads to imperfect co-ordination. This inevitably results in both doctor and patient meeting difficulties in their attempts to obtain the benefits of

the various services which are provided in separate sections by different authorities.

Secondly, the different organs of administration function at different levels and many problems arise because the areas in which they operate are not the same. When the areas of the Regional Hospital Boards were being marked out, it was suggested that the following factor was to be taken into consideration: "Wherever possible the boundaries of the areas should coincide with those of the local health authorities, in order to secure the maximum of administrative efficiency. Where it is necessary to infringe this principle, boundaries should wherever possible coincide with those of boroughs or country districts."

When the fourteen regional hospital areas were delineated there were many districts where this principle was violated. In many areas the boundaries of the hospital authorities and the local health authorities do not coincide and in some areas the hospital divisions cut across boroughs and county districts. The worst anomalies occur in the London area where the boundaries of three Metropolitan regional hospital boards cut across five Metropolitan boroughs.

Thirdly, except in the case of the major local authorities, the county and county borough councils, the public have no opportunity of electing their representatives to these important executive bodies. This makes it very difficult for democratic influence to be exercised. The public cannot recognise the members of the various bodies as their personal representatives, upon whose decisions and actions they can express approval or disapproval through the ballot box. The constitution of the regional hospital boards and hospital management committees in particular have placed the elected representatives of the people in a distinct minority.

The doctors, in the early discussions on the Bill, expressed a fear of local government bureaucracy. In its stead we now have a centralised bureaucracy in Whitehall and a bureaucracy of technicians at all levels of administration.

As already mentioned, the administration should give due regard to the opinions and advice of health workers of all grades. The Health Act has taken this proposition to its logical absurdity and placed one section of the health workers, the doctors and specialists, in commanding positions at all levels of administration.

The Central Health Services Council, with various standing

committees of experts on particular subjects, has been created by the Minister of Health for his own guidance on professional and technical subjects arising in his work. Of the thirty-five members appointed by the Minister to the Central Council, fifteen are doctors, two dentists, two nurses, one a midwife and two pharmacists. This gives the doctors a fair representation and presents them with a good opportunity to have their voices heard and their influence felt on all medical subjects.

They also have a good representation on the organs of government at all levels of administration. For instance, of the twenty-four members of the executive councils which organise the work of the general medical practitioners, dentists and pharmacists, seven are appointed by the local medical committee, three by the local dental committee, and two by the local pharmaceutical committee. These professional committees are recognised by the Minister as representing the local practitioners of the area. This method of appointment gives the doctors a formidable representation on a committee which deals with matters affecting very intimately their own interests as well as those of the public.

The members of the regional hospital boards include persons appointed by the Minister after consultation with the appropriate university and organisations representing the medical profession. Apart from their chairmen, the 364 members of the fourteen boards include upwards of 120 doctors, of whom sixty are specialists.

The members of the hospital management committees have included members appointed by the regional hospital boards after consultation with the executive councils in the area, the senior medical and dental staff of the hospital or group, and other appropriate organisations, which have generally included the local branch of the British Medical Association. This method of appointment has again resulted in a strong representation of doctors on an important administrative body.

The major health authorities, where the area served by the county council is a large one, have formed sub-committees of their health committees and have delegated various health functions to them. Various professional and administrative bodies are permitted to appoint a representative to the sub-committees and the major health committees.

The British Medical Association is usually represented and the hospital management committee often send a doctor as

their representative. The medical profession have thus a direct voice and power on the traditional organs of popular election and control.

The doctors are playing a prominent part at all levels in the various organs of administration. This utopian Wellsian revolution by technicians is unique in the history of government and has not been instituted in other national services, e.g. with the miners, the railwaymen, etc. There is a distinct danger that the interests of a small section of the people—that of the doctors—might conflict with those of the people as a whole. In these circumstances, the placing of doctors in such strong positions of power may lead to decisions and actions contrary to the general interests of the public.

The lack of co-ordination which is in evidence at all the intermediate and lower levels of administration is also revealed at the highest level—the centre of government. The National Health Service Act of 1946 made no attempt to obtain complete unification of the central administration of the health services. The Ministry of Health is still burdened with the onerous and difficult task of housing administration. On the other hand, many other ministries grapple with health problems in complete isolation from the Ministry of Health.

The Ministry of Labour is responsible for the work of the supervision of the factories; the Ministry of Education for the school medical services; the Ministry of Supply for the medical service in the Royal Ordnance factories; the Ministry of Fuel and Power for the mines; the Board of Trade for the Merchant Navy; and the Home Office for the prison medical service.

The functions of the Board of Control have been transferred to the Ministry of Health, while the control of clean-milk food production has been transferred to the Ministry of Agriculture and Fisheries and that of clean food production and standards of food to the Ministry of Food.

The main faults in the administration of the health services are therefore the lack of co-ordination between the various services at all levels and the lack of popular control in the organisation of the services. These serious defects can be overcome by a thorough overhaul of local government.

The National Health Service Act has made the need for the reform of local government even more urgent, for the Act has reformed the health services in such a way as to strike the most

severe blow suffered by the British system of local government in the whole of its history.

In transferring over 300,000 beds to the newly appointed regional hospital boards, the Minister has eliminated from the hospital services the vital element of democratic control which was exercised by the elected councillors. The importance of the services remaining under the democratic control of the local authorities can be gauged by the relative expenditure on them. The cost of the maternity and child welfare services and the provision of the new health services is estimated at only one-tenth that of the hospital services, which is estimated at over £200 million. This reform in administration is a continuation and extension of the policy begun over thirty years ago.

There have been two major factors which have produced and aggravated the crisis in local government. The first is the changing character of the population and the second the changing relationship between central and local government.

There has been no fundamental reform in local government since 1888, when the present system of county councils and county borough councils was established. Even then the boundaries of the counties were largely based on the ancient counties derived from the early Middle Ages. The county boroughs were intended to be the largest towns, and only ten were proposed when the Local Government Bill, 1888, was first introduced. The basic conflict between county and town government was as fierce then as now, and by the time the Bill passed through Parliament sixty-one county boroughs were created. Since then additional county boroughs have been formed, with the growth of the population in the towns. At the same time towns which were large in 1888 have lagged behind in population growth and development but they have nevertheless remained county boroughs.

The immense growth in population since 1888 has created considerable disparities in population and resources among the eighty-three county boroughs and the sixty-one counties which are now the major local authorities in England.

The size of the county boroughs ranges from Birmingham, with a population of 1,085,000, to Canterbury, with 25,000; and of the counties, from Middlesex, with 2,270,000, down to Rutland, with 18,000. One in three of the counties and county boroughs have populations of under 100,000. Twenty-three out

of the sixty-one counties have populations below 200,000, and of these thirteen are below 100,000.

The growth of population and urban development has been specially concentrated into a few main industrial areas, so that Greater London and the six principal industrial districts contain 80 per cent. of the total population, though only 27 per cent. of the land in the country. A striking example of the anomalies which have arisen as a result of the uneven growth in population with little or no alteration in local government boundaries is shown in the fact that the aggregate population of the two largest authorities (Middlesex and Birmingham) is equal to that of fifty of the small counties and county boroughs.

Anomalies have also arisen in the growth of large conurbations. The most striking of these is Greater London, which is divided up between six county councils and three county boroughs, all wholly independent of one another, and 109 lesser authorities. The urban area round Manchester is ruled by three county councils and six county boroughs, and a similar situation prevails in all the principal industrial areas.

Although many adjustments have been made in the boundaries of local government since 1888, they have been quite inadequate, and have not met the actual requirements of the growing responsibilities of local government. The bitter conflict between the county boroughs, aiming to extend their boundaries, and the county councils, determined to resist every extension to the utmost, has prevented the making of suitable adjustments in the structure of local government.

In addition to the alteration in the character and numbers of the population, there have been considerable changes in the methods and technique of the main public utilities and social services. Their efficient administration now requires far larger resources and populations that most county and county borough councils possess. This is partly due to the fact that the smaller authorities can no longer afford the increasing costs of the administration of these services and partly to the fact that it is uneconomic to organise these services for small numbers of people.

Typical examples are the hospital services, where the employment of specialists and the provision of specialist equipment requires large sums of money and a large population; technical education, which calls for the provision of highly equipped

technical institutes and a large enough area from which to draw pupils; and, finally, the obvious examples of gas and electricity distribution and passenger transport.

The history of local government in the control of the various functions of public utilities and social services falls into various phases, which overlap to a certain extent. The prestige and powers of local government grew as the *ad hoc* bodies—the boards of health, the school boards, the Metropolitan Asylums Boards and the boards of guardians—were abolished and their functions transferred to the new local authorities. In addition, the Government added further duties and responsibilities to the local authorities.

The control and supervision of the central authorities over the functions of local government were restricted to approving the capital expenditure, auditing the accounts and investigating the abuses of the local authorities. With the expansion of the public utilities and the social services as a result of public demand and pressure, the Government were compelled to take an increasing share in the cost of these services. As a result, they took an increasing share in their administration. In addition, the derating scheme reduced the local authorities' income and made them more dependent on central grants. The Government then required the local authorities to submit detailed schemes for their local services, and the appropriate Ministers had the power to alter the schemes. At the same time, various local services were transferred from the smaller district authorities to the larger county and county borough councils on the grounds of increasing costs, easier control and greater efficiency.

The next phase was the complete nationalisation of some of the local services and the establishment of *ad hoc* bodies for such services as gas, electricity and the hospitals, etc., which had been administered in part by the local authorities. This process began with the transfer of the care of the unemployed from Public Assistance authorities to the Unemployment Assistance Board in 1934 and the transfer of 3,500 miles of trunk roads to the Minister of Transport in 1936. This process of nationalisation has been accelerated since the Labour Government came to power in 1945. Local authorities have already been deprived of electricity distribution, public assistance, a further 3,700 miles of trunk roads and the hospitals. Legislation has been passed which will shortly lead to the loss of production and

distribution of gas, road passenger transport and valuation for rating.

The unplanned and haphazard character of the changing relationships of central and local authorities could only lead to unsatisfactory, muddled government. The postponement of the task of curing the anomalies in local government has resulted in a crisis affecting both local and central government.

The two major faults in government administration to-day are the transfer of power from elected representatives to appointed members and the centralisation of government and administration. The evils of *ad hoc* bodies with appointed members, with the resulting suppression of the vital democratic control of elected councillors, have already been mentioned. An important cause of the growth in the influence, powers and duties of local government was the constant pressure exerted by progressive councillors elected on to the various local authorities.

The great tradition of the steady expansion of local authority government has come to an abrupt end, and the general movement to-day is in a retrograde direction. There has been some increase in the duties and functions of local government, especially with regard to education and town planning, and local authorities have even acquired new powers to run civic restaurants and entertainments. These advances, valuable as they are, cannot obscure the rapidly declining importance of local government in the affairs of the nation.

The building up of a centrally appointed regional bureaucracy to administer services which have traditionally been run by elected local authorities is a most dangerous and undemocratic development. The Labour Party, in its pamphlet, *The Future of Local Government* (1943), recognised that government by appointed regional boards was a direct danger to democracy and the expression of the will of the people. The pamphlet was prepared by the Advisory Committee of the Central Committee of Reconstruction after consultation with numerous local authorities and conferences in all the larger towns.

The Committee said: "Before the war there were regional organisations for electricity, the Ministry of Labour, the Ministry of Health, the Advisory Boards, etc., while during the war a number of Ministries have adopted the Civil Defence regions for special administrative purposes. It must be emphatically stated that this type of organisation cannot be permitted to

supplant a system of democratically elected local authorities. Nor must these regions condition the area of the new, bigger local government authority, since they are much too large and unwieldy and therefore too remote to maintain a common interest. The democratic tradition in local government must be preserved. Full authority must be vested in the elected representatives of the people."

In the setting up of the regional hospital boards and other regional bodies (for electricity, etc.), the principles outlined in the Labour Party's programme for local government in 1943 were forgotten.

The second major fault is the remoteness of control of the administration from the people who are supposed to be benefiting from the services and whose affairs are being governed. Large authorities should be able to reduce overheads, employ a more qualified and competent staff and cover larger areas with greater efficiency. If, however, the organisation becomes impersonal in dealing with the personal needs of the people, bureaucracy creeps in and the results cannot be satisfactory.

The transfer of the personal health services to the major local health authorities, although controlled by the elected representatives of the people, gives rise in the larger counties to bureaucracy and the isolation of members and officials from the people they are supposed to be serving.

As the Labour Party's pamphlet on *Local Government Reform* (1946) said: "In the first place, a large area means that the centre of administration is often a long way from the ordinary ratepayer. Not only do councillors have to make long journeys to attend meetings, but citizens who want to make complaints or obtain information have to travel a long way to do it. Equally, the councillor who wants to see for himself how the services for which he is responsible work has a wide area to cover. In the second place, a large area means that there are a great many decisions to make. Agendas become very long and the work of the authority takes up a great deal of time. Long journeys, long meetings, and bundles of reports to read would all tend to cut off the ordinary man from membership."

The Local Boundary Commission, in their report of 1947, made similar observations and came to the same conclusions.

Although attempts are being made to overcome these difficulties by delegating the day-to-day functions of the county councils

to sub-committees with local district representatives, the scheme has not yet functioned satisfactorily in practice.

The crisis in local government could no longer be ignored by the central Government, and in 1945 the Coalition Government appointed the Local Boundary Commission, with power to alter the boundaries and status of local authorities in order to adapt the system to the needs of post-war England and Wales within the framework of the county and county borough system. The Commission had no powers to create new types of local authorities or to change the allocation of functions between the different authorities.

These restricted terms of reference were not altered by the Labour Government. The task of the Commission remained that of patching local government instead of introducing the much-needed radical reforms. After two years spent in investigating all the major local authorities, the Commission came to the conclusion that their limited powers were quite inadequate and that no satisfactory reform of local government could be achieved without the creation of new types of local authorities and a redistribution of their functions.

The Boundary Commission confined their recommendations to the administration of the functions which at present remain with local government, and omitted from their scheme the functions and duties which local government recently lost to regional boards. The result is that, although the recommendations would produce a considerable improvement in the present structure of local government, they would not solve the main crisis in local government. The reason for this method of approach to the problem was to cause the minimum disturbance to all existing authorities.

This attempt to appease the big cities, the medium-sized towns and the counties would only leave behind what the Commission pointed out as one of the greatest sources of weakness in the present system of local government—the long-standing antagonism and conflict between the county and county borough councils.

The most serious criticism of the Commission's scheme is that it took for granted the fact that local government will never regain the services of which the local authorities have been deprived in recent years. The Commission did not consider the alternative of regional councils which would rehabilitate local

government and solve the many problems arising from the establishment of *ad hoc* bodies with appointed members. Regional authorities have already been constituted. The whole country is covered with a network of hospital boards, electricity boards, gas boards and transport boards, and in addition there are regional offices of the Ministries of Health, Town and Country Planning, Transport, Food and the Board of Trade.

The general conception of regional administration is therefore not a new one but the foregoing types of boards, as the Labour Party Committee said, "cannot be permitted to supplant a system of democratically elected Local Authorities." The real solution of the crisis in local government is to have regional authorities with elected members. The modern development of social services and public utilities requires large resources and a large population. The size of the local authorities must be expanded to enable them to take over most of the work of the regional bureaucracies.

The elected regional councils will then not only be able to regain the functions and duties previously removed from the local authorities, but will be capable of having new powers transferred to them. For instance, the duties of the Board of Trade with regard to the location of industry could be delegated to regional councils to enable them to carry out their town and country planning more effectively. Similarly, the powers of the New Towns Corporations could be transferred to the new local authorities.

The principle of elected regional councils was accepted by the Labour Party before it came to power. The Committee on *The Future of Local Government* (1943) said: "Any change in Local Government structure must vest full authority in the elected representatives of the people. The democratic tradition in local government is very powerful, and nowhere more so than in the ranks of the Labour movement. *It is not enough merely to affirm this principle.* Efforts must be made to translate Labour's ideas and ideals into a constructive system of government that will conform to the necessities of historical development."

After declaring that "full authority must be vested in the elected representatives of the people," the Committee recommended that "the country should be divided into areas each suitable for a regional or major authority, i.e. sufficiently large to have adequate resources to provide large-scale services and

to cope with the task of reconstruction, but not so large as to lose the sense of a common interest in its government."

Referring specifically to the health services, the Advisory Committee said: "The scheme [of a comprehensive medical service] must be effectively co-ordinated and should be administered by a *reorganised and democratically elected local authority.*" Hospitals are included among the powers suggested for these elected regional authorities.

The Labour Party's pamphlet, *National Service for Health* (September, 1943), made the following statements: "Labour's plan for the reform of local government recommends that the country should be divided into regions, each having a Regional Authority for certain purposes of Local Government; and that these Authorities (unlike the regional organisation during the war) should be *democratically elected.* The Party also proposes that, for health purposes, each of these *elected* Regional Authorities should appoint a Health Committee for its region. Under these Regional Health Committees there should be appropriate sub-committees." The programme goes on to describe the type of hospitals which would be organised within the region, associated with divisional health centres, etc.

It is also interesting to note that the Labour Party's programme included the central co-ordination of the health services. The programme stated this principle as follows: "The powers of the Ministry will need revision, however. On the one hand, its powers should be extended to cover all the Health Services, including those now controlled by other Departments, such as the School Medical Service and the health service in the factories; for technical reasons the medical services of the Armed Forces should be excepted. On the other hand, the Ministry of Health should be relieved of responsibility for services which affect health only indirectly, and which involve large scale organisation. (This principle is being adopted in the case of housing)."

Owing to the vital importance of local government in the health services scheme, plans for its reorganisation will be given in greater detail.

The Labour Party, in *Local Government Reform*, May, 1946 (Labour Discussion Series, No. 4), reaffirmed its previous programme: "The need for wider areas on the one hand and for preserving local interest on the other leads straight to the proposals made by the Labour Party and other bodies for a

new two-tier system. The major local authorities of the existing two-tier system would be enlarged into regional authorities, and the other might be known as area authorities. The regional authorities would plan for the whole region (which would be smaller than the wartime Civil Defence region) and carry out major schemes, leaving in many cases details of administration and local services to the area authorities."

A region would have to be large enough to administer efficiently all the services including hospitals and would be based as far as possible on an area with common economic interests and traditional, social, political and cultural associations. The fourteen hospital regions or the twelve electricity regions are far too large and are therefore remote from the influence of the people. They are essentially regions which are convenient from the point of view of a centrally controlled bureaucracy.

For example, Lancashire ought probably to be divided into three regions, based on Manchester, Liverpool and Preston (and possible a fourth, based on Bolton), instead of the way in which it is now divided between the Manchester and Liverpool hospital areas, which include portions of other counties and county boroughs (e.g. Chester, Westmorland and Derby); or, again, as with the Electricity Board, where it forms part of a huge region stretching from Cheshire to Westmorland.

About twenty-five regions would be required for England and, generally speaking, most regions would have a population of at least a million, while some would be a good deal larger. Greater London would be included in one region.

The regional councils would only control those services which require very large areas and populations for their effective control in administration. Smaller areas would, however, be required, such as the borough or district council in order that the system of government should be responsive to the people's needs. The country district councils have suffered very severely from the incessant drive for larger areas of administration. In the last few years the following services have been transferred from the district councils to the county councils—the borough police forces, elementary education, fire brigades, town and country planning and all the personal health services, maternity and child welfare, etc. These changes often resulted in the control of services passing from district councils with Labour majorities to county councils with Tory majorities.

This process was accelerated by the fact that many boroughs and district councils were too small to administer these expanding services, and no attempt was made to reorganise them into larger units.

Every little town was only too anxious to separate itself from the surrounding countryside and form itself into an urban district so as to secure better services than the impoverished countryside could afford. Many of the rural districts, in particular, were never formed on any rational principles, but were simply the areas left over after the small towns had become urban districts. This sharp separation between town and country no longer accords with the interests of the urban and rural workers.

The solution of the problems of administration in the lower tier of government in the "borough councils" or "district councils" lies in the transference to them of the vital personal services of health and education. This would inject a new element of democracy into these services and bring them close to the needs and wishes of the people. It would also enhance the reputation and influence of the lower organs of local government, for the expanding services of health and education are becoming more and more important.

The size of the various "district councils" would have to be determined in each area on the minimum population necessary for satisfactory local administration of the services of health and education. In the sparsely populated rural areas, the population would have to be smaller than the normal minimum, so that the authority might maintain close contact with the people; whereas in "district councils" based on existing borough and county borough councils it would be necessary to have populations larger than the minimum.

The system of regional government would thus be a two-tier system of government with the regional councils as the first tier and district or borough councils as the second tier. The county councils would be merged with the regional councils, while the county borough councils would be borough councils working with the regional councils. As the regional councils would be regaining many of the functions which the county boroughs have lost, the latter would actually have a net gain in powers and duties with this extension of democratic control.

For instance, the regional aspects of town and country planning, sewage disposal and technical education, would be

administered by the regional councils, while the management of hospitals in the boroughs would be delegated to the borough councils, the general planning of hospitals remaining with the regional councils.

Generally speaking, the "district councils" would have full responsibility, including financial, of all the health services, except with regard to hospitals, where there would be a system of delegation, but a far more flexible one than exists to-day.

The regional councils would be the general planning authority for all the services in the area and would exercise a general supervision over the administration of the services.

At the same time, local government finance could be reformed and the burden placed more equitably. As the Labour Party Committee stated in *The Future of Local Government*: "It is an axiom of democracy that autonomy should be accompanied by financial responsibility; therefore the region and its component areas must, subject to Government grants, provide the money they respectively spend. This is essential if local government is to retain an adequate measure of independence and liberty of action."

The valuation for rating, which is now being transferred to the central authority, could be referred back to the local government authority, the regional council. The Labour Party Committee said: "As a step towards securing a national basis of assessment, more uniformity would be achieved by placing the responsibility upon the major authority, which would be responsible for making assessments to rates, through skilled assessors working locally."

The methods of levying rates at the present time lead to the poorer sections of the population shouldering the main financial burdens of local government. The Labour Party, in *Local Government Reform* (Labour Discussion Series, No. 4), May, 1946, said: "There is no doubt about the uneven incidence of rates as a form of taxation. The proportion of family income spent on rent increases in the lower income groups. As rates are closely linked to rent, this means that the burden of rates falls more heavily on poorer people. It falls more heavily also on people with large families, who need large houses for them."

The only real solution to the raising of local government finance is by levying a local income tax. This would spread the financial burden according to ability to pay and would restore

the traditional independence of local government. The criticisms that there would be an inadequate budget in the poorer districts and that some rich people might avoid the tax by moving to "the watering-places of the Sussex coast" as "lower tax" retreats, are answered by the points that the areas of the regional councils would be large enough to compensate for the poorer districts, that the task of assessing and collecting the tax would be much easier than it is to-day, and, finally that, if necessary, central government grants could be given to assist any area which had financial difficulties.

The discussion on local government reform has been rather lengthy, for in it lies the solution of many of the problems which arise in the present complicated set-up of administration in the health services. Elected regional councils with "district councils" as a second tier would revitalise local democracy and the interest of the people in their health services.

The organisation of all the health services under one head of administration would result in a more satisfactory co-ordination of the various services and a more close co-operation with the people in the area. Finally, the new local authorities would have sufficient financial resources and local support from the population to be capable of administering the local services satisfactorily with as little central interference as possible, and with the elimination of bureaucracy.

CHAPTER XVI

CONCLUSION

WE ARE NOW IN A position to examine the present-day health services in their proper perspective. The development of the present health services from those of the past has not been a slow, evolutionary process towards an ideal service. Each new development in the health services was determined in its inception and progress by the conditions of the time and by the limited purposes for which it was fashioned. It was rare for the main criterion to be the preservation of the health of the community or the best possible attention for the sick. The main consideration has always been the solution of some political or administrative problem, with the role of finance predominant.

The health services, like the other social services, have been built up in periods of struggle for the improvement of the general working and living conditions of the population. The great struggle during the Industrial Revolution for improvement in sanitary environment gave place to the battle for improvement in the personal health services. These battles were not always crowned with victory, and the fight was often bitter and relentless.

As the social basis of production matures there develops a growing interest of the population in the progress of society and the social services. As the art of medicine is transformed by the science of medicine there develops a closer linkage with other sciences and scientific workers. Medicine ceases to be the prerogative of the skilled physician or surgeon alone. It becomes essentially a matter for team work based on the development of industry and the nation as a whole. With the advance of democracy in the nation there is a corresponding advance in the democratisation of medicine.

It was the former Vice-President of the United States—Henry Wallace—who said that the present century was the century of the common man. To-day the Labour Movement is growing more and more powerful. In spite of substantial progress, the present service has not yet achieved the aims of the principles

of the Labour Party's programme for a "National Service for Health"; nor has it achieved the aims of the policy outlined by Mr. Winston Churchill on March 2nd, 1944: "Disease must be attacked in the poorest or in the richest, in the same way as the fire brigade will give its full assistance to the humble cottage as readily as to the most important mansion. Our policy is to create a National Health Service to ensure that everybody, irrespective of means, age, sex, or occupation shall have equal opportunities to benefit from the best and most up-to-date medical and allied services available."

The reasons are not too far to seek. Vested interests and the well-to-do, generally, have always opposed the advances of the social services. They were powerful in their opposition to the sanitary reforms, to the birth and growth of the health services and to the National Health Service Bill. Their bitter resistance to the Bill was not faced firmly and with fierce resolution, for the Government did not rely on their main support and allies, the people. The Health Act was therefore a series of compromises. Although many of its measures were very progressive—the provision of doctors, the supply of medical, dental and optical appliances for the whole population, and the general abolition of medical fees—the balance was often weighted in favour of the reactionaries, who are prepared to retard social progress in working for their own selfish interests.

The worst of the series of compromises was the lack of democratic influence in the administration, the permission for specialists to have pay-beds in the hospitals, and the capitation fee methods of payment for the general practitioners.

The major struggles for a real health service for the nation are yet to come; the struggle for the setting up of health centres, for the extension of the hospitals and local authorities' services and, above all, for the democratisation of medicine.

The victory in these struggles and the achievement of a national health service will not be won by slogans, programmes or plans alone, however attractive they may be. They will only be won when the whole strength and power of the Labour Movement is thrown into the struggle. As the Labour Movement develops still further, the workers become interested in issues apart from wages and their conditions of work. Health is one of the most important issues in which the interest of the workers can easily be roused.

An understanding of the principles involved and the forces to be overcome would soon bring the people decisively into the battle for health. Victory for a real health service for the nation will only be achieved when *the health of the people becomes the concern of the people.*