THE ROCK CARLING FELLOWSHIP

1997

Public Health
The vision and the challenge

THE ROCK CARLING FELLOWSHIP

1997

PUBLIC HEALTH

The vision and the challenge

The pursuit of public health can have no finality... The problems of public health are changing rapidly with increasing medical knowledge and changes in social and economic conditions, the age distribution of the population and the outlook of the people.

Sixth Annual Report of the Department of Health for Scotland 1934

Walter W Holland

CBE, FRCP, FFPHM

LSE Health, London School of Economics and Political Science

London

AND

Susie Stewart

DL, MA, HON MFPHM

Department of Public Health,

University of Glasgow

Glasgow

Published by
The Nuffield Trust
59 New Cavendish Street, London WIM 7RD

ISBN 1-902089-10-3

© Nuffield Trust 1998

Publications Committee
Sir Derek Mitchell, KCB, cvo
Professor John Ledingham, DM, FRCP
John Wyn Owen, CB

Designed by Benjamin Rowntree Reports Limited
PRINTED IN GREAT BRITAIN BY BIDDLES & CO

The Rock Carling Fellowship
commemorates the late
Sir Ernest Rock Carling
for many years a governing Trustee
and Chairman of the Medical
Advisory Committee of the
Nuffield Provincial Hospitals Trust.

It was stipulated that each holder
of the Fellowship will seek to review
in a monograph the state of
knowledge and activity in one
of the fields in which Sir Ernest
had been particularly interested,
and which is within the purposes
of the Trust.

The arrangements provide that
the monograph will be introduced
by a public lecture given at a
recognised Medical Teaching Centre
in the United Kingdom.

Public Health
The vision and the challenge

CONTENTS PAGE

Acknowledgements ... iii

Prologue — *What is Public Health?* ... *v*

Chapter One ... 1
Updating the Poor haw — The foundations of modern public health

Chapter Two ... 27
Between the Wars
1918-1939

Chapter Three ... 61
Towards the National Health Service
1940-1948

Chapter Four ... 95
Changing Names —from Public Health to Community Medicine 1948-1914

Chapter Five ... 126
Community Medicine in Turmoil
1914-1989

Chapter Six ... 145
The Health of the Nation
1989-1991

Chapter Seven ... 166
A Perspective on Public Health Past

Chapter Eight ... 192
Where now for Public Health? — The art of the possible

Annexe 1 ... 222

Annexe 2 ... 224

Index ... 237

Acknowledgements

It would be impossible for us to acknowledge all the help we have been given in the preparation of this monograph. We are, however, particularly grateful to Sir Donald Acheson, Dr Michael Ashley-Miller, Dr Virginia Berridge, Prof Peter Burney, Dr Alan Bussey, Sir Kenneth Caiman, Dr Simon Capewell, Dr Gareth Crompton, Dr Cam Donaldson, Dr Michael D'Souza, Sir George Godber, Mr Peter Griffiths, Prof Andy Haines, Prof David Hunter, Dr Azim Lakhani, Dr Christopher Lycett, Prof James McEwen, Mr Gordon McLachlan, Dr Harold Markowe, Mr Douglas Mason, Dr Robert Maxwell, Dr Richard Mayon-White, Mr David Mead, Prof David Miller, Prof David Morrell, Prof Jerry Morris, Dr Michael O'Brien, Prof Stephen Palmer, Prof Peter Pharaoh, Dr Lewis Reay, Sir William Reid, Dr Geoffrey Rivett, Dr Sally Sheard, Mr Allan Stewart, Dr David Stone, Prof Michael Warren and Mr John Wyn Owen for their comments and constructive criticisms. The opinions we express are of course entirely our own responsibility. Miss Heather Lodge, Librarian UMDS, provided inestimable help as did the Research Unit and Library of the Royal College of Physicians, the Library of the Royal College of Physicians and Surgeons of Glasgow and the Library of the University of Glasgow. We thank also Mrs Cindy Mitchell for valuable help with picture and bibliographical research, Mrs Hilary Flenley for preparing the index and Mrs Patricia McKellar of The Nuffield Trust who oversaw the various stages of production with competence and calm. Mrs Fiona Holland and Misses Anna Hanson and Deme Nicolaou of LSE were of great assistance in deciphering our tapes and handwriting and typing the various drafts.

Walter Holland
Susie Stewart

March 1998

Walter Holland CBE, FRCP, FFPHM

Walter Holland qualified from St. Thomas's Hospital Medical School in 1954. His entire career has been in medical research. His interests in epidemiology were aroused by his involvement in investigations of the 1957 influenza pandemic while doing his national service in the RAF. After gaining experience at the London School of Hygiene and John Hopkins University School of Hygiene, he returned to St. Thomas's in 1962 where he remained until 1994. His major research interests have been in the epidemiology of chronic respiratory disease, blood pressure and the application of epidemiological principles to health services research. He has pubhshed widely, including editing the Oxford Textbook of Public Health. He was President of the International Epidemiological Association and the Faculty of Public Health Medicine. He has served on many national and international committees concerned with public health and has spent periods of time in Australia, France, Germany, and various parts of the United States. He has had experience of life at the 'sharp end' by being a member of a District Management Team, member and vice-chairman of a health authority and non-executive director of a health authority. Susie Stewart and Walter Holland have published together on several occasions including *Screening in Health Care* which was pubhshed by the Trust in 1990.

Susie Stewart DL, MA, HON MFPHM

Susie Stewart graduated from St. Andrews University in 1962 and obtained a postgraduate diploma in Social Studies from Edinburgh University in 1963. She became an honorary member of the Faculty of Public Health Medicine in 1992. Her career began with a research post in mental handicap and genetic counselling. In 1971 she took up a research and editorial post with Professor Holland in the Department of Community Medicine, St. Thomas's Hospital. Following a move back to her home town of Glasgow in 1977, she was for ten years technical editor of two of the British Medical Association's specialist journals and technical editor for the Panel of Social Medicine and Epidemiology of the Commission of the European Communities. In 1990 she was appointed Executive Secretary of the Scottish Forum for Public Health Medicine and the subsequently established Scottish Needs Assessment Programme (SNAP). Work on the present monograph began in 1995 and she now has a part-time appointment as research manager in the Department of Public Health at the University of Glasgow and acts as an editorial adviser to The Nuffield Trust.

Prologue

WHAT IS PUBLIC HEALTH?

The concept of public health was easy to define in the period before the Second World War. The major threats to life were the result of insanitary conditions such as a foul water supply and defective or absent sewage and waste disposal, inadequate or over-crowded housing, poor and adulterated food and thus poor nutrition, hazardous workplaces and little effective clinical care. Thus what was considered as public health was concerned with rectifying these conditions — largely through legislative and population policies. The tasks of our predecessors entailed identifying the malpractices of landlords, employers, the state and others and persuading these groups that improvements were essential and could lead to improvements in health status and better life expectancy.

At the beginning of this century many of these ills had been tackled and we no longer had open sewers or child labour. The most dramatic event, however, was the finding that a very high proportion of young men needed to fight in the Boer War were incapable of doing so because of inadequacies in their physique and health. This provided a new focus for public health in improvement of health as well as prevention of disease and death. As a consequence, public health began to be involved far more actively in health surveillance and in identifying particular groups who needed additional help — pregnant mothers, for example, and infants and small children. These strands of public health activity were developed and strengthened in the period between the two World Wars.

In 1911, Lloyd George introduced a health insurance system for the employed. With the creation of the Ministry of Health in 1918, analysis of the factors that influenced health demonstrated the need to include health services for populations and groups in the consideration of the public health responsibilities of central government. Over the past 80 years there have been major changes not only in our way of life, organisation of services, and the environment but also in the

abilities of medical science to prevent as well as cure disease. Concomitant changes have occurred in our understanding and concerns in public health. Not only are we involved with the control of infectious disease but also with the control of other conditions which entail not only population/legislative control but also changes in individual behaviour.

In this context, public health cannot be concerned only with the control of disease and the improvement of health. The factors that can contribute towards achieving these goals involve all aspects of our lives. Public health must, therefore, also mean involvement with a local community on two levels. Firstly, the public health professionals must work with representatives of the people in their community to find the best structure for what requires to be a reciprocal process of communication and a real partnership. Secondly, they must work with and guide those responsible for the planning and provision of those structures and activities which affect the health of a population — for example, housing, water and sewerage, education, social services, employment, transport and clinical services - since only by effective collaboration across departmental boundaries can health be maintained and improved.

For this reason, we have tried in this monograph to look at the broad focus of public health over the years and how many factors interact in the pursuit of improvements in the health of the population. The only limiting feature is that public health is concerned with the health of groups and populations and not with the treatment of individuals. This must be acknowledged and its implications accepted by politicians and policy-makers. Only if it is will the specialty receive its fair share of limited financial resources for health.

The definition of public health, and indeed of health itself, has long been the subject of discussion.

Professor AG Gilliam, an eminent American public health practitioner — one of the first to become concerned with the control of cervical cancer in the early 1930s following his work on infectious diseases for the US Public Health Service — was asked in 1931 for his definition of public health. He replied simply 'it is what I do' *(personal communication to Walter W Holland 1961).*

We make no attempt here to compose yet another definition

but emphasise again that public health must remain open and flexible in response to changes in society and medical science. The best working definition of public health and the one to which the specialty should adhere remains that put forward by the Acheson Committee in their 1988 report.

> Public health is the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society.

1

Updating the Poor Law — the foundations of modern public health

Sanitary neglect is mistaken parsimony. Fever and cholera are costly items to count against the cheapness of filthy residences and ditch-drawn drinking water... The physical strength of a nation is among the chief factors of national prosperity.

John Simon 1858

HISTORICAL BACKGROUND

To understand the development of the specialty of public health in the United Kingdom in the twentieth century, it is necessary to look back at least to the middle of the nineteenth century when the scene was being set. The true origins of present day public health lie further back still in the Elizabethan Poor Law of 1597 which laid out a broad framework for poor relief in England and Wales.[1]

In examining the whole climate for the enormous progress that was made in a relatively short period of time in Britain, however, it is important also to acknowledge the pioneering earlier contribution to the growth of interest in public health which came particularly from Germany, from Johann Peter Frank and his *System einer vollstandigen medizinischen Polizey* — probably best translated as System of a Complete Medical Policy.[2] This was published between 1779 and 1827 in six volumes and three supplementary volumes, two of which appeared after Frank's death.

Since the word 'Polizey' also means Police, the title has often been mistranslated as a System of Medical Police with authoritarian undertones. In his introduction to the work, however, Frank explains his intention clearly:

> to produce a doctrine whereby human beings and their animal assistants can be protected against the disadvantageous consequences of crowding too thickly upon the ground; and especially it is an art for the

promotion of their bodily weal in such a way that, without suffering from an overplus of physical evils, they may defer to the latest possible term the fate to which, in the end, they must all succumb.

Frank studied the influence of the entire social environment on the individual. His remarkable system of public and private hygiene concerned itself with many aspects of public health including a school health service, accident prevention, care of pregnant and newly-delivered mothers, sewerage and public water supply. He formulated and presented a coherent, comprehensive and very detailed health policy which had considerable impact both within Germany itself and in countries such as Hungary, Italy, Denmark and Russia where cultural contact with Germany was close.[3]

In Germany authority tended to come from the ruler or adviser to the people and the people were likely to conform. In Britain, by contrast, the idea of central authority was not well established or popular and public health pioneers tended to appeal first to the people and only later to the state.[4] But although the influence of Frank's work in this country may have been indirect, it was considerable and helped to create a heightened awareness of the importance of many non-medical influences on health and welfare.

REFORMS AND LEGISLATION

In Britain the Poor Law system had been designed originally for the small, largely rural population of the late sixteenth century. It was based on the parish and proved ill equipped to cope with the rapidly increasing and more urbanised population of the Industrial Revolution. Urban development in nineteenth century Britain was not a gradual or controlled process. It was more of an explosion which by its very rapidity created immense problems in terms of society's ability to make adequate response.

Before the Industrial Revolution, the essential work of government, apart from national defence, was to secure peace and to encourage the cultivation of the soil and the exercise of craftsmen's skills.

Local government was extremely varied in quality and answerable only to itself. In 1832, for example, there were over

15,000 parishes in England, each a separate unit of local administration.[5] There was no uniformity of size, method of operation or policy and it was becoming abundantly clear that the old system could not meet the requirements of management in the new industrial towns.

The Reform Act of 1832 and the Poor Law Act of 1834 determined the main principles of central control of local authorities until 1929. But still, throughout the whole of the nineteenth century, the theory of laissez-faire dominated the thinking of the electorate and there remained considerable resistance to central control.

From 1832—88 relations between central and local government were influenced by three new problems.[5] Firstly, any central attempt to alleviate deprivation in a new industrial age when the theory of laissez-faire was so widely accepted was hard to implement. Secondly, the protection of health in entirely new conditions of crowded and insanitary living was difficult when little was yet known about the nature and causation of disease and the methods by which it could be controlled. Thirdly, the search for a representative and competent form of local government was hesitant and bedevilled by controversy.

During the nineteenth century the overall population of Great Britain increased three-and-a-half-fold (Table 1). As Wohl[6], among others, has highlighted, at the beginning of the nineteenth century only 20 per cent of the population of England and Wales lived in towns with a population of over 5,000. By 1911 that figure had risen to almost 80 per cent. This astonishing growth, which applied also to Scotland, is illustrated by the figures in Table 2 which shows the increase in population in ten major British towns and cities between 1801 and 1901.

Table 1.

Population growth in the nineteenth century.

Country	1801	1901
England and Wales	8,892,536	32,527,843
Scotland	1,608,420	4,472,103

Table 2.
Growth of towns in the nineteenth century.

Town	Population 1801	Population 1901
Birmingham	73,000	522,204
Bristol	68,000	328,945
Edinburgh	66,544	316,479
Glasgow	77,385	761,709
Leeds	53,000	428,968
Liverpool	77,000	684,958
London	831,181	4,509,618
Manchester	75,275	606,824
Salford	14,477	220,956
Sheffield	45,755	409,070

POOR LAW AMENDMENT ACT

In addition to its inadequacy in terms of provision, the actual administration of the Poor Law was also extremely variable over the country as a whole and amendment was urgently required. In 1832 a Royal Commission was appointed to consider the position and make recommendations for its updating and the 1834 Poor Law Amendment Act established the Poor Law Commission as a central board of administration.

In the prevailing climate of emphasis on voluntary local action to alleviate poverty and deprivation with minimum state intervention, there was considerable opposition in Parliament and the press to any idea of centralisation and any form of state control. This successfully limited the life span, and thus the powers, of the Commission to five years in the first instance. From 1839 to 1842 the Commission's powers were renewed annually but in 1842 it was given a further five year term. In 1847 the Commission was replaced by the Poor Law Board which continued until 1871.[7]

An outspoken and combative lawyer, Edwin Chadwick

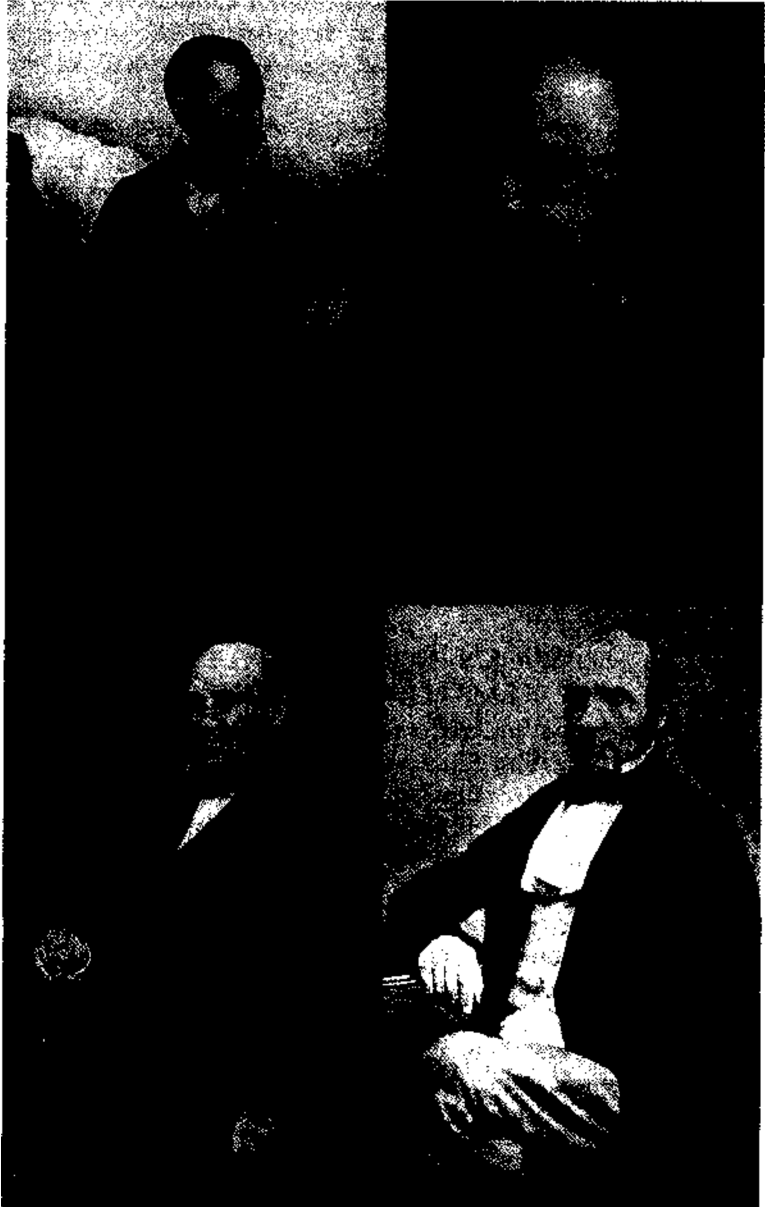


Figure 1. Four giants of nineteenth century pubhc health - top, left to right, John Simon, Edwin Chadwick. Bottom, left to right, William Farr, John Snow.

(Figure 1), had been co-opted to the Royal Commission on the Poor Laws and was appointed as Secretary to the Poor Law Commission and not, as he had expected, to a seat on the Commission itself.

Chadwick was not a man open to compromise when the implementation of the Poor Law Amendment Act proved unpopular. He was frequently in conflict with his three commissioners in this context. His abilities and persistence, however, were unrivalled. He believed fervently in what he had committed himself to achieve and he was an efficient and determined administrator.[8] He gave public health a set of clear objectives by showing how the Census and Bills of Mortality — official returns of the deaths in a district which began to be published in 1592 for 109 parishes in and around London — could be used to identify particular public health problems which required legislation and he laid the sohd foundations for much of what was to come in the twentieth century. He lacked, however, the tact and patience necessary to sustain effective public administration and made many enemies.

CHADWICK'S INQUIRY INTO PUBLIC HEALTH CONDITIONS

In 1839 Parliament ordered a full-scale investigation into public health conditions. The commissioners seized the opportunity to sideline Chadwick by releasing him from his Poor Law duties to conduct the enquiry. This attempt to marginalise him failed and the appointment proved to be a major turning point in public health in Britain.[9]

At every stage of his enquiry Chadwick had to confront the kernel of the public health dilemma at that time — the relationship between central and local government. His way of thinking had been strongly influenced by Jeremy Bentham — the English philosopher and economist and one of the principal influences on reforming thought in the nineteenth century — for whom he had worked as secretary. In all his work Chadwick focused on three central points: fresh thinking was needed to address the problems of public health and to show that old approaches should be discarded; central government action was essential if social reform was to be really effective; and everything had to be judged by the principle of utility — reforms

were only good if they increased the sum total of human happiness.[10]

At the time of Chadwick's investigations, action on public health issues was the responsibility of local government. Inevitably some local authorities were active and effective while others needed constant pressure from the centre to make them reach even minimum standards. In fact the massive improvements in sanitary conditions in the late nineteenth century were achieved both by local initiative and central direction but there remained huge discrepancies in the way different towns tackled their health and social problems. Liverpool, for example, then one of the unhealthiest cities in Great Britain, was a pioneer in public health — in 1846 it appointed William Henry Duncan as the first Medical Officer of Health in the country. Five years earlier in 1841 it had built a municipal wash house. By 1865, in contrast, many large towns including Cardiff, Leeds and Manchester still had no such municipal facilities.[6]

Chadwick conducted his enquiry with great zeal and thoroughness, using poor law mechanisms to obtain information from all over the country. His Report on the *Sanitary Conditions of the Labouring Classes* was completed early in 1842 and presented to the House of Lords in July of that year. The Commission, in whose name it was supposed to be published, found its contents excessively radical and the report eventually appeared under Chadwick's name alone.[11]

This powerful report described to politicians in clear terms the appalling living conditions of the poor and the association between poverty and ill health. Inadequate drainage, sewerage and water supplies, together with chronic overcrowding, brought the inevitable consequences of disease, high rates of mortality and limited life expectancy.

Examples were given of poor conditions throughout the country. One of the informants from Buckinghamshire and Berkshire was particularly critical of the town of Windsor — 'which from the contiguity of the palace, the wealth of the inhabitants, and the situation might have been expected to be superior in this respect to any other provincial town. Such, however, is not the case; for of all the towns visited by me, Windsor is the worst beyond all comparison'.

Table 3.
Summary of public health and related legislation in England and Wales in the second half of the nineteenth century

Year	Legislation	Comments
1848	Public Health Act	Established General Board of Health. Granted permissive sanitary powers
1853	Vaccination Act	Compulsory vaccination for all infants in England
1858	Medical Act	Registration of doctors - GMC
1860	Adulteration of Food Act	Local authorities empowered to control adulteration of food
1866	Sanitary Act	Made local authorities responsible for inspecting and controlling all nuisances
1867	Reform Act	Enfranchised urban working class householders
1867	Factory Act	Tightened previous factory legislation
1868	Artisans and Labourers Dwelling Act	Local authorities empowered to force owners to demolish or repair insanitary dwellings
1872	Public Health Act	Public Health put under new urban or rural sanitary authorities and required to appoint an inspector of nuisances and a medical officer of health in urban areas
1872	Adulteration of Food, Drink and Drugs Act	Strengthened and extended the 1860 Act
1875	Public Health Act	Consolidated and extended previous Public Health Acts
1875	Artisans and Labourers Dwellings Improvement Act	Local authorities permitted to rebuild slum areas
1878	Factories and Workshops Act	Consolidated previous legislation, established central inspectorate
1884	Reform Act	Enfranchised rural working class householders
1880	Elementary Education Act	Elementary education made compulsory
1889/99	Infectious Diseases (Notification) Acts	Compulsory notification of infectious diseases
1890	Infectious Diseases (Prevention) Act	Permitted inspection of dairies

Chadwick himself found Glasgow to be far from satisfactory—'It might admit of dispute, but, on the whole, it appeared to us that both the structural arrangements and the condition of the population of Glasgow was the worst of any we had seen in any part of Great Britain'.

The purpose of Chadwick's report was to influence and mobilise public opinion in favour of reform and in this it succeeded. It contained few detailed proposals but its broad principles included observations on techniques of sewerage.

The report was enthusiastically received and public health became an important political issue. It led eventually to the impressive programme of public health and related legislation in the second half of the nineteenth century and early part of the twentieth as summarised in Table 3.

CENTRAL BOARD OF HEALTH

Chadwick's impatient and powerful personality and insistence that public health of the time was mainly a question of engineering naturally led him into conflict with some politicians and with a medical profession anxious to maintain its position and seeking a purely medical explanation for all causes of infection. But in relation to deciding the correct priorities for the time, Chadwick was undoubtedly right.

He forced recognition of the need for adequate sanitation if health was to improve and the Public Health Act of 1848, largely the result of his work and pressure, marked the beginning of modern public health in Britain and had international implications. This Act replaced the Poor Law Commission with a Central Board of Health with three commissioners — Chadwick himself, Dr Southwood Smith, a physician to the London Fever Hospital and Lord Shaftesbury. The Board, however, had virtually no statutory powers and had to rely for its effectiveness almost entirely on advocacy and influence.[9]

MAIN PUBLIC HEALTH ISSUES

The main and inter-related public health issues of the time were sanitation, housing, infection, nutrition and the poor health and excess mortality of the population.

SANITATION

Sanitation was perhaps at the forefront of these issues and inextricably linked with housing conditions and hygiene. The realities of life in Victorian cities are horrifying to contemplate from the comfort of the late twentieth century — 'a compound of inadequate sewers, overflowing cesspools, poorly-drained cowsheds, abattoirs, domestic pigsties, exposed dung-heaps and industrial waste'.[6] The lack of even remotely adequate toilet facilities was widespread.

In Greenock, for example, a town of almost 50,000 inhabitants in the mid 1860s, most houses lacked any toilet facihties whatsoever. 'The common method of getting rid of refuse in houses is by depositing the contents of chamber vessels with ashes and other filth in the roadway between the hours of 10pm and 8am. For the fourteen hours of the daytime, such matters have... to be voided and retained inside the close and crowded rooms'.[12] In Glasgow in 1870 over 40 per cent of the population hved in houses without water closets while in Manchester only 10,000 of the 70,000 houses had them.

Clean water supplies were another problem. Not only were water sources woefully insufficient and often contaminated but few houses had running water. Buckets had to be drawn and paid for at the local pump or tap and carried home. In some towns, such as Bristol, it was an offence to draw water on a Sunday. Lack of cleanliness was an inevitable consequence. John Liddle, Medical Officer of Health for Whitechapel, commenting on house visitations in poor areas, wrote:

> The filth of their dwellings is excessive, so is their personal filth. When they attend my surgery, I am always obliged to have the door open.

And, according to Louis Parkes, Medical Officer of Health in Chelsea, the working classes formed a kind of human air pollution. 'The air of a London police court', he wrote, 'furnishes a striking example of such air pollution'.

The broad principles of Chadwick's 1842 report centred on the removal of sewage. He suggested that the answer was to remove sewage by suspension in water. For this there were two essential elements — first an adequate supply of piped water and second an entirely new system of sewers.

As is so often the way, political expediency played its part in

the eventual introduction of a satisfactory system of sewerage in London, resisted for so long on grounds of the immense cost.

Cholera was a major threat at that time and its causes were not well understood despite the epidemiological efforts of Dr John Snow, another public health pioneer of that time (Figure 1).

In 1848, during the second major epidemic to threaten Britain, Parliament reluctantly passed the previously rejected Public Health Act which allowed for the establishment on certain conditions of local boards of health with powers to undertake work including sewerage and water supply systems, if they wished to do so. One important requirement, in an otherwise permissive Act, was that all new housing built in a board area must be connected to a main drainage system.

The bitter battles that were waged by some politicians and many members of the medical profession against Chadwick and his adherents are well illustrated by a quote from a Leader in *The Times* when in 1854 Parliament refused to renew the Public Health Act:

> Aesculapius and Chiron, in the form of Mr Chadwick and Dr Southwood Smith, have been deposed, and we prefer to take our chance of cholera and the rest than be bullied into health.

Parliament then set up a new Board of Health under Sir Benjamin Hall, a vociferous medical opponent of Chadwick. Another cholera epidemic that year helped the cause, however, as Hall was forced to take measures similar to those initiated by his predecessor during the 1848 epidemic.

In 1855 Hall appointed, for the first time in history, a permanent medical officer to advise the government. The first of these advisers was John Simon, previously Medical Officer of the City of London and another public health giant of his time (Figure 1).

The Board of Health was formally disbanded in 1858 and its functions divided between a newly established Local Government Act Office and the Privy Council which contained John Simon as Medical Officer in a new Health Department.

The problems of resistance to central government involvement in local matters continued and any progress had to be attempted through the local health boards with wide

Figure 2. Punch cartoon of 3 July 1858 depicting the condition of the Thames at that time (reproduced with permission of Punch Ltd).

variations as before in local standards.

Public health problems were among their worst in London and during his six years as Medical Officer of Health in the City of London Simon had overseen the introduction of an adequate sewerage system there. A scheme for the whole Metropolitan area, drawn up by an engineer Joseph Bazalgette, was submitted to Parliament in 1856. It underwent two years of discussion, controversy and amendment.

Once again political expediency had played its part. In the summer of 1858, there was a sharp deterioration in the state of the Thames and on 11 June in the House of Commons, a Mr Brady said 'it was a notorious fact that honourable gentlemen sitting in the committee rooms and the library were utterly unable to remain there in consequence of the stench which arose from the river...'.

Parliament reacted in two ways to what became known as The Big Stink (Figure 2). First, it fitted blinds coated with

caustic soda to its riverside windows. Secondly it passed an Act to sanction the immediate implementation of Bazalgette's scheme which was opened by the Prince of Wales in 1865 and remains the basis of present day sewerage arrangements.

There followed an intensive period of legislation for public health with, in quick succession, the Sanitary Act of 1866, the Local Government Act of 1871 and the Public Health Act of 1872 (Table 3). These were all fairly hurried and imperfect measures but they did indicate that public health matters were now at last at the forefront of the political agenda. An element of compulsion was also introduced at this time to ensure that certain measures were taken. The 1872 Act, for example, required local authorities to appoint an inspector of nuisances and a medical officer of health.

The whole framework of public health administration came together in the great Public Health Act of 1875 which laid such sound foundations for modern public health that no major changes were required for more than 60 years.

The Act consolidated rather than extended previous legislation. For the first time a complete statement of the powers and responsibilities of local sanitary authorities were clearly stated.

In Scotland, as Brotherston has shown,[13] the approach was somewhat different from England where sanitary reform was, as we have seen, the main focus of public health efforts in the nineteenth century.

Even late on in the century, and with unemployment and overcrowding intensified by the influx of Irish immigrants in search of work and the rural urban shift of population, Scotland was slow in creating a climate of public opinion favourable to sanitary reform.

> The needs were appreciated by a minority at least as early, and as clearly, as in England; yet reform was slower. At the same time the problems in Scotland were more acute, for the country had been hustled with disastrous rapidity from a much more primitive social and economic state.

Although in Scotland legislation came later — for example, in the Public Health (Scotland) Act of 1897 — the provisions were similar.

One death in three between 1848 and 1872 was the result of infectious disease and there were recurrent epidemics of both cholera and smallpox. Curative medicine had not yet taken the massive steps forward that were to be a feature of the early and middle twentieth century.

This was an age, therefore, when an improvement in the health of the population had to come through control of environmental threats to health such as inadequate sanitation and defective water supplies and to improvements in nutrition and the standard of living in general.

HOUSING

The rapid increase in population in Britain in the first half of the nineteenth century produced, as one of its consequences, poor building standards and an inadequate supply of decent housing with serious overcrowding.

Chadwick and Simon, among many others, drew attention to the health consequences of bad housing, and urban congestion in particular, and highlighted housing reform as a central political issue.

Yet another commission of inquiry reported in 1885 — the *Report of the Royal Commission on the Housing of the Working Classes* contained a sweeping indictment of housing conditions, especially among the poorer section of the population, with gross overcrowding and lack of sanitation which in some areas had changed little since the publication of Chadwick's report some 40 years earlier.[14]

The *Report of the Royal Commission on the Sanitary State of Large Towns and Populous Districts* was also important in drawing attention forcibly to the relationship between overcrowding and unemployment and contained the essence of much of the housing legislation that followed. Healthy housing became one of the cornerstones of the sanitary reformers' programme and vision.

One such reformer, quoted by Wohl,[6] put it in lyrical terms:

> When a man is emancipated from this physical degradation of overcrowded living and exposed to air and light, his feelings are elevated, his health improves, his whole nature expands, and then, if there be seeds of goodness in him, they swell, burst, grow, flower and bear fruit.

There were throughout the country at this time a number of enlightened employers — such as Robert Owen of New Lanark, Sir Titus Salt of Saltaire, William Lever of Port Sunlight and George Cadbury of Bournville — who looked after their workforces well in terms of housing, with the laudable and sensible aim of producing hard-working, productive and happy communities.[15]

Already in 1800, Robert Owen, a visionary but sternly moral industrialist, was constructing housing for his cotton workers at New Lanark. In mid-century, Sir Titus Salt, a Bradford textile manufacturer, built a large set of mills four miles north-west of the city, with housing to the south. The village name Saltaire was a combination of the name of the creator and the River Aire on which the development was sited. It included a large park, an Institute, a Church and Almshouses for retired employees.

Two of the most influential model industrial communities, -which in many senses set environmental standards for the twentieth century, were those established by Lever and Cadbury.

William Lever had expanded the family grocery business into an industrial empire based on Sunlight soap. In 1888 he acquired a site on the west bank of the Mersey and building began on a model village for his workers, named Port Sunlight in honour of his most profitable product.

In 1879 Cadbury's chocolate factory moved from the centre of Birmingham to benefit from the purer air of Bournbrook near Selly Oak. In 1895 Cadbury and his architect began to plan a complete village, stressing the amenity, economic and recreational role of the individual garden. In contrast to Port Sunlight, Cadbury also made up to half the housing created available for non-Bournville employees which improved social integration and reduced the paternalistic character of the community.[15]

In 1884 William Morris stated very clearly and eloquently his aims for town and environmental planning:

> i) Good lodging; ii) Ample space; iii) General order and beauty... no one for instance be allowed to cut down, for mere profit, trees whose loss would spoil a landscape: neither on any pretext should people be allowed to darken the daylight with smoke, to befoul rivers, or to degrade any spot of earth with squalid litter and brutal wasteful disorder.

Figure 3. Ebenezer Howard in his mid 30s, from a contemporary photograph.

One of the undoubted visionaries in housing in the second half of the nineteenth century and the first two decades of the twentieth was Ebenezer Howard (Figure 3). His book, first published in 1898 under the title *Tomorrow: A Peaceful Path to Real Reform,* was re-issued in 1902 with slight revisions and a new title — *Garden Cities of Tomorrow.*[1]

According to Osborne, one of his disciples, who contributed to the garden city literature some time later,[18] Howard's work has been almost universally neglected by sociologists and recognised authorities on town planning. Howard was not himself an academic or a political theorist but an inventor and a creative realist whose skill lay in moderating the extremism of Utopian concepts without sacrificing their central principles. His eventual occupation was as a shorthand reporter of parliamentary proceedings with the predecessors of Hansard. But his real interest and enthusiasm focused on mechanical invention and his garden city movement.

His book holds a unique place in town planning and was the origin of ideas which, after a long interval, transformed the scientific and political outlook on town structure and growth.

Howard himself, in consultation with the Garden Cities and

Town Planning Association, defined a garden city as a 'Town designed for healthy living and industry; of a size that makes possible a full measure of social life, but not larger; surrounded by a rural belt; the whole of the land being in public ownership or held in trust for the community'.

He begins his book by observing that it is difficult to find a single question vital to national life and well-being - be it temperance or the traffic in opium, two current issues of the day — on which all political parties and opinions agree. Revealing his familiarity with parliamentary proceedings, he then identifies one such question — urban overcrowding and rural depletion. He quotes Lord Rosebery on London:

> There is no thought of pride associated in my mind with the idea of London. I am always haunted by the awfulness of London: by the great appalling fact of these millions cast down, as it would appear by hazard, on the banks of this noble stream, working each in their own groove and their own cell, without regard or knowledge of each other... sixty years ago a great Englishman, Cobbett, called it a wen. If it was a wen then, what is it now? A tumour, an elephantiasis sucking into its gorged system half the life and the blood and bone of the rural districts.

Strong words indeed and ones which made a deep impression on Ebenezer Howard. He developed his magnet theory, introducing a third alternative to town life and country life — town-country life (Figure 4):

> Town and country must be married, and out of this joyous union will spring a new hope, a new life, a new civilization.

His plans for a garden city are shown in Figure 5 and it was his hope that one small garden city would be built as a working model to be followed by a cluster of 'social' cities linked by railway but each surrounded by open countryside. His ultimate vision was a radical reconstruction of London.

Howard's first Garden City of Letchworth, begun in 1903, was a faithful fulfillment of his ideas. Welwyn Garden City, established as a result of Howards personal initiative in 1919, carried still further the techniques of civic design and architectural harmony.

In the final analysis, however, the drive to improve the insanitary environment characteristic of the nineteenth century by providing better housing, reducing overcrowding and

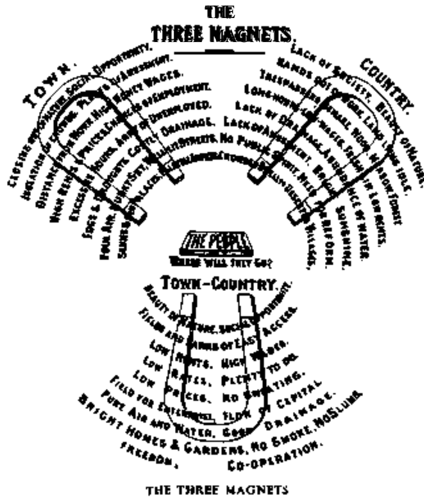


Figure 4. Howard's magnet diagram (reproduced by kind permission of Faber and Faber).

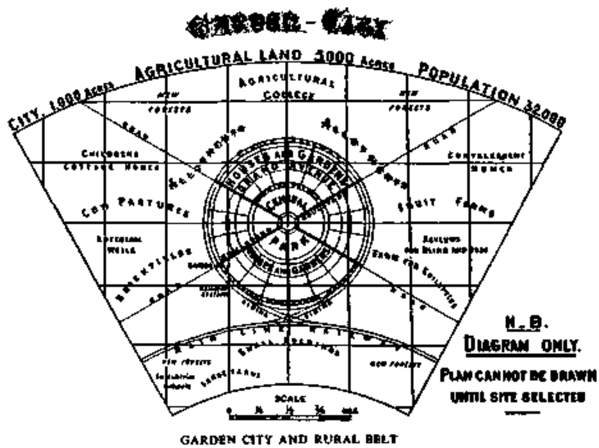


Figure 5. Howard's diagram of garden city and rural belt (reproduced by kind permission of Faber and Faber).

clearing the slums met with only partial success at this time. But there was a growing recognition of the problems arising from deprivation and poverty. Burnett[14] quotes the Medical Officer of Health for Kensington in 1890 thus — 'What are the main causes of overcrowding? — Poverty and high rents'.

NUTRITION

In his social history of diet in England since 1851, Burnett[19] draws attention to the paucity of authoritative material on the subject and to a number of myths about the food of the past which are still believed in many quarters today. Chief among these is that food in the mid-nineteenth century was cheaper, more plentiful and more wholesome than either before or since and that those who lived on the land fared better, in terms of diet, than those in towns enduring the harsh impact of the industrial revolution.

Burnett successfully destroys these myths and shows, among other things, that the agricultural labourer was the worst fed of all nineteenth century workers, that 'working class' diet remained remarkably unchanged until the twentieth century, that food has never been as pure as it is today and that adulteration of food was a widespread problem which improved only gradually with general advances in conditions and legislation.

With increasing urbanisation, traditional rural skills, such as domestic baking and brewing, gradually declined and by 1850 many in the towns at any rate had become dependent on professional food suppliers. The diet of labourers, both urban and rural, was insufficient and poor in quality.

There was a wide gulf between rich and poor in nutrition as in living conditions. Burnett[19] recalls Brillat-Savarin's epigram - 'Tell me what you eat and I will tell you what you are'.

Quality of food also became a serious issue with adulteration widespread and increasing. Accum, an analytical chemist, first drew attention to the subject in print in 1820,[20] showing adulteration affecting common foods and drinks ranging from bread, tea and confectionery to wines and spirits (Figure 6).

As Wohl[6] points out, primitive or non-existent cooking facilities, lack of cheap fuel, poverty, ignorance and adulterated products combined to produce a nation of 'undernourished, anaemic and feeble pygmies'.

THE USE OF ADULTERATION.

Little Girl. "IF YOU PLEASE, SIR, MOTHER SAYS, WILL YOU LET HER HAVE A QUARTER OF A POUND OF YOUR BEST TEA TO KILL THE RATS WITH, AND A OUNCE OF CHOCOLATE AS WOULD GET RID OF THE BLACK BEADLES!"

Figure 6. Punch cartoon of 4 August 1855 on the adulteration of food (reproduced with permission of Punch Ltd).

INFECTION

In the nineteenth century infectious diseases were undoubtedly the major cause of death in Britain and there were various theories explaining their transmission.

In the 1860s John Simon was calling, unsuccessfully, for an effective system of notification and isolation for cases of infectious disease.[21] It was not until the Infectious Disease (Notification) Act of 1889 that notification by doctors to local authorities was made compulsory in London and optional elsewhere, although tuberculosis was omitted from the list of notifiable diseases. A similar Infectious Disease Notification Act was passed the same year for Scotland and in 1899 compulsory notification was extended throughout England and Wales. Provision of isolation facilities, however, remained extremely unsatisfactory for some considerable time.[6]

The fall in mortality over the course of the century was almost certainly due in large part to a reduction of deaths from infectious diseases - firstly, from some of the airborne infections such as tuberculosis and later from water-, milk- and food-borne infections such as typhus, typhoid and cholera.

VITAL AND HEALTH STATISTICS

Another important element in the jigsaw of public health at this time was the passing in 1836 of the Act making civil registration of births, deaths and marriages obligatory in England and Wales.[22]

Vital and health statistics in the modern sense had really begun with the work of John Graunt, a London haberdasher and politician, in the middle of the seventeenth century. Graunt was the first to study the Bills of Mortality in a scientific and systematic way to find out about birth and death in a large population. He classified deaths and death rates by causes and noted seasonal and annual variations. His study showed that mortality was higher in towns and was growing. [23]

Predictably there was opposition to the collection and analysis of numerical data. When Britain's first Census was agreed in 1801, after 50 years of argument, one speaker in the final parliamentary debate protested: 'I do not believe there is a set of men, indeed any individual of the human species, so presumptuous and so abandoned as to make this proposal — I

hold this project to be totally subversive to the last remains of English liberty'.

Despite such eloquence, however, progress continued and after the 1836 Act William Farr was appointed as Compiler of Abstracts to the Registrar General (Figure 1). In his first Report in 1839 he wrote:

> medicine, like other natural sciences, is beginning to abandon vague conjecture where facts can be accurately determined by observation; and to substitute numerical expressions for uncertain assertions.

Farr's appointment was hugely significant for the public health movement since it meant that for the first time accurate measurements of birth and death rates became possible both locally and nationally. Farr, a doctor as well as a statistician, used his medical experience to organise the collection of statistical data relating to causes of death. He demonstrated the actual cost of poor public health arrangements in human terms — '38 persons are destroyed every day in London by local causes'.[24]

In 1841 life expectancy at birth was 41 years for men and 43 for women.[25] Of babies born, only 68 per cent of boys and 71 per cent of girls survived to become adults. Males aged 15 years could expect a further 44 years of life and females 45 years.[25,26] By the end of the century, the death rate had fallen markedly — from 20.5 per 1,000 in 1861 to 16.9 in 1901.[27] While the reasons for this were complex, a substantial part of the credit must go to the more effective arrangements for sanitary control embodied in the 1875 Act and an improvement in housing conditions. Dramatic improvements in morbidity were also recorded in every age group except that for babies under the age of one year.

In the period 1848-72 the most important cause of death was infection — infectious diseases accounted for one death in every three, and one-third of these deaths were caused by respiratory tuberculosis.[28] Mortality rates from all causes had fallen markedly by the turn of the century, except in infants aged less than one year, and the falls in deaths from infection were remarkable even in the infant age group (Tables 4 and 5).

Reasons for the intractability of the infant mortality and morbidity were many, among them lack of attention to antenatal care for pregnant women in the more vulnerable sectors of the

community and contamination of milk supplies. It does seem strange that the two main government agencies with responsibility for public health — the Privy Council and subsequently the Local Government Board — were prepared to examine the connection between infant mortality and working mothers but not to look in a similar way at the relationship between unhealthy and deprived pregnant women and mothers and prematurity, stillbirth and perinatal mortality.[6]

Table 4.

Changes in mortality rates for men and women aged between 25 and 44 years over the nineteenth century (mean annual death rates per one million living).

	1848-72	1901-10	% change
All causes			
Males	11,415	7,161	-37
Females	10,891	5,959	-45
Infectious diseases			
Males	5,559	2,795	-50
Females	5,538	1,960	-65

Table 5.

Changes in mortality rates for infants under the age of one year over the nineteenth century (mean annual death rates per one million living).

	1848-72	1901-10	% change
All causes			
Males	202,655	167,097	-18
Females	162,281	132,998	-18
Infectious diseases			
Males	36,103	19,295	-47
Females	31,289	17,351	-45

CONCLUSION

The history of public health in the nineteenth and early twentieth centuries should thus be seen as a time of massive challenge and massive achievement. There can be little doubt that the awareness of public health issues generated by Chadwick and consolidated by Simon, with improved health statistics and appropriate legislation, had ensured that Britain at this time had created the most efficient and advanced system of public health law and administration in the world.[21]

The Victorian achievement in improving public health was enormous and improvements were evident to a greater and lesser degree in many areas including water supplies, sewerage, street cleaning, working and living environments and personal hygiene.

In 1897 the official journal of Medical Officers of Health summarised the position in the following words:

> Of all the achievement of the Victorian era... history will find none worthier of record than the efforts made to ameliorate the lives of the poor, to curb the ravages of disease, and to secure for all pure air, food and water, all of which are connotated by the term 'sanitation'.

At the beginning of the twentieth century, however, there was certainly 'no complacency or weakening of the reform impulse'.[6]

This was due in part to the positive legacy of public health legislation and the growing power and effectiveness of many of the Medical Officers of Health. There also emerged a concern over physical degeneration of the population generated by the results of recruitment for the two wars of this otherwise settled period.

Unlike most of Europe, which was beset by recurrent wars and revolutions throughout the nineteenth century, it was for Britain a time of extraordinary peace.[29] The only two notable conflicts were the Crimean War and the Boer War and, according to army statistics, 34 per cent of men medically examined for enlistment between 1893 and 1902 had to be rejected as medically unfit. Debate raged in the medical journals but most medical opinion tended to support the view of Arthur Newsholme, Medical Officer of Health for Brighton for 19 years and subsequently Chief Medical Officer to the Local

Government Board, who argued that it was both unscientific and misleading to judge a nation by the quality of its potential army recruits.

One positive result of the debate over physical deterioration was a critical focusing on the relationship between urbanisation, deprivation and health and a recognition of the importance for a fit youth of maternal and child health.

Britain, therefore, entered the twentieth century with sound foundations for improved public health but with public health and health service mountains still to climb.

References

1) Digby A. *The Poor Law in the Nineteenth Century.* London:The Historical Association, 1982.
2) Sigerist H E. *Landmarks in the History of Hygiene.* London: Oxford University Press, 1956.
3) Rosen G. *A History of Public Health.* New York: MD Pulications, 1958.
4) Greenwood M. *Some British Pioneers of Social Medicine.* London: Oxford University Press, 1948.
5) Smellie KB. *History of Local Government.* London: George Allen and Unwin, 1946.
6) Wohl A S. *Endangered Lives. Public Health in Victorian Britain.* London, Melbourne,Toronto: J M Dent and Sons, 1983.
7) Watkin B. *Documents of Health and Social Services.* 1834 to the present day. London: Methuen, 1975.
8) Hodgkinson RG. *The Origins of the National Health Service.* London: Wellcome Historical Medical Library, 1967.
9) Flinn M. *Public Health Reform in Britain.* London:Macmillan 1968.
10) Rees RA. *Britain 1815-1851.* Harlow: Longman, 1990
11) Chadwick E. Report to Her Majesty's Principal Secretary of State for the Home Department from the Poor Law Commissioners on an Inquiry into the Sanitary Condition of the Labouring Population of Great Britain. 1842.
12) Buchanan G. *Report on Epidemic Typhus at Greenock* 1866 (see Wohl pp 92, 366).
13) Brotherston JHE *Observations on the Early Public Health Movement in Scotland.* London HK Lewis, 1952.
14) Burnett J. *A Social History of Housing 1815-1985.* London and New York: Methuen, 1980.
15) Miller M. *Letchworth: the First Garden City.* Chichester: Phillimore, 1989.
16) Morris W. *Art and Socialism: the aims and ideals of the English Socialist of Today.* Lecture delivered before the Secular Society of Leicester, 23 January 1884.
17) Howard E. *Garden Cities of Tomorrow.* London: Faber and Faber, 1902.

18) Osborn FJ. *Green-belt Cities. The British Contribution.* London: Faber and Faber, 1946.
19) Burnett J. *Plenty and Want. A Social History of Diet in England from 1815 to the present day.* London: Nelson, 1966.
20) Accum F. *A Treatise of Adulterations of Food and Culinary Poisons.* 1820.
21) Lambert R. *Sir John Simon. 1816-1904 and English Social Administration.* London: Macgibbon and Kee, 1963.
22) Thorne RT. *The Progress of Preventive Medicine during the Victorian era.* London: Shaw and Sons, 1888.
23) Wain H. *A History of Preventive Medicine.* Springfield, Illinois: Charles C Thomas,1970.
24) Tenth Annual Report of the Registrar General, 1847.
25) Charlton J, Fraser Patricia, Murphy Mike. *Medical advances and iatrogenesis.* In *The Health of Adult Britain 1841-1991.* Charlton J, Murphy M (Eds). Volume 2, chapter 14. London:The Stationery Office, 1997.
26) Charlton J. *Trends in all-cause mortality.* In *The Health of Adult Britain 1841-1991.* Charlton J, Murphy M (Eds).Volume 1, chapter 3. London: HMSO, 1997.
27) Sixty-fourth Annual Report of the Registrar General, 1901.
28) Charlton J and Murphy M. *Trends in all-cause mortality: an overview* In *The Health of Adult Britain 1841-1991.* Charlton J, Murphy M (Eds). Volume 1, chapter 4. London: HMSO, 1997.
29) Thomson D. *England in the Nineteenth Century.* Harmondsworth: Penguin Books, 1991.

2

Between the Wars 1918- 1939

Public health is an abstract idea; it has not the glamour or drama of disease. The newspapers can fill a column with an account of the saving of life by an eminent surgeon or physician called as a last resort to the bedside of their child, or with a description of some novel operation on the heart or brain. In contrast there is little news value in the activities of public health; what is there to say about an epidemic of typhoid fever that never occurred.

Fraser Brockington.1949

There are various views among historians about the mood in Britain after the First World War.[1-5] Of course, in the immediate aftermath, there was enormous relief and revelry. Taylor[4] gives a graphic account of the scenes in London when news of the armistice spread:

> Work ceased in shops and offices. Crowds surged through the streets. Omnibuses were seized and people caroused on the open upper decks. A bonfire heaped against the plinth of Nelson's column in Trafalgar Square has left its mark to this day. Total strangers copulated in doorways and on the pavements. They were asserting the triumph of life over death. The celebrations ran on with increasing wildness for three days, when the police finally intervened and restored order.

There is no doubt, however, that the material, financial and moral cost of the First World War was immense for Britain. Three-quarters of a million men from the United Kingdom were killed during its course and one-and-a-half million were permanently impaired by wounds and the effects of gas. Demobilisation also threatened to provoke serious disturbances when the War Office devised an elaborate scheme for releasing first key men most required for industry who were usually the last to have been called up.[4] Mutinies and marches led to the scrapping of the scheme in favour of the simple principle of'first in, first out'.

There was a tendency among many to look back at the halcyon pre-war days and see them as a golden age of stability and prosperity[1] And, although it was not that simple and the roots of many subsequent problems were planted in that supposed golden age, the end of the war saw not only financial problems in terms of repayment of war loans and disruption to international trade and investment, but also a real but less tangible sense of moral bankruptcy.

It was a time of unrest, mainly for economic and social rather than political reasons. Even before the war ended there were strikes among munitions workers, cotton workers and the London police. Marwick[6] describes the paradoxical aftermath of the First World War:

> society had changed, the state had not... war had thrown the forces of social change and the forces of political change out of joint.

It was very different from the mood prevailing after the Second World War when matters had been a great deal better organised in terms of issues such as food rationing and where there was a general acceptance that planning for some kind of a national health and welfare system was inevitable.

By 1921, however, public opinion had begun to polarise into two groups — the disillusioned and the idealists — of whom the latter was fortunately by far the largest. There was relief that the conflict was over and great hopes for national reconstruction.[6] There were few who did not hope for a happier society at home and international peace.[5]

There were hopeful signs also for public health. The work of the giants of the nineteenth century had established much improved environmental and living conditions, including sanitation. Medical Officers of Health — first appointed to Liverpool on 1 January 1847 when Dr William Henry Duncan, a local physician, became the first Medical Officer of Health in the country, to London in 1848 and to the whole country by 1872 — continued to grow gradually in influence and esteem. And early in the twentieth century the specialty was beginning to free itself from the perception that it was concerned only with sewers and drains and had begun to present itself in a more positive light.

REPORT OF THE ROYAL COMMISSION ON THE POOR LAWS AND RELIEF OF DISTRESS

One of the most influential bodies in the early twentieth century was the Royal Commission of 1905—09 which was set up to examine the erosion of the principles of the 1834 Poor Law Act. Poor Law officials, headed by JS Davy, permanent head of the Poor Law Division of the Local Government Board, believed that the poor should be discouraged from applying for relief if at all possible. Davy was of the view that most 'paupers' were the authors of their own misfortune and he was uncompromising even on the question of those who wanted to work but could not find a job — 'an unemployed man must stand by his accidents; he must suffer for the general good of the body politic'.[78]

The Commission, however, was not prepared to be deflected by officialdom and made extensive enquiries throughout England, Wales and Scotland. The Commissioners themselves visited around 400 work houses and institutions throughout the United Kingdom and some of them travelled through Europe to allow them to make comparisons with other systems of poor relief.

Membership of the Commission include four senior civil servants working alongside the great social reformer Beatrice Webb and her colleagues associated with the Charity Organisation Society. The latter provided much of the enthusiasm for thorough research and the collection of detailed factual information and were convinced of the need to reform the harsh conditions established by the 1834 Poor Law Act.

In these circumstances it seems hardly surprising that the Commission failed to produce a unanimous report. Four Commissioners, including Beatrice Webb, signed a Minority Report. There was a great deal of common ground between the Majority and Minority Reports, published in 1909.[9] Both agreed that general mixed workhouses should be replaced by separate institutions for the able-bodied, the sick, the elderly and children, that local administration should be brought under more stringent central control, that outdoor relief should be administered more efficiently and that there should be better

co-ordination of charitable aid. Both reports were in favour of the old age pensions which had been introduced in 1908 and recommended the introduction of state insurance schemes for sickness and unemployment.

Detailed proposals for dealing with the growing problem of unemployment, however, differed substantially. The Majority Report recommended a national scheme of labour exchanges which came into being in 1909, better vocational emphasis on elementary education, a state system of insurance for unemployment and the scheduling of public works to match periods of trade depression. The Minority Report recommended the abolition of the Poor Law in its entirety and the allocation of its functions between various specialised local committees.

The Inquiry had little immediate effect, probably mainly because of its lack of unanimity, and by the time war was declared in 1914 no legislative action had been taken on the major proposals of either report. There were various unsuccessful immediate post-war attempts to legislate for reform of the Poor Law but, after the resignation of Dr Addison as Minister of Health in 1921, the matter lay dormant for three years.[8]

Between them, however, these two reports raised all the issues which were to be debated right up until 1948 in relation to the provision of medical and social care, with the exception of the planning of hospital services on a regional basis.

THE MINISTRY OF HEALTH

Health care and public health after the First World War was something of a patchwork of ramshackle and unco-ordinated services. Since 1848 administration of health had been under various authorities of limited effectiveness in terms of co-operation and co-ordination (Table 1). The Local Government Board in its later years had become somewhat discredited as being inefficient and obstructive. John Simon, for example, had previously expressed the view that the system of sanitary supervision the Board was supposed to organise was totally

Table 1.
Administration of public health 1848-1919.

Year	Organisation	Comment
1848	General Board of Health	Members were Chadwick.Southwood Smith, Lord Ashley. Disbanded in 1854, defeated by mistrust of centralisation, apathy and parsimony.
1854	Board of Health	Newly constituted Board had as its first President Sir Benjamin Hall, one of Chadwick's leading opponents. Disbanded in 1858 - defeated by opponents of sanitary reform who wished to end what they saw as state interference.
1858	Local Government Act Office Privy Council	Functions of Board of Health divided. Within the Privy Council a new Medical Department had John Simon as Medical Officer and continued to work in much the same way as before.
1868	Royal Sanitary Commission	Appointed to consider the whole question of public health administration.
1871	Local Government Board	Took in almost all of the offices which had previously handled aspects of public health - Local Government Act Office, Registrar General, Medical Department of Privy Council, Poor Law Board. The latter was the largest constituent and continued to submit public health administration to the repressive standards of the Poor Law.
1872	Urban and Rural Sanitary Authorities	Local public health was to be put in the hands of one authority in any one area. Each authority was required to appoint an inspector of nuisances and a medical officer of health.
1919	Ministry of Health	Created after much political machination. Control of school medical service remained under control of Board of Education.

inadequate.[11] Ensor,[2] from a later perspective, stated that it was difficult 'to overestimate what the country lost through having its local authorities placed under a central department constantly on the alert to hinder them, and rarely, if ever, to help'.

By 1914 three central departments and eight local agencies had become involved in the administration of maternal and child health services alone (Figure 1).[10] Even more departments and agencies were involved in other areas of health. One family, for example, might receive care from as many as nine different doctors working under five different departments. There was a clear need for a central body to co-ordinate the improvement in the nation's health.

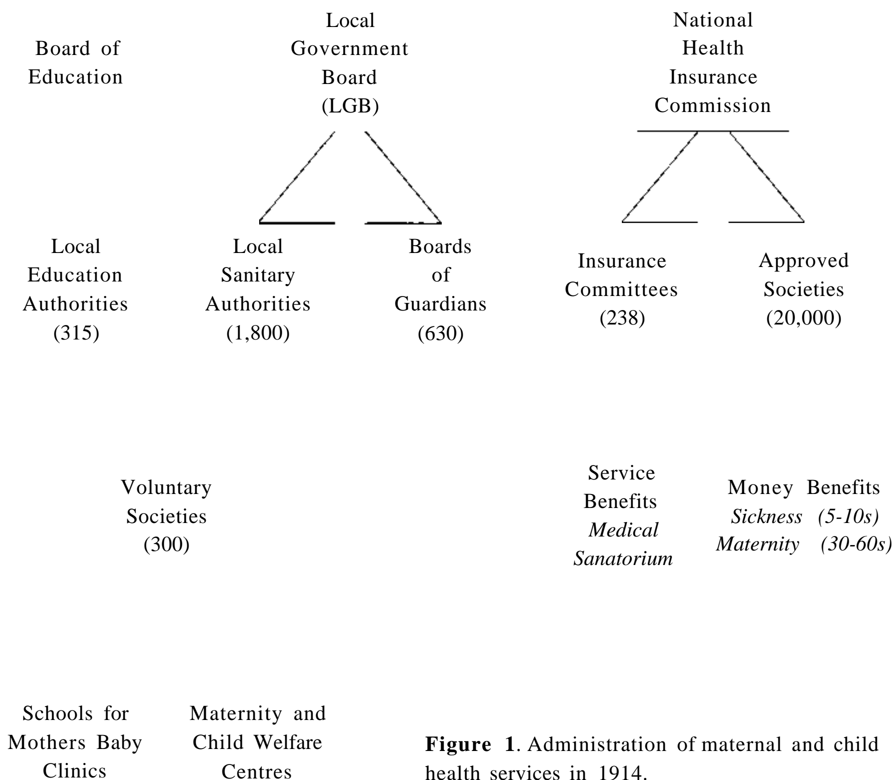


Figure 1. Administration of maternal and child health services in 1914.

As Honigsbaum[10] has pointed out, doctors themselves were in large part to blame for the delay in creating a central Ministry of Health. With a few honourable exceptions, the profession showed interest in the subject only when it seemed to promise an improvement in their economic position. Their main concern was protection against competition from unqualified practitioners. This was partially achieved by the 1858 Medical Act which confined friendly society posts to registered doctors and by Lloyd George's 1911 National Health Insurance Act.This had extended medical cover to all wage-earners — one third of the population — but still excluded the vulnerable groups of the elderly and mothers and babies, was not adequately associated with the public health work of local authorities and did not provide specialist treatment.[10]

The Act, which was amended nine times between 1911 and 1936, was also important in its provision that one penny for each insured person should be set aside for the purposes of medical research. This paved the way for the establishment in 1920 of the Medical Research Council as a special committee of the Privy Council.

In the end it was public and not medical opinion that achieved the establishment of the Ministry of Health. The First World War with its high rates of mortality and concurrent low birth rates showed the country that it could no longer afford the prevailing high infant and maternal mortality. Infant mortality of course had been a cause for concern even before the war — alone among public health indices it had failed to fall in the nineteenth century and in 1917 no less than 1,000 babies were dying every week: for every nine soldiers dying in the trenches, twelve babies were dying at home.[10] Those leading the campaign to reduce infant mortality produced the slogan — 'it is more dangerous to be a baby in England than a soldier in France'.[11] The poor condition of recruits to the Boer and Crimean Wars, mentioned in Chapter 1, also caused concern as did the *Reports of the Royal Commission on Physical Training (Scotland) 1903* and the *Interdepartmental Committee on Physical Deterioration 1904,* both of which drew attention to the bad physique of schoolchildren.

As MacNalty has shown,[12] there was a great opportunity for the organisation of a comprehensive system of preventive and curative medicine.

> The hour came but not the man... the opportunity was not seized. Instead piecemeal measures were planned to meet the most clamant needs - measures excellent of their kind, but involving cumbrous administration and duplication of effort.

These measures included the establishment of the School Medical Service, the Education (Provision of Meals) Act and the Education (Administrative Provisions) Act (Table 2).

To compound the health problems, the country was hit by a pandemic of influenza in late 1918 which recurred early in 1919 and killed over 150,000 people — 18,000 of them in London alone.

A key figure in the formation of the Ministry of Health was an astute and very skilful civil servant, Sir Robert Morant, who until 1911 had served as Permanent Secretary to the Board of Education. From his experience there, he realised the fundamental importance of the health of the nation:

> the physical condition of the child lies at the basis of everything educational as well as at the base of the State.

In his search for ways of extending public health provision, Morant was confronted by a huge barrier in the form of the 1875 Public Health Act which, apart from infectious diseases, permitted state aid only through the Poor Law "which was administered by the ineffectual and parsimonious Local Government Board.

Morant's first approach, therefore, was to extend services using other departments. He used his knowledge of education to bring forward a Bill calling for the medical inspection of schoolchildren which soon expanded to include treatment as well.

The National Health Insurance Act of 1911 had extended GP and drug care and foreshadowed further expansion, although it had certain hmitations referred to above. By 1914 health services were expanding in all directions and Great Britain was once more in the forefront of public health. Morant accepted

Table 2.
Main legislation on public health and related issues 1902-1939.

Year	Legislation	Effect
1902	Midwives Act (Amended 1918, 1936)	Aimed to ensure better training of midwives and to regulate their practice.
1906	Education (Provision of meals) Act	Empowered local authorities to provide school meals for needy children.
1907	Education (Administrative Provisions) Act	Imposed a duty of medical inspection and the power of treatment on local authorities.
1911	National Insurance Act	Provided a system of insurance against ill-health for a large section of the working population within certain age and financial limits.
1913	Mental Deficiency Act	Local authorities required to set up MD committees and take responsibility for the care of MD educable children.
1917	Venereal Diseases Act	Made provision for free diagnosis and treatment at special clinics, education of the public, and banning of advertisement of quack remedies and unqualified practice.
1918	Ministry of Health Act	Created the Ministry of Health 'to bring every advance in medical science, every measure calculated to maintain health... and to make health the birthright of every inhabitant of this country'.
1918	Maternity and Child Welfare Act	Placed maternal and child welfare under the general supervision of the Ministry of Health.
1929	Local Government Act	Greatly increased the hospital resources of county and county borough councils and enabled co-operation between municipal and voluntary hospitals.
1930	Mental Treatment Act	Included the provisions of the Lunacy Act which gave responsibility to local authorities for the care of the needy insane and stated that councils must appoint special committees to oversee this. Provided for voluntary treatment in public mental hospitals and precluded the use of the terms asylum and lunatic in official documents except in relation to 'criminal lunatics'.
1933	Factory Act	Enabled the appointment of inspectors of factories.
1936	Public Health Act	Consolidated the existing sixteen statutes relating to public health and simplified public health administration.

Figure 2. Key figures in the creation of the Ministry of Health. Clockwise from top; Beatrice and Sidney Webb, Sir George Newman, Arthur Newsholme and Sir Robert Morant.

the chairmanship of the English National Health Insurance Commission with the main aim of extending and eventually unifying the public health services.

In his efforts Morant worked with Lloyd George, with the social reformers Sidney and Beatrice Webb and with two influential Medical Officers of Health, George Newman and Arthur Newsholme (Figure 2). There was a difference in emphasis with Lloyd George, in common with the medical officers of health and other medical leaders, favouring initial extension of services under the Local Government Board. The Webbs were intent on achieving unification and the complete removal of health from Poor Law control. In the event, the former policy prevailed initially and reform began at local level and moved ahead at first within the framework of the Local Government Board.[8] There remained conflict between that Board and the Board of Education in terms of administration of a grant allocated for maternity and child welfare services. This was resolved in 1917 when it was agreed to turn all maternity and child welfare services over to a new Ministry of Health as soon as one could be created. The Board of Education kept responsibility for the school medical service.

The formation in 1919 of the Ministry of Health was evidence that at last health, and in particular public health, was coming to the forefront of the political agenda during the period of post-war reconstruction.

And public health had at that time some vigorous and effective proponents. In a memorandum of that year addressed to the Minister of Health, Christopher Addison - who also had responsibility for housing and was himself a doctor — the Ministry's first Chief Medical Officer, Sir George Newman, had this to say: 'The science and art of medicine is not restricted to the diagnosis and cure of disease in its gross forms ... It is, in fact, the science and art of Health, of how man may learn to live a healthy hfe at the top of his capacity of body and mind, avoiding or removing external or internal conditions unfavourable to such a standard.'[13]

In his lengthy memorandum, Newman reiterated the need for simplification and unification of medical administration which

the creation of the Ministry made possible.

> Above all, a medical service must seek to fulfil and conjoin all the varied elements of a national health policy, environmental and personal. There must be no divorce between the epidemiologist and the practitioner. Their purpose is ultimately the same... there must be partnership, at the centre and right out to the circumference, between medical men and laymen, between science and administration.

The Ministry of Health had been established to unify and co-ordinate the health policy and activities of government. Its responsibilities were partly central and partly local.

The central concerns were reasonably clear cut: a) general sanitation, housing, epidemiology and infectious diseases; b) prevention and treatment of tuberculosis and venereal disease; c) food control in respect of disease; d) maternity and child welfare; and e) health insurance and other public medical services. The Ministry was also charged with co-ordinating the medical work of other departments as outlined in Table 3.

Table 3.
Health responsibilities in government departments outwith the Ministry of Health in 1919.

Department	**Medical/health responsibility**
Board of Education	Health of Schoolchildren
Home Office	Industrial Hygiene
Board of Agriculture	Food Control
Ministry of Pensions	Health Insurance
Board ofTrade	Health and Safety at Work

The local elements were less clear and very variable in terms both of the size of the administrative unit and of the standard of service. Newman drew attention to inequalities between areas in, for example, infant welfare and treatment of tuberculosis and venereal disease. He argued strongly that an 'equable, just and fairly uniform system of (local) administration must be secured'.

Newman went on to expand on the remit of public health and preventive medicine — 'in short, preventive medicine to be effective must deal with the man, the whole man, as an individual as well as a member of the community. It must deal with the causes of his health, for then it may discover the causes of his disease.'

In concluding his memorandum, Newman lists ten principal elements of an effective policy in preventive medicine (Table 4).

Despite some of the wording, which may grate on the late twentieth century ear, it is an astonishingly comprehensive list, including emphasis on the importance of research as an integral part of the remit of a Ministry of Health.

Table 4.

Newman's ten principal elements for a national policy in preventive medicine.

i) Eugenics and the principles of sound breeding

ii) Maternity and the care, protection and encouragement of the function of motherhood

iii) Infant welfare and the reduction of infant mortality

iv) The health and physique of the school child and adolescent

v) Sanitation and an improved personal and domestic environment

vi) Industrial hygiene, the health of the worker in the workshop

vii) The prevention and treatment of infectious disease

viii) The prevention and treatment of non-infectious disease

ix) The education of the people in hygiene

x) Research, inquiry and investigation; and the extension of the boundaries of knowledge

In his first annual report as Chief Medical Officer, Newman pointed to the difficulties of the new task of the Ministry as the national health organisation. Chief among these were three. Firstly there remained a very British suspicion of a unified, national approach and a lack of real understanding of the meaning and scope of preventive medicine. Secondly, there was the problem of pulling together the former separate parts of the organisation which had grown up over time — first under the Poor Law Commission and then under the Local Government Board. Thirdly, there were considerable divisions and conflicts over matters of control and funding.

Newman saw the immediate priorities of a Ministry of Health as four-fold and public opinion was behind him.

i) To deal with outbreaks of disease such as the 1918—19 influenza pandemic.

ii) To continue to improve the health and welfare of child-bearing women and their children.

iii) To simplify co-ordination of measures to combat tuberculosis and to provide treatment especially for TB sufferers discharged from the forces.

iv) To develop the medical services urgently required in the post-war period.

The climate of the time seemed to favour the establishment of some sort of national health service.

THE DAWSON REPORT

In 1920 the Dawson Report on the *Future Provision of Medical and Allied Services* was published and presented to the Minister of Health.[14]

The remit of the Consultative Council on Medical and Allied Services which was set up by Dr Addison as one of his first acts as Minister of Health under the Chairmanship of Lord Dawson of Penn, was as follows:

> To consider and make recommendations as to the scheme or schemes requisite for the systematised provision of such forms of medical and allied services as should, in the opinion of the Council, be available for the inhabitants of a given area.

In the long term, as Watkin[8] has pointed out, this has been a very influential document and it is certainly entitled to be regarded as one of the founding documents of the National Health Service.

The report recommended the integration of preventive and curative medical services and stated:

> they must likewise be both brought within the sphere of the general practitioner whose duties should embrace the work of communal as well as individual medicine.

It advocated the introduction of local Primary Health Centres staffed mainly by general practitioners and Secondary Health Centres staffed mainly by consultants and specialists. It stressed the importance of Secondary Health Centres having a relationship with Teaching Hospitals and the need for grants in aid for the Voluntary Hospitals which were under increasing pressure both because of rising post-war costs and the growing complexity of medical investigation and treatment. The report went on to detail the proposed method of administration of the scheme:

> all the services, curative and preventive, would be brought together in close co-ordination under a single Health Authority for each area.

The Dawson Report was indeed a visionary document. What it set out was nothing less than a blueprint for a national health service. In a very real sense, the story of the making of the present National Health Service is the story of the long-delayed implementation of Dawson's recommendations. In 1920, however, the Government, faced with considerable economic and political pressures, was not sympathetic to perceived radical proposals requiring massive public expenditure.

A further serious blow to progress was the sudden death that same year of Sir Robert Morant. He was described by a contemporary as 'a most remarkable man, a legend among administrators even in his lifetime, a man of vision and boundless energy, always ready to seize the opportunity when it offered and to create it when it did not'.

In the short-term, therefore, the Dawson Report was quietly shelved a few months after publication and no further meetings

of the full Consultative Council were called. Almost 30 years and another World War were to pass before Britain achieved its National Health Service.

CHANGES IN HEALTH

The main focus of public health at the beginning of this period was on surveillance, containment and prevention of infectious diseases — in 1918 clinical medicine had little to offer in terms of effective drug therapy. This of course was to change rapidly and by the 1930s 'the main stream of chemotherapy began bringing with it a new art in the healing of disease'.[15] Insulin was discovered in 1921 and became generally available three years later with dramatic consequences in the treatment of diabetes. The sulphonamides followed during the 1930s and penicillin, the first of the antibiotics, in the 1940s. The therapeutic era of medicine had begun. Tuberculosis — the 'white plague' — remained a major cause of morbidity and mortality. Before compulsory notification there was reluctance to disclose the disease which contributed to its spread. The steady fall in tuberculosis death rates, well established by the late nineteenth century, was achieved almost entirely without effective clinical treatment. The disease was agreed to be related to poverty, with poor housing and inadequate nutrition acknowledged as contributory factors. It was only after the Second World War that the impact of mass prevention and cure campaigns became important.[16,17]

Dr AK Chalmers and Sir Alexander Macgregor (Figure 3), both eminent and effective Medical Officers of Health in Glasgow at the beginning and middle of the twentieth century, provide fascinating accounts of public health in that city at the time.

Chalmers saw bad housing and poverty as powerful obstacles to public health progress in Glasgow as elsewhere. He showed that one-seventh of the population lived in one-roomed accommodation and their death rate was almost twice that of the city as a whole.[18]

Macgregor[19] outlined the changing picture during the 1920s

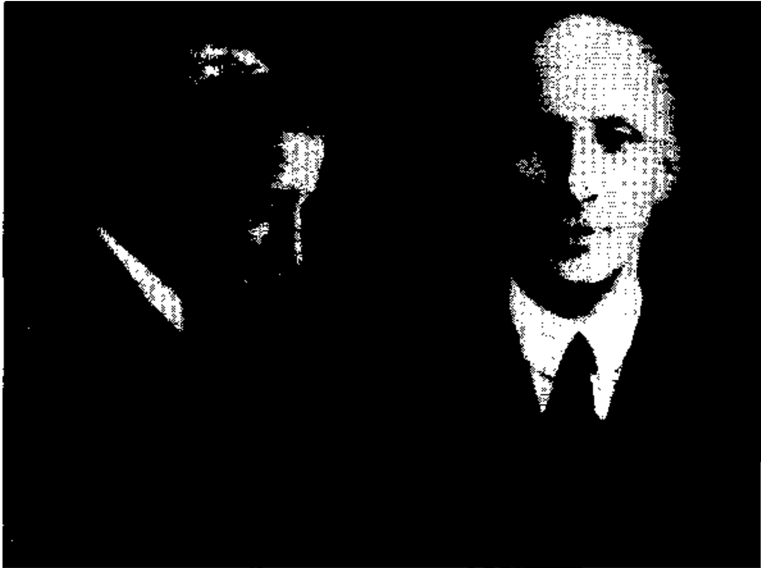


Figure 3. Two eminent Medical Officers of Health in Glasgow in the early twentieth century — left to right — AK Chalmers and Alexander Macgregor.

with clear evidence of gradually lessening severity of the most common infectious diseases. Table 5 illustrates very clearly how the formerly fatal diseases of childhood lessened in the importance of their effects over a period of 50 years.

Table 5.
Cases and deaths from four common infectious diseases in Glasgow 1905-54.

Disease	Cases			Deaths		
	1905	1930	1954	1905	1930	1954
Measles	12,329	12,406	5,747	551	266	4
Whooping cough	2,309	5,787	3,308	621	225	7
Scarlet fever	970	4,960	1,350	35	41	0
Diphtheria	726	2,621	12	107	145	1

Table 6.
Decline in child mortality in Glasgow 1900-1938.

Year	Infant Mortality Rate per 1,000 births	Deaths 1-5 years Actual no number	Rate per 1,000 population
1900	153	2,754	39.2
1911	139	1,862	26.7
1921	106	1,494	19.2
1931	105	1,341	17.2
1938	87	753	9.8

He cited as the best evidence of progress in public health in the first decades of the twentieth century the downward trend of child mortality and the corresponding improvement in child health (Table 6). He states:

> This is particularly true of the age group 1-5 years; its vital statistics may be regarded as affording the most sensitive index of the state of health of a community. In a public health sense, a community is judged by the health of its children.

ANNUAL REPORTS OF THE CHIEF MEDICAL OFFICER

The annual reports of the Chief Medical Officer to the Minister of Health during the inter-war period reflect the current public health concerns and illustrate graphically how familiar many of these remain to those working in public health today.[20]

Newman remained Chief Medical Officer until 1935 when he was succeeded by Arthur MacNalty.

Newman was a strong believer in effective education for both the medical profession and the public in public health matters.

In his 1920 annual report, for example, he mentions the necessity of discovering exactly what the facts were in each of

the 1800 sanitary areas of England and Wales.

> Who is at work there and what is he doing and with what results? If all is being rightly and economically done, all is well. If not, what steps ought to be taken for improvement, and if necessary for reform? These appear to be simple questions, but we all know they are in practice complex and sometimes difficult.

The seeds of audit in public health medicine in the 1990s perhaps?

In the same report Newman also drew attention to the need for scrutiny of hospital provision in England and Wales and called for 'formal and deliberate consideration' of hospital provision in every sanitary area.

In 1922, Newman emphasised the issue of education:

> The progress of preventive medicine depends in extraordinary degree upon the enlightenment and education of the people.

He quotes in support the words of an unidentified but 'responsible' writer of the time:

> of all the forces making for health, by far the most important is the enlightened goodwill of the individual citizen. This, it is obvious, is the beginning of a new era in the communal pursuit of health.

He stressed the importance of medical education in particular of the general medical practitioner who cannot 'yield his best unless he possesses the preventive viewpoint' of which he should be 'exponent, interpreter and practitioner'.

In 1922, the General Medical Council revised the ordinary medical curriculum to direct students' attention towards preventive aspects and issued new rules for the Diploma in Public Health.

Newman inveighed against the neglect of 'minor' disease such as:

> dental caries, oral sepsis, habitual constipation, neglected colds, dyspepsia, measles or discharging ears. They are the beginning of incapacity and invalidity, yet we are not fully prepared against them...We have been spending much money and labour for many years in dealing with gross disease in the adult, yet we are only now learning the old lesson that we must prevent its onset in childhood.

Subsequent reports focus on various relevant public health issues such as control of the milk supply — a matter of concern in 1923 and 1924 — tuberculin testing in cattle, meat inspection and linking and co-ordination of health agencies. In 1924 Newman made an explicit plea that:

> every Local Sanitary Authority in the realm should seriously consider what its public health policy and practice are going to be and pursue its course, with knowledge, thoroughness and persistence.

And in the same year he returned forcibly to the theme of prevention:

> There are 12,000 doctors who have entered the service of the State to care for the health of 14,000,000 insured persons in the interest of Preventive Medicine in its broadest meaning, yet neither patient nor doctor seems yet to be using the opportunity to its full preventive capacity.

Newman continued:

> Consider what happens when a patient goes to his doctor. This is what he asks - a) What is the matter with me? b) Can you put me right? c) How and why did I get it? d) How can I avoid it in future? These four everyday questions concern diagnosis, treatment, causation, prevention which are the bricks and bulwarks of preventive medicine.

In 1927 there was a call for economy in prescribing, a familiar topic 50 years later. In 1929 and 1930 the reports contained a detailed critique of the imphcations of the Local Government Act of 1929. This Act was a significant advance. It associated preventive medicine firmly with curative medicine and paved the way for the final ending of the Poor Law. It separated health policy from 'pauperism' and thus brought to fruition the integration of Poor Law and public health services sought in vain by John Simon. It defined and augmented the position of the Medical Officer of Health and his staff as the 'responsible and primary advisers' of each authority.

The Act also set up a new standard of achievement with two new principles. Firstly, health authorities were required to achieve and maintain 'a reasonable standard of efficiency and progress in the discharge of their functions relating to public health services'. Secondly, regard had to be paid to the question

of whether the health or welfare of the inhabitants, or some of them, had not been and were not likely to be endangered by the action or inaction of the authority. These must have been extremely difficult principles to evaluate nationwide with their emphasis on the rather loosely defined principles of 'efficiency' and 'progress'.

The 1931 report contains much of interest. Firstly, Newman highlights the dramatic decline in infant mortality. In 1900, almost 150,000 children aged less than 12 months died. By 1930 this number had fallen to around 39,000. This he attributed partly to an improved external environment and partly to the improved maternal care of the newborn child. He also made the point that this decline in mortality had ensured the survival of many 'weakly and perhaps even defective children' and commented 'merely to save life, or merely to prolong it, is not enough'. A comment which is certainly very relevant to the high technology medicine of the late twentieth century.

Another issue of growing importance at this time was that of road accidents which in 1931 stood among the first seven or eight main causes of death. Table 7 shows the number of injuries and deaths known to the police as having been caused by

Table 7.
Road accidents - fatalities and injuries 1931.

	Motor vehicles	Horse-drawn vehicles, cycles etc	Total
Number of accidents	132,121	32,991	165,112
Persons killed	5,328	703	6,031
Persons injured	149,746	35,025	184,771
Total persons killed or injured	155,074	35,728	190,802

Reproduced from the Annual Report of the Chief Medical Officer for 1931. London: HMSO, 1932.

vehicles and horses in streets and roads during the year. The death rate from this cause had risen from 7 per 100,000 population within a decade.

Newman concluded:

> The time may not be far distant when an examination of persons seeking licences to drive mechanically propelled vehicles will be regarded as a natural precaution, a precaution perhaps already overdue when we reflect that mortality of this kind plainly comes within the class of preventable mortality.

The time was indeed not too far distant and the driving test was introduced in 1935.

Suicide — another potentially preventable cause of death — was also on the increase. In 1930 recorded mortality from suicide, almost certainly an underestimate of the true figure, showed that 3,527 males and 1,524 females had taken their own lives — that is, 1,100 more males and 526 more females than ten years previously.

Newman's 1931, 1932 and 1933 reports comment on the effect of the prolonged economic depression and widespread unemployment on the public health. He noted that despite 'a long continuing experience of unemployment... the mortality of the country as a whole, with few exceptions, and even of many of the depressed areas themselves, has been uniformly decreasing. Nor have we any evidence of increased morbidity'.

He quotes on this issue from a number of annual reports from local Medical Officers of Health.

Dr Frazer, Medical Officer of Health in Liverpool, in his 1933 report had stated:

> It must be remembered that before industrial depression made itself felt, Liverpool was a city in which, owing to the prominent part played by the port in its industrial life, casual labour was common. Men were in work one week and out of work the next, a state of affairs which led to great distress among their wives and families. The steady income of the dole is better in many cases than the fluctuating income of casual labour. Observations seem to show that, on the whole, men and children have not suffered from lack of nourishment but that many women have.

In 1931, the County Medical Officer of Health for

Monmouthshire had made a special enquiry into the state of nutrition of all schoolchildren in the county and concluded 'despite the industrial depression our children are improving'.

In Warrington in 1932, there was an increase in the average weight of children at each age period compared with the average in 1931 and 'this is all the more noteworthy as having taken place in spite of the period of economic stress through which we are passing... No deterioration in the nutrition of the child has been observed'.

This was largely the picture throughout England and Wales although there were, then as now, both urban and rural blackspots.

The Medical Officer of Health in Jarrow in 1931, for example, had this to say:

> The long continued trade depression, with resulting unemployment, has undoubtedly had an adverse effect on the health of the inhabitants. This is particularly noticeable in regard to overcrowding which is a potent factor in our high mortality rate and pneumonia and tuberculosis death rates.

A degree of malnutrition was said to be present in West Suffolk but the Medical Officer of Health did not attribute this directly to the current depression in the area:

> It must be clearly understood that the essential cause of the trouble has existed for years before the present position developed. There is unquestionably a great lack of knowledge amongst all classes of parents in regard to the nutrition of children and, until ignorance gives place to understanding, there can be no real hope of permanent improvement.

In Wales, harmful effects appeared to be restricted to mining districts in the south of the country. They were evident only in the unemployed miners themselves, particularly middle-aged men with families and were shown mainly in terms of 'physical deterioration due to prolonged idleness and worry, rather than true malnutrition due to lack of food'.

POVERTY AND PUBLIC HEALTH

The connection between poverty levels and public health was

obvious in the nineteenth century, but by the 1930s the problem was different and more difficult to disentangle. By this time, some welfare provision was available, and the unemployed received dole payments. Thus the effects of deprivation were not so obvious. In the past, simple physical medical examination could reveal the problem — for example, scurvy or rickets. More covert effects, such as deficit in growth rate, are more difficult to identify and require relatively sophisticated methods of measurement and analysis. Although Newman instituted a system of using local medical officers to undertake surveys of medical conditions, these were unlikely to reveal more than the grossest of abnormality. He did not, for example, have available tuberculosis incidence rates by area or social class. However, by using the reports of local Medical Officers of Health, he was able to describe quantitatively some ideas on the problems of poverty and ill health. There was also interest about the role of nutrition in ill-health.[21]

Dr GCM M'Gonigle, Medical Officer of Health of Stockton-on-Tees in the 1930s (Figure 4) was one public health figure who was convinced of the connection between deprivation and poor nutrition and ill-health and he was the only Medical Officer of Health to address this issue in a consistent, thorough way at this time in his reports.

In his book entitled *Poverty and Public Health,*[22] he opens chapter 1 with the following quote from a memorandum on the duties of Medical Officers of Health issued in 1925 by the Ministry of Health:

> He (the Medical officer of Health) should endeavour to acquire an accurate knowledge of the influences, social, environmental and industrial, which may operate prejudicially to health in the area...

In welcoming the broadening of perspective encapsulated in this instruction, M'Gonigle produced an admirable appraisal of the fundamental importance of poverty and in particular poor nutrition to state of health. In considering the condition of the population — and echoing the concerns mentioned in the previous chapter in relation to recruitment for the Boer and Crimean Wars — he drew attention to the results of medical

Figure 4. GCM M'Gonigle, Medical Officer of Health in Stockton-on-Tees in the 1930s.

examinations for Army recruits in the First World War.

The official report on this had concluded:

> These results may be summarised by saying that medical examination showed that, of every nine men of military age in Great Britain, on average three were perfectly fit and healthy; two were upon a definitely infirm plane of health and strength, whether from some disability or some failure in development; three were incapable of undergoing more than a very moderate degree of physical exertion and could almost (in view of their age) be described with justice as physical wrecks; and the remaining man was a chronic invalid with a precarious hold on life.

M'Gonigle also turned his attention to the physical condition of primary school children. Of 1,855,499 children who underwent routine medical examination in 1933, 303,199 (17.33%) were found to require immediate medical attention. As a local illustration, he quoted from the returns of the school medical officer on the incidence of conditions in a sample of

Stockton-on-Tees children attending child welfare centres in 1928 (Table 8).

He compared the incidence of these conditions in children with satisfactory and unsatisfactory diets and concluded that there was a 'substantial correlation' between faults in diet and bone defects, pharyngeal conditions, dental decay, squint and anaemia.

Later in his book, and earlier elsewhere,[22,23] M'Gonigle describes a natural public health investigation which he was able to oversee in Stockton-on-Tees. In 1927 part of a slum area (Housewife Lane) was demolished and its inhabitants (152 families, comprising 710 individuals) re-housed in a purpose-built, self-contained municipal housing estate (Mount Pleasant). The other part of the slum area (Riverside) — containing 289 families and 1,298 individuals — remained in their original houses and served as a control group. As M'Gonigle observed 'such favourable circumstances for human field research rarely occur'.

Table 8.

Incidence of conditions noted in 741 Stockton-on-Tees children attending child welfare centres in the borough during 1928.

	Condition	Incidence
1	Diet unsatisfactory	49.8%
2	Bone conditions (rickety stigmata)	43%
3	Pharyngeal conditions (tonsils etc)	17%
4	Dental decay	27%
5	Squint	3.8%
6	Anaemia	31.2%
7	Diarrhoea	39%
8	Bronchitis	36.7%
9	Otorrhoea	11.5%

Table 9.
Crude and age/sex standardised death rates for Stockton-on-Tees and the two slum areas in the five years before the demolition of one area and the five years after.

	Crude death rate (per 1,000)		Death rate standardised for age and sex (per 1,000)	
	1923-27	1928-32	1923-27	1928-32
Stockton-on-Tees	13.96	13.28	12.32	12.07
Housewife Lane	18.75	36.71	22.91	33.55
Riverside	22.16	20.45	26.10	22.78

Crude death rates for the two areas had been collected for the five year period 1923-27 in anticipation of action under the provisions of the Housing Acts and these are shown in Table 9 together with those for the subsequent five years.

Naturally M'Gonigle sought an explanation for the extraordinary increase in mortality in the Housewife Lane population, which contained a high proportion of young people now living in environmental conditions apparently approaching the ideal, while those remaining in the unreconstructed slum area of Riverside showed a reduction.

As Table 10 shows, this discrepancy could not be explained easily by an increased overall mortality rate. The hypothesis that the increased overall infant mortality rate might have affected individuals at each extreme of life was not confirmed — on examination of the figures there was a net increased death rate of 9.2% among children from birth to 10 years, of 18.4% from 10-65 years and of 16.9% in those aged over 65 years. M'Gonigle, in accordance with the Ministry of Health's instruction quoted at the beginning of his book, pursued the factors responsible for this unexpected finding with vigour. He found the answer in a simple economic analysis as shown in Table 11.

Table 10.
Birth rate and infant mortality rate in England and Wales, Stockton-on-Tees and the two slum areas in the five years before and after demolition of Housewife Lane.

	Birth rate (per 1,000)				Infant mortality rate (per 1,000) live births			
Mean	E+W	S-o-T	HL	R	E+W	S-o-T	HL	R
1923-27	18.24	22.9	35.08	36.51	71.80	91.80	172.60	173.20
1928-32	16.27	21.29	44.25	32.02	66.20	78.80	117.80	134.00

Families in both areas suffered from high rates of unemployment and limited incomes but those remaining in the slum area had considerably more money available for buying food and other necessary household items. M'Gonigle obtained complete weekly budgets from a sample of families who had moved to the Mount Pleasant estate and of those remaining in Riverside. Analysis of these budgets showed that, after payment of rent and other necessary expenditure, unemployed families on the new estate had only 2 shillings $10^{1}/_{2}$ pence per person to spend on food as compared with 3 shillings $9\,^{1}/_{4}$ pence.

Table 11.
Rent and rates per family per week in Housewife Lane and Riverside.

	Housewife Lane (Mount Pleasant)	Riverside
1927	4 shillings 8 pence	4 shillings $7^{3}/_{4}$ pence
1928	9 shillings	4 shillings $10^{3}/_{4}$ pence

Table 12.
Quantities of food purchased as percentages of the BMA scale of minimum diets.

	Housewife Lane (Mount Pleasant)		Riverside	
	Employed %	Unemployed %	Employed %	Unemployed %
First class protein	59	45.5	68	56
Total protein	87	65	83	74
Fats	117	73	101	85
Carbohydrates	114	82	99	90
Calories	125	79	94	85

One result of this elegant study was that some months after publication of the original report in 1933, the British Medical Association appointed a Committee:

> to determine the minimum weekly expenditure on foodstuffs which must be incurred by families of varying size if health and working capacity are to be maintained, and to construct specimen diets.

The Committee decided that a minimum of 3,400 calories was necessary, made up as follows: first class protein 50g, total protein 100g, fat 100g, carbohydrate 500g.

Table 12 shows how the diets of the budget families in the two areas shaped up on the BMA scale.

There was thus shown to exist a serious shortage of first class protein in all the families, most acute among the unemployed, and a woeful lack of all dietary constituents except carbohydrates in both groups of unemployed. M'Gonigle further observed that figures for the five year period showed no evidence of an epidemic or undue incidence of infectious disease affecting only the new estate. There was an increase in the death rate from measles of 1.15 per 1,000 of the population on the new estate, of 0.87 from cancer, of 2.59 from heart

conditions and of 3.74 from bronchitis and pneumonia. During the same period, however, this population suffered fewer deaths from whooping cough, diphtheria, cerebrospinal meningitis, tuberculosis, appendicitis and what was described as 'congenital debility'.

M'Gonigle concluded:

> it is difficult to come to any other conclusion than that the increased mortality was associated with dietary deficiencies.

He also stated:

> it is a matter for regret that no similar inquiry elsewhere has yet been undertaken."

This was surely contemporary local public health at its best and M'Gonigle, who has appeared somewhat underrated in the history of public health, should be acknowledged as one of the most effective Medical Officers of Health of the period.

HOSPITAL SERVICES

The hospital services during this period also faced serious difficulties. A wide-ranging report on the British Health Services, published in 1937,[15] called the adequacy of hospital accommodation into question. Its authors found that the long waiting lists of the larger hospitals exaggerated the problem by including many who no longer required admission and stated that beds could always be found for emergencies.

> Nevertheless, there is a genuine shortage of hospitals beds in Great Britain, and occasionally this shortage is very serious.

There were in effect three types of hospital — the voluntary hospitals, the public hospitals (General and Poor Law) and institutions provided by local authorities exclusively for tuberculosis, maternity, smallpox, and other infectious diseases — and the level of co-operation between them was dismal.

Abel-Smith[24] mentions reports in the popular press of the day that Lord Rhonnda, President of the Local Government Board, was drawing up a 'scheme 'which would throw the whole medical system of the country in the melting pot' and which

included plans for a state takeover of the established voluntary and Poor Law hospitals. The scheme aimed at 'nothing less than the nationalisation of the medical profession, involving free medical attendance for all without any element of charity'. The scheme, which provoked a predictable outcry from the British Medical Association, was not approved by the Cabinet.

There was widespread support towards the end of the war for health reform during which Beatrice Webb and her Labour Party colleagues produced a policy report which envisaged the creation of a Ministry of Health and of a National Health Service under central and local democratic control.[25]

There then followed both the Dawson Report,[14] described earlier, and a move to implement the Maclean Report of 1917 on the transfer of hospitals between authorities, both strongly supported by the Minister of Health, Dr Addison. Homes for heroes and a country fit for heroes to live in had also been promises in the 1918 general election campaign and Addison had ordered local authorities to build unlimited houses and let them at what amounted to controlled rentals, 'without sufficient regard to cost.

In the aftermath of war with its horrendous economic implications, the Government could not sustain the mood for health and housing reform nor provide the necessary financial resources. Following an outcry against the waste of public money, Addison left the Ministry of Health in March 1921 to spend a few months in the role of Minister without Portfolio. He was then deprived of office altogether when Lloyd George apologised to the House of Commons that misplaced loyalty — not normally one of his characteristics — had made him cling to an incompetent minister!

The Poor Law hospitals, thought to have been doomed in 1918, survived — some for ten years, others until a similar mood of reform created by the Second World War led to their disbandment 30 years later.

The voluntary hospitals were forced to accept temporary support from public funds to cope with rising costs and contributory schemes began to be developed and to grow despite considerable opposition, particularly from the British

Medical Association.

Abel-Smith[24] quotes an exasperated statement from a meeting of the Fabian Society in 1927: 'I do not think that there is a single exception where for a quarter or half a second the BMA has ever put aside the pecuniary interests of its members for the sake of an improvement in public health'.

The change in public attitudes brought about by the war-time experience of hospitals and their use by all social classes and the introduction of contributory schemes had begun. Patients became more aware and prepared to complain about issues such as hospital food and early waking. The move towards a National Health Service may have taken time but it was unstoppable.

CONCLUSION

The period between the two World Wars was one of substantial progress for public health — a proud era.

The formation of the Ministry of Health provided a central focus, however imperfect, for the development of health services and the importance of preventive medicine was acknowledged both in health and political circles.

The Ministry provided leadership and structure to the functions of public health, enabling practitioners of the specialty to highlight the problems of infectious diseases and methods by which these could be contained. The vision and influence of Newman as Chief Medical Officer for most of the period was considerable and many of his ideas are expressed in public health today, albeit in different terms. His pioneering efforts emphasised the important impact of social and environmental issues, such as road accidents and unemployment — on the incidence of disease. Probably the major issue of his day was housing — and much public health effort was concentrated on this.

Medical Officers of Health at local level throughout the whole country, with only few exceptions, were also achieving improvements in the health of their populations despite the very unfavourable economic conditions.

Towards the end of the period, however, dramatic advances in chemotherapy were bringing clinical medicine to the forefront. Major improvements in health had been previously associated with sanitary measures and improvements in nutrition and housing. The emergence of effective therapeutic agents for the acute treatment of disease began to overshadow disease reduction through public health effort.

References

1) Thomson D. *England in the Twentieth Century.* London: Penguin, 1991.
2) Ensor RCK. *England 1870-1914.* Oxford: Oxford University Press, 1936.
3) Hobsbawm E. *Age of Extremes.* London: Abacus, 1994.
4) Taylor AJP. *English History 1914-1945.* Oxford at the Clarendon Press, 1965.
5) Mowat CL. *Britain Between the Wars. 1918-1940.* London: Methuen, 1955.
6 Marwick A. *The Deluge. British Society and the First World War.* Houndmills: Macmillan, 1991.
7) Mackintosh JM. *Trends of Opinion about the Public Health.* London: Oxford University Press, 1953.
8) Watkin B. Documents on Health and Social Services. London: Methuen, 1975.
9) *Royal Commission Report on Reform of Poor Law. 1909.*
10) Honigsbaum F. *The Struggle for the Ministry of Health 1914-1919.* Occasional Papers on Social Administration No 37. London: G Bell and Sons, 1971
11) Colville C. *Crowded Life.* London:Evans Brothers, 1963.
12) MacNalty Sir Arthur. *Fifty years of public health legislation.* BMJ 1950,1: 48-53.
13) Newman Sir George. *An Outline of the Practice of Preventive Medicine.* London: HMSO, 1919.
14) Report on the Future Provision of Medical and Allied Services (The Dawson Report). 1920.
15) PEP. *Report on the British Health Services — a survey of the existing Health Services in Great Britain with proposals for future development.* London: Political and Economic Planning, 1937.
16) Woods R, Woodward J (Eds) *Disease and Mortality in Nineteenth Century England.* London: Batsford Academic and Educational, 1984.
17) Woods R, Woodward J (Eds). *Urban Disease and Mortality in Nineteenth Century England.* London: Batsford Academic and Educational,1984.
18) Chalmers AK. *The Health of Glasgow 1818-1925. An Outline. Glasgow:* Corporation of Glasgow, 1930.
19) Macgregor Sir Alexander. *Public Health in Glasgow 1905-1946.* Edinburgh and London: E and S Livingstone, 1967.

20) Annual reports of the Chief Medical Officer. 1920-1933.
21) Boyd Orr J. *Food, health and income: report on a survey of adequacy of diet in relation to income.* London: Macmillan, 1937.
22) M'Gonigle GCM, Kirby J. *Poverty and Public Health. London:* Victor Gollancz, 1936.
23) M'Gonigle GCM. *Poverty, nutrition and the public health.* Proc. Roy. Soc. Med. 1933,667-677.
24) Abel-Smith B. *The Hospitals.* London: Heinemann, 1964.
25) *The Organisation of Preventive and Curative Medical Services and Hospital and Laboratory Systems under a Ministry of Health.* London: Labour Party, 1918.

3

Towards the National Health Service 1940 - 1948

In the face of the spiritual and political tyranny of today, we shall serve the community best by standing by our essential freedoms. Do not sell that birthright for a mess of pottage. Do not exchange that freedom for pay and a pension... Do not become gagged Government functionaries with minds in cold storage.

RT Payne, *BMJ* 18 January 1947

The [National Health Service] Act sets out to effect a revolution — that no longer will poverty and lack of means be a bar to obtaining the best medical facilities and treatment available. Revolutions always disturb established customs. Such a great social advance cannot be made without some risks and disadvantages__The Act is now on the Statute Book and we have one last chance to offer expert advice in clothing its bare bones.

DG ff Edwards, *BMJ* 25 January 1947

THE SECOND WORLD WAR AND ITS IMPACT

Politically, the years of the Second World War, or the People's War as it has been described,[1] was a period of coalition. In May 1940 a long period of Conservative dominance was shattered when Neville Chamberlain, as head of the Tory-dominated National Government (Annex 1), had to give way without a general election to Churchill's more balanced coalition of Conservative and Labour forces.[2] During the war years there was a growing swing to the left in public opinion that led to Labour's landslide victory in July 1945.

Taylor[3] reminds us of the enormity of Britain's precarious financial situation at the end of the war. In August 1945 the Treasury warned that the country faced 'a financial Dunkirk';

without substantial American aid, it would be 'virtually bankrupt and the economic basis for the hopes of the public non-existent'.

Three days later American aid ceased. Added to this government expenditure abroad was five times as high as before the war. Exports would have to increase, although industrial efforts could not be concentrated solely in that direction. The people expected immediate improvements in their living conditions after the privations of war.

In general, however, there was an optimistic outlook after the Second World War despite the vast legacy of physical destruction and psychological damage and the necessity of regearing industry almost completely. The Government had learned hard lessons from the First World War and had better plans for regeneration.

As Addison[4] has argued persuasively, the war provided a catalyst for change in terms of the widening of the role of central government and placed firmly on the political agenda the main strands of the post-war welfare state.

Addison[4] and Stevenson[5] are among historians who have highlighted two lasting post-war changes in the role expected of central government. Firstly, all the major political parties accepted the general principles of the Beveridge Report[6] for a system of comprehensive social welfare. This implied a much larger commitment by the state — so resisted in previous decades — to provide minimum standards of health, education and living conditions.

Secondly, and equally crucial, was the acceptance by the government of their responsibility for maintaining full employment after the war, a commitment which required continuing intervention in the management of the economy.

Between 1938 and 1950, the percentage of the working population employed in the public sector rose from less than one-tenth to almost a quarter — more than five and a half million individuals.

> Democratisation, collectivism and egalitarianism all contributed to the greater involvement of the state in the lives of its citizens, part of a process which saw social amelioration and a reduction of privilege as

> part of the necessary consequence not only of total war, but also of longer-term [post-war] pressures.

Stevenson[5] also draws attention to the difficulty of reaching a proper perspective on the performance of the British economy in the years up to and after the Second World War. There may have been too much emphasis on the theme of decline — balance of payments and exchange rate difficulties, inflation, poor industrial relations, and the re-emergence of high rates of unemployment.

While the fact of relative economic decline is not in question, these years also saw major scientific and medical advances, a sizeable rise in real income for those in work and a major shift in resources towards the provision of welfare benefits.

During the Second World War, Britain undoubtedly made the jump from the nineteenth into the twentieth century. After the war the country was able to begin to rely on the new developing industries such as electricity, chemicals, cars, iron and steel, machine tools, nylon — all poised for expansion.

It was very different from the end of the First World War.

> The very spirit of the nation had changed. No one in 1945 wanted to go back to 1939... The British people were the only people who went through both world wars from beginning to end. Yet they remained a peaceful and civilised people, tolerant, patient, and generous. Traditional values lost much of their force. Other values took their place. Imperial greatness was on the way out; the welfare state was on the way in.

By the beginning of the Second World War, public health presented a mixed picture.[5] As we have described in the previous chapters, the preceding 100 years had seen marked improvements in mortality and morbidity rates and in public health issues such as sanitation, water supply, control of infectious diseases, housing and nutrition.

Serious deficiencies, however, remained. Foremost among these, particularly for the less affluent, was access to hospital treatment and the lack of any form of health insurance. Half the adult population was still outside the system of state insurance provided under the National Insurance Act of 1911 and even those inside it were not eligible for specialist treatment.

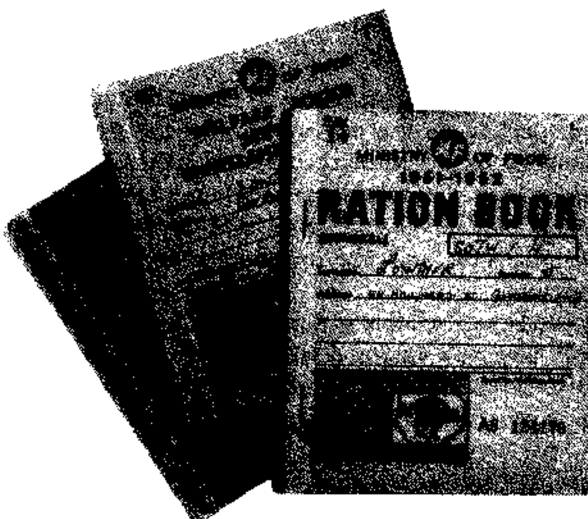


Figure 1. Ration Books.

This short period thus had a particular significance for public health on various important issues including the improvement of diet and nutrition, the development of the hospital service, the introduction of the welfare state and the national health service and — as has so often been the case in the history of the specialty — missed opportunity in its omission from the mainstream National Health Service.

NUTRITION AND DIET

No consideration of public health at this period could be complete without some scrutiny of nutrition and diet. As Burnett[7] has pointed out, there is a curious irony in the fact that the two crucial periods in the improvement of the diet of the majority of British people coincided with times of national crisis — the Great Depression of the 1880s and the war-time and post-war difficulties of the 1940s. In both cases the basic reason

for the improvement was a rising standard of living as a result of an increase in purchasing power of the population. But here the parallel ends.

In the first time-period this increase in spending power was due to external factors over which the government had no control. In the second, the State played a direct part through price fixing, rationing and deliberate pursuit of a nutritional and social policy to raise standards. 'This was possibly the most remarkable, though least publicised, achievement of war-time control.'

The organisation of food control was in many ways easier in 1939 than it had been in 1914. British agriculture had expanded considerably in the 1930s with increased mechanisation and more efficient methods of fertilisation and the country was not so dependent on imported foods. Production was increased and government planning of food control was well established.[8] A Ministry of Food had originally been set up in 1916 and in 1936 the Food (Defence Plans) Department was created, reporting at first to the Board of Trade.

On the outbreak of war this department became the centre of the new Ministry of Food. The operational structure of rationing had been drawn up. Divisional food officers and local food executive officers had been appointed and trained. All branches of the food trades had been consulted and prominent individuals from each branch chosen to control their particular commodity. Details of rationing had been fully specified and the ration books printed (Figure 1).

> Britain's preparedness for war was, in this respect at least, remarkably well advanced, and it was the confidence which knowledge of this engendered that made public acceptance of food control so easy and complete.

The science of nutrition had also developed and it was possible to plan a dietetically adequate scheme of rationing which had not been possible in the First World War. An eminent nutritionist, Professor JC Drummond, was appointed as Scientific Adviser to the Ministry. He was uniquely well placed to apply scientific principles to nutritional strategy and his knowledge of the inadequate diet of the poorer sections of the

population between the wars made him determined to use food control to improve the nutritional value of the British diet.[10]

Drummond was interested in food technology and the new process of dehydration and saw that the Food Advice Division of the Ministry provided information to housewives and caterers by means of radio, newspapers, posters and leaflets. Some degree of food control and rationing operated during this period in almost every country in the world. Those involved in the Second World War were obviously subject to greater restrictions than those who were not.

In Britain the system of rationing was developed along different lines from most other countries and proved to be an immensely powerful public health tool. It was, for example, less rigid than the German system, offering more flexibility and freedom of choice. Bread and potatoes were not rationed and price control and wage policies ensured that they were affordable to the population. The British scheme rationed meat, bacon, cheese, fats, sugar and preserves in fixed quantities per head. The extraction rate of flour was raised to 85 per cent, increasing the intake of iron, riboflavin, and nicotinic acid, and margarine was fortified with vitamins A and D, compensating partially for the scarcity of eggs.

This basic system applied to everyone but it was recognised that certain sections of the population had special nutritional needs and supplementary schemes were, therefore, added as appropriate.

Among these were schemes to provide extra proteins, vitamins and minerals to pre-school children, nursing and pregnant women. Children under the age of one year, for example, were entitled to two pints of milk a day, nursing and expectant mothers and children under five years to one pint at the subsidised price of two pence a pint or free if income was below a certain level. The school milk scheme, which had begun before the war, was expanded to include all schoolchildren.

Communal feeding was also encouraged. Firms employing more than 250 people were required to operate staff canteens and smaller firms encouraged to do so. School canteens were registered as priority catering establishments with the aim of

providing all schoolchildren with one well-balanced meal a day at a subsidised price, or free for families of very low income.

The idea of British Restaurants — or Communal Feeding Centres as they were originally rather unattractively called — was quite new. They were introduced as an emergency measure for bombed areas but eventually spread and came to play an important part in war-time feeding, providing hot nutritious meals at a cost of about 1 shilling per person. By mid-1943, 2,115 such restaurants were in operation, providing about 615,000 meals per day. They were open to the public but the policy was to site them in areas with many small firms without canteens so those workers in particular could benefit.

Another innovative feature of the British food control system was the points rationing scheme, which started in late 1941. This applied to certain foods which were limited in supply and valuable nutritionally but not essential additions to the basic diet — for example, tinned meat, fish and fruit and, subsequently dried fruits, sugar, tapioca, rice, biscuits, dried peas and beans, breakfast cereals. Each individual had an allocation of 'points' each week to spend on whatever such items were preferred. The scheme also allowed the Ministry to direct demand for food in short supply by raising or lowering the points value of a particular item.

Burnett[7] quotes an example:

> when the points system began, the public quickly bought up available supplies of tinned salmon at 16 points and ignored the unknown American pork sausage meat, also at 16 points; when salmon was raised to 24 points and sausage meat lowered to eight, demand changed immediately.
>
> The points system was highly successful in spite of the need to explain it to the public and obtain the co-operation of shopkeepers. Its acceptance was surprisingly easy and the operation of a 'black market' surprisingly small.

Rationing worked as well as it did in Britain because it was not only just but could be seen to be just.

> The system of partial rationing seemed to suit the British temperament better than any system of complete control would have done. The feeling of independence and choice, while limited, was important. Most

housewives were left with almost half their budget to spend on completely unrationed foods, which included bread, flour, oatmeal, potatoes, fish, fresh vegetables and fruit apart from oranges.

Government surveys collected details on budgets from 600-700 working class households each month which showed that on the whole the diet was up to nutritional needs, except in some cases in respect of Vitamin A. Similar data from middle class households showed that there was at that time little difference between their diet and that of the less affluent household, indicating a general levelling of standards.

Almost everyone, whatever their status, was eating at the level of the prosperous artisan of the interwar years. 'Undoubtedly, the war spread the embrace of equality far more widely than ever before.'

INFECTIOUS DISEASES AND IMMUNISATION

During the war the traditional responsibilities for the control of infectious diseases came to the forefront, not only when water, sewerage and cleansing services were interrupted but also as a result of population movements, evacuation of children and some mothers from high-risk areas and overcrowding in air raid shelters.

There was a wide attempt to provide immunisation and no major outbreak occurred. Despite the lack of explicit statutory authority for immunisation for anything except smallpox until the NHS Act of 1946, from the end of 1941 the Medical Officers of Health ran a most effective campaign of immunisation against diphtheria.[10] Deaths fell by a third within a year and incidence and mortality were down by three-quarters by 1946.

In the mid-nineteenth century, one death in every three could be attributed to infectious diseases — about one-third from tuberculosis and one-fifth from scarlet fever and diphtheria. By the beginning of the twentieth century infectious diseases were responsible for one in five deaths and by the 1960s they had become an insignificant cause of death. As Galbraith and McCormick point out,[10] morbidity as well as mortality declined, particularly after the 1930s...

diphtheria, tetanus, whooping cough and poliomyelitis were controlled by immunisation, smallpox eradication was almost complete, bovine

tuberculosis was virtually eliminated and brucellosis eradication was soon to begin.

Many other infections could be successfully treated by newly discovered antibiotics and the outlook for patients with infectious disease was transformed.

The incidence of venereal diseases was declining at the beginning of the war following twenty years of treatment programmes organised by Medical Officers of Health. The wartime disturbance of family life produced an increase but this was kept under control by more organised contact tracing and temporary requirements of notification.

EVACUATION

The official evacuation scheme was somewhat chaotic.[9] A report by Sir John Anderson, published in 1939, set out plans for moving civilians from 'evacuation' to 'reception' areas. In reality, the burden of responsibility for evacuation was placed on the local authorities and financial provisions were variable and complicated. When war broke out, of the three million declared eligible for the official scheme, only half went. A further two million made their own private arrangements.

Many mothers and children returned within days to their homes in the cities and by the end of 1939, 900,000 of the original evacuees had drifted home.

In February 1940, a new scheme was drawn up which came into effect with the Blitz and there was a third wave of evacuation in 1944 during the flying bomb attacks.

Evacuation was in its small way a social revolution. In Marwick's words[9]:

> If for genteel families in rural areas the invasion of slum children, some disgustingly lacking in the rudiments of toilet training, others pathetically unable to believe that they were actually to sleep in, and not under, their beds, accompanied by mothers who were often worse, could be hard to bear; it could also be a staggering revelation of the nature of the society in which they lived.

The Economist[11] described evacuation as:

> the most important subject in the social history of the war because it revealed to the whole people the black spots in its social life.

DEVELOPMENT OF THE HOSPITAL SERVICE

By 1939 Britain had approximately 3,000 hospitals containing around a quarter of a million beds. These fell into three main categories. The first and largest group was the voluntary hospitals, charitable institutions that depended for their survival on donations, endowments and patients' fees. The second group comprised the municipal hospitals run by local health departments and funded by local rates. Poor Law hospitals were the third group, which had developed under the Public Assistance Committees to deal with sick and infirm 'paupers', often the elderly.

The Dawson Committee's proposals for a reorganisation of the hospital service in 1920 had been mothballed on cost grounds and the patchwork of hospital provision remained.

In 1928 local authorities were given the power to take over Poor Law hospitals if they wished but were not forced to do so and the pattern varied. There was co-operation between voluntary and local authority hospitals, better in some areas than others but they remained separate.

A scheme introduced in 1922 enabled individuals earning under £6 per week to pay three pence a week for free treatment in a voluntary hospital and by 1939 most hospital patients paid for their treatment either through an insurance scheme or by private arrangement with the hospital almoner. Only the very poor received free treatment but this was arbitrary and depended on the policy of the particular hospital involved.

The pressing need was for a hospital system which offered reasonable access to all and which did not exclude those who required treatment but could not afford to pay for it.

By the autumn of 1939 there had been important changes in the views of many doctors including some of those concerned with the voluntary hospitals.

It was increasingly apparent that some regional planning of

the hospital services was needed. The British Hospitals Association showed a new willingness to accept grants from public funds and the medical profession had at last agreed to consider the possibility of a salaried service on its merits.[12,13]

Hospital planning for the Second World War was radically different from that for the First, which had focussed heavily on the need to provide adequate facilities for wounded servicemen. In contrast, planning in 1938-39 was dominated by the estimated need to provide hospital care for civilians wounded in air raids — estimates that, in reality, vastly exceeded the number of actual casualties.

Faced with the expected demand for beds, the Ministry of Health carried out the first official survey of the condition of hospitals in Britain. The result was less than reassuring (Table 1).

In June 1938, the Ministry of Health assumed all responsibility for civilian air raid casualties while the War Office retained responsibility for service patients on the premise that military hospitals would return them more quickly to duty.

The country was divided into regions headed by hospital officers and within each region, hospitals were grouped geographically and graded. A programme of structural improvement was set up.

An Emergency Medical Service (EMS) cadre of doctors of all levels was recruited to run the medical services and all doctors had to be prepared to serve anywhere in the country and to work in voluntary or local authority hospitals. This did produce

Table 1.
Ministry of Health's planning for use of hospital beds in wartime 1939

Expected number of hospital beds required for air raid casualties (basis of estimates unknown)	Number of beds to be provided by Ministry of Health for air raid casualties	Number of beds found by survey to be suitable for prolonged treatment of casualties
1 - 3 million	300,000	80,000

From Abel Smith.[12]

an improvement in hospital care in all areas because of the dissemination of consultants throughout the country. There were to be uniform conditions of service on a whole-time basis with no private practice permitted. This meant a substantial increase in pay for junior doctors and a significant fall for successful consultants, used to lucrative part-time private earnings. The British Medical Association attempted to establish a system whereby private consultants not recruited into the Emergency Medical Service would give half of any increased earnings to their service colleagues. It did not, however, prove possible to implement this scheme because of the reluctance of the former to participate![12]

When war was declared on 3 September 1939, therefore, the Government's plans for hospital services were ready and, on paper at least, seemed excellent.

What happened in reality was rather different. In the early days of the war around 140,000 civilian patients were discharged from hospital and these included 8,000 patients with tuberculosis 'cleared' from local authority sanitoria — almost 30 per cent of those receiving inpatient treatment for tuberculosis at the time. In Wales around 60 per cent of tuberculosis patients were discharged within a week.[13]

The beds were ready and, under financial arrangements agreed previously, paid for in part by the Ministry of Health whether occupied or not. But in the first nine months of the war there were very few air raid casualties. In fact, throughout the whole war, the number of air raid casualties treated in hospital was 'roughly 40 per cent less than the number of sick people turned out of hospitals in about two days in September 1939'.[13]

Adjustments were made to the original plans and such beds as were used were primarily occupied by servicemen. When the position became clear as early as October 1939, the Ministry of Health attempted to persuade the voluntary hospitals to admit more civilian sick. The hospitals, however, were receiving a subsidy of around £100,000 per week for keeping their casualty beds empty and any reduction in their number meant a reduction in subsidy.[12]

Ultimately, a few more beds were provided for the civilian sick and doctors under-employed in casualty stations and outlying hospitals were allowed to return to civilian patient care. The rule on private practice for EMS doctors was also amended to allow those of specialist rank or higher to practise privately provided that in an acute wartime emergency they could be called on full-time with no extra remuneration.

THE WELFARE STATE

In June 1941 Sir William Beveridge, a former civil servant turned academic (Figure 2), was appointed Chairman of the Inter-departmental Committee on Social Insurance and Allied Services which was established to conduct a comprehensive survey of the British system of social insurance. The exact terms of reference for the committee were as follows:

> To undertake with special reference to the inter-relation of the schemes, a survey of the existing national schemes of social insurance and allied services, including workmen's compensation, and to make recommendations.

The report was issued on 1 December 1942 on the responsibility of Beveridge alone.[6] The other members of the committee were all working civil servants and since the document dealt with broad aspects of policy in addition to details of administration, they could not be publicly associated with it.

As Watkin[14] emphasises, this report thus incorporates to an extent almost unique among such documents the vision of one man who was able to see much of that vision become reality.

The time was ripe on this occasion, as it had not been when the Dawson Report appeared. By 1942 political and public attention was beginning to focus on the task of social as well as physical reconstruction that was facing Britain. The preceding decade had been one of depression and distress and there was a widespread view that Britain after the war should be a better place to live in than before.

The Beveridge Report became a best seller. The Stationery Office had 70,000 copies for sale on 2 December 1942 and by

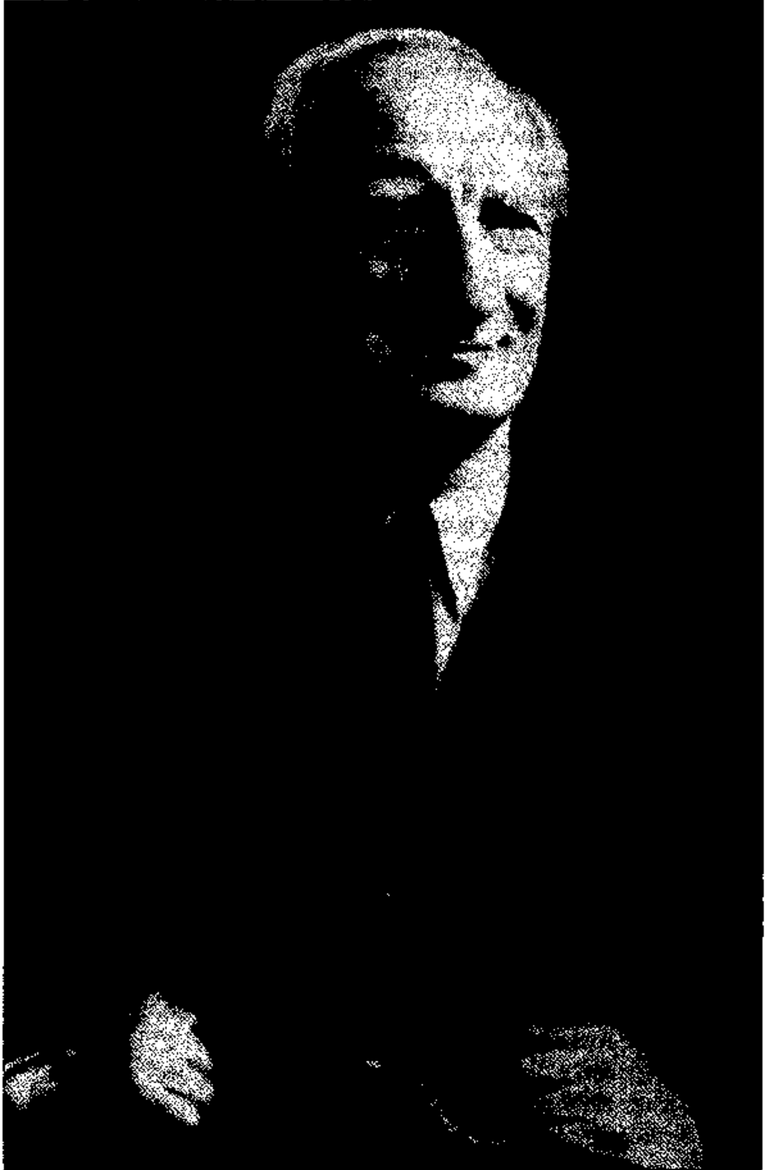


Figure 2. Sir William Beveridge.

midday it had sold out. *The Times* of that date published the Report along with various comments on the proposals. These included one from a spokesman for the insurance industry on the proposed death benefit.

> The working-class population have shown their willingness to maintain this form of insurance voluntarily without any charge on the State or industry, and it is difficult to see what justification there would be for damaging well-conducted private enterprise in order to impose these fresh burdens on taxpayers and employers.

The TUC was predictably critical of the medical benefit:

> It is simply a general practitioner's service without provision for proper diagnostic facilities, specialist opinion or hospital treatment.

And, equally predictably, the British Employers Confederation opined:

> It is imperative that the expenditure on these services, and the other social services, must be directly related to the individual performance of the country on which they ultimately depend for their continuance.

In Parliament there was heavy pressure on the government to commit itself to Beveridge's recommendations. The Report stated that:

> provision for most of the varieties of need through interruption of earnings and other causes that may arise in modern industrial communities has already been made in Britain on a scale not surpassed and hardly rivalled in any other country of the world.

Beveridge pointed out, however, that, while this was generally true, some other countries were ahead of Britain in the provision of medical services and that the other services, which were provided in Britain, had their deficiencies, including a serious lack of co-ordination.

The overall aim of the *Plan for Social Security* was:

> to abolish want by ensuring that every citizen willing to serve according to his powers has at all times an income sufficient to meet his responsibilities. (Figure 3)

Beveridge saw this as a practicable post-war objective and claimed that even in the grim years before the war, Britain had

been wealthy enough to have abolished want had the political will existed.

Beveridge's plan for social security was underpinned by three basic assumptions:

1) Child allowances up to the age of 15 years or 16, if in full-time employment.

2) Comprehensive health and rehabilitation services for the prevention and cure of disease and restoration of capacity for work, available to all members of the community.

3) Maintenance of employment — that is to say, avoidance of mass unemployment.

Child allowances would take account of the relationship between family size and poverty. In Beveridge's mind also was the belief that the health service would eventually pay for itself by producing a fitter, more productive population.[6,14] He, therefore, viewed expenditure on health services as an investment — an idea that tended to be accepted until the experience of several years of rising health service costs after 1948 with demand increasing rather than diminishing, led to a reappraisal and —

> a realisation that to a large extent health care was part of a high standard of living rather than a direct contribution to the nation's productive capacity.

Central to the Beveridge plan was the avoidance of mass unemployment — of crucial importance in the light of experience during the 1920s and '30s when the existing unemployment insurance scheme had proved totally inadequate in the face of a major recession. Beveridge believed that because of the practice of Keynesian economics, governments now had the techniques to avoid another such enormous crisis of unemployment.

Beveridge was a remarkable individual — a man of immense vision, capable also of planning in minute detail. And, as Watkin[14] observed, his penchant for making lists of key points helped to make his report easy and memorable to read. He had,

TRANSFORMATION SCENE

"Avaunt, foul sprite! and be no longer seen
I'll have you know I am the Fairy Queen!"

Figure 3. The Banishment ofWant — Beveridge's main aim.
(Reproduced with permission of Punch Ltd.)

for example, three guiding principles:

1) Now, 'when war is abolishing landmarks of every kind' was the ideal time to make a fresh start
2) Social insurance should be treated as one part only of a comprehensive policy of social progress, attacking the five giants of Want, Disease, Ignorance, Squalor and Idleness. Social Insurance by itself attacks only one of these giants — Want
3) Social security must be achieved by co-operation between the state and the individual. The State should offer security but should not, in so doing, stifle initiative, opportunity, responsibility.

Beveridge went on to list four conditions for the 'banishment of want.'

1) The world after the war is a world in which the nations set themselves to co-operate for production in peace.
2) The readjustment of British economic policy and structure that will be required by changed conditions after the war should be made so that productive employment is maintained.
3) A plan for social security — that is, for maintenance of income — should be adopted, free from unnecessary costs of administration and other wastes of resources.
4) Decisions as to the nature of the plan for organisation of social insurance and allied services should be taken during the war.

He also had six fundamental principles within his plan.

Firstly was a flat rate of subsistence benefit. This principle suggested benefit at a flat rate, irrespective of previous earnings interrupted by unemployment, disability or retirement. The only exceptions to this were where prolonged disability was the result of an industrial disease or accident, and for maternity benefit and loss of a spouse where there was to be temporary benefit at a higher rate.

Secondly came flat rate of contribution. The compulsory contribution of each insured individual or his/her employer was to be at a flat rate, irrespective of means. All insured persons, rich or poor, would pay the same contributions for the same security — those with larger incomes would pay more only because as taxpayers they paid more to the National Exchequer and thus to the State's share of the Social Insurance Fund. The only exception here was 'the raising of a proportion of the special costs of benefits and pensions for industrial disability in occupations of high risk by a levy on employers proportionate to risk and pay-roll...'.

Thirdly came the unification of administrative responsibility. This was devised in the interests of efficiency and economy. For each insured person there was to be a single weekly contribution in respect of all benefits. In each area, a Security Office able to deal with claims and cash benefits of every kind would be established. There would be flexibility of method of payment to allow for those unable to get to the office. All contributions would be paid into a single Social Insurance Fund from which all benefits and claims would be paid.

Fourthly was adequacy of benefit in amount and time. The flat rate proposed was intended to be sufficient without further resources to provide the minimum income necessary for subsistence in all normal circumstances. Benefits were seen as adequate also in time and and would continue indefinitely, without means testing, as long as the need persisted.

The fifth fundamental principle of comprehensiveness was that social insurance should be comprehensive in respect both of individuals covered and of their needs.

The sixth and final principle — classification — stated that social insurance, while unified and comprehensive, should take account of the different ways of life of different sections of the community: of those dependent on earnings by employment under contract of service, of those earning in other ways, of those rendering vital unpaid service as housewives, of those not yet of age to earn and of those past earning. The term 'classification' was used to denote adjustment of insurance to the differing circumstances of each of these classes and to many

varieties of need and circumstance within each insurance class. But the insurance classes were not economic or social classes in the ordinary sense. The insurance scheme was one for all citizens irrespective of their means.

In summary, the Beveridge plan for social security was based on the following twelve points, as listed in Table 2.

1) The plan covers all citizens without upper income limit, but has regard to their different ways of life; it is a plan all-embracing in scope of persons and of needs, but is classified in application.

2) Classification of population:
   i) employees,
   ii) others gainfully employed,
   iii) housewives,
   iv) others of working age not gainfully employed,
   v) below working age,
   vi) retired above working age.

3) Children's allowances for class v); retirement pensions for vi); and for all other classes security appropriate to their circumstances. All classes covered for comprehensive medical treatment and rehabilitation and for funeral expenses.

4) Every person in classes i), ii) and iv) will pay a single security contribution by a stamp on a single insurance document each week or combination of weeks. Contributions higher for men than for women to allow for benefits to group iii).

5) Subject to simple contribution conditions, group i) will receive unemployment and disability benefit, retirement pension, medical treatment and funeral expenses; group ii) all these except unemployment and disability benefit during the first thirteen weeks; iv) all except unemployment and disability benefit; iii) maternity grant, provision for widowhood and separation and retirement pensions by virtue of husband's contributions; thirteen weeks maternity benefit for housewives who take paid work.

6) Unemployment and disability benefit, basic retirement pension and training benefit at subsistence rates. Maternity

Table 2.
Summary of the Beveridge Plan.

Basic assumptions

i) children's allowances
ii) comprehensive health and rehabilitation services
iii) maintenance of full employment

Guiding principles

i) now was the time to make a fresh start
ii) social insurance was only one part of a comprehensive policy of social progress
iii) social security must be achieved by co-operation between the state and the individual

Conditions for the banishment of want

i) in the post-war world nations must co-operate for production in peace
ii) readjustments in British economic policy must be made so that productive employment can be maintained
iii) plan for social security should be adopted
iv) decisions on the nature of the plan should be taken during the war

Principles of social insurance

i) flat rate of subsistence benefit
ii) flat rate of contribution
iii) unification of administrative responsibility
iv) adequacy of benefit
v) comprehensiveness of benefit
vi) classification

benefit for housewives who work at a higher rate than the single unemployment or disability rate, while their unemployment and disability benefits will be at a lower rate. Special provision for disability due to industrial accident or disease.

7) Unemployment and disability benefits to continue at same rate as long as unemployment or disability lasts.

8) Pensions to be paid only on retirement from work. Rate of pension increased if retirement is postponed.

9) No permanent pensions for widows without dependent children, but temporary benefits at higher rate than unemployment benefit in early months of widowhood.

10) For limited number of cases of need not covered by social insurance, national assistance subject to a uniform means test.

11) Medical treatment covering all requirements to be provided by a national health service organised under the health departments for all citizens and post-medical rehabilitation for all capable of profiting by it.

12) The setting up of a Ministry of Social Security.

What transformed this report into a truly historic document was Beveridge's insistence that 'organisation of social insurance should be treated as one part only of a comprehensive policy of social progress'.

But Beveridge with his tendency to go into everything in meticulous, almost obsessive, detail was not universally popular and his report was not without its detractors. The moment it was published, opposition was open and vociferous. As Marwick has pointed out,[9] the files held in the London School of Economics reveal the powerful attacks made by the vested interests of the insurance and medical professions and from within the Government itself. Churchill, for example, was not enthusiastic about the recommendations and, although the Report was published at the beginning of December 1942, there was no parliamentary debate on it until 16 February 1943 when the two government spokesmen 'were so feeble and hesitant in their

support of the Beveridge Report that they aroused the justifiable suspicion that the Government had no serious intention of implementing it'.

The Report did have the support of the British people, however, and two weeks after it was published a national opinion poll showed that 95 per cent of those interviewed had some knowledge of its contents and 88 per cent liked the idea of doctor and hospital services for all, regardless of income.

In the event, the Government issued a series ofnWhite Papers in 1943 and 1944, which committed it to the Beveridge proposals, and to a general policy of social planning and reform.

Three Acts of Parliament embodied the realisation of Beveridge's three assumptions.[14]

The first was the Family Allowances Act of 1945.nThe original Bill had proposed that the allowances should be paid to the father but an amendment proposing that they must be claimed by the mother, although they could actually be paid to either parent, was passed in the House of Commons on a free vote. An allowance of five shillings a week was to be paid for every child after the first.

The National Insurance Act of 1946 covered every man, woman and child in the country and was the first scheme of its kind in Britain to cover the entire population and to provide such a wide range of benefits as summarised in Table 3. The Beveridge principle most seriously compromised in this Act was that of adequacy of benefit. Because of the need for financial stringency, several of the benefits were at a lower rate than the Report had recommended. In addition, benefits under the Act were to be related to an individual's record of weekly contributions.

The National Assistance Act of 1948 renamed the Assistance Board as the National Assistance Board and gave it the responsibility of assisting —

> persons in Great Britain who are without resources to meet their requirements or whose resources... must be supplemented in order to meet their requirements.

The Board was also charged with providing residential care

Table 3.
Benefits provided under the National Insurance Act 1946.

Benefit	Conditions of eligibility
Unemployment	Dependent on a minimum number of contributions and on certain conditions designed to prevent abuse. Self-employed excluded. Limited to 1 year.
Sickness	Payable on production of a medical certificate from claimant's doctor. Could continue until retirement if enough contributions were paid before onset of incapacity.
Maternity	i) lump sum to meet immediate expenses — dependent on contribution record of husband ii) attendance allowance iii) maternity benefit — a weekly allowance to let women give up work in good time before the birth and recover fully afterwards — dependent on contributions of the woman herself. Originally payable for 13 weeks, later increased to 18.
Retirement	Retirement from work a condition for payment of pension at age 65 for men and 60 for women. At age 70 (men) and 65 (women), pension to be paid unconditionally.
Widows	For widows under 60 a relatively high allowance for the first 13 weeks (later 26 weeks) .After the period of readjustment, a widow with dependent children entitled to a widowed mother's allowance and a widow over 50 to a widow s pension. Benefits to cease on remarriage or cohabitation.
Guardians	Payable to individuals - not institutions or authorities - responsible for the care of orphan children.
Death grants	Intended to help families meet expenses of a simple funeral — dependent on a certain number of contributions having been paid by deceased person or husband/father. Unpopular with insurance companies who previously provided funeral cover.

for anyone who, 'by reason of age, infirmity or any other circumstance, are in need of care not otherwise available to them'.

THE NATIONAL HEALTH SERVICE

The 1911 health insurance scheme had been the beginning of the notion of a national health service and rising costs of medical care between the wars — caused by the development of more complex methods of treatment and investigation — had made a re-think on the financing of health care essential.

Table 4 summarises the reports and legislation from 1911 onwards, which paved the way for the introduction of the National Health Service.

In 1937 the Political and Economic Planning think-tank pubhshed a detailed and influential report of a survey of the existing health services in Great Britain with proposals for future development.[15]

In 1941, before the publication of the Beveridge Report, Ernest Brown, Minister of Health, had announced the Coalition Government's plans in answer to a question on post-war hospital policy in the following terms — 'It is the objective of the government as soon as may be after the war to ensure that by means of a comprehensive hospital service appropriate treatment shall be readily available to every person in need of it'.

Brown subsequently put forward a plan for a health service in which administration would be carried out by local government, the voluntary hospitals would retain much of their independence and GPs would be salaried officials. The British Medical Association described the plan as 'an unfruitful basis for discussion'. In late 1943 Brown was replaced as Minister of Health and by February 1944 his successor, HU Willink, had produced a White Paper which incorporated a number of concessions to the medical profession.

The White Paper on a National Health Service recorded the Government's acceptance of Beveridge's recommendation that access to medical services should be determined by need and not by ability to pay:

the real need being to bring the country's full resources to bear upon reducing ill health and promoting good health in all its citizens.

When the White Paper was debated in the House of Commons, Willink outlined four principles as follows:

1) the provision of a comprehensive service available to all.

Table 4.
Summary of main documents and legislation surrounding the establishment of a social security system and the introduction of the National Health Service

No.	Document	Year
1	National Insurance Act	1911
2	Dawson Report	1920
3	Report of the Royal Commission on National Health Insurance	1926
4	BMA Proposals for a General Medical Service for the Nation	1929
5	Local Government Act (transfer of workhouses and infirmaries to local authority control	1929
6	Report of the Voluntary Hospitals Commission - Sankey Report	1937
7	PEP Report on the British Health Services	1937
7	A General Medical Service for the Nation - BMA (revision of 2)	1938
8	Beveridge Report on Social Insurance and Allied Services	1942
9	Government White Papers on a National Health Service	1943/44
10	Family Allowances Act	1945
11	National Insurance Act	1946
12	National Health Service Act	1948

2) freedom for both doctors and patients to take part in the service or not, according to their wishes.

3) democratic control through Parliament and the elected local authorities.

4) machinery to ensure that the views of the professions were taken into account in the development of the service.

In spite of the weight it gave to the views of the medical profession, the plan was not well received by the doctors - in particular general practitioners — many of whom remained deeply suspicious of the idea of a salaried service.

The public, however, was once again favourable in its reaction to the plan. They were naturally positive about the notion of a service freely available to all, regardless of means, and not concerned about how and by whom the service would be administered and how doctors would be paid.

Discussions continued throughout 1944 and by early 1945 Willink and his advisers were ready to start drafting a Bill. This never came to fruition, however, because of the General Election of July 1945 when Labour took power and Aneurin Bevan became Minister of Health.

According to Honigsbaum,[16] Bevan (Figure 4) was 'a man of immense charm and great imagination, the poet in politics who coaxed, cajoled and pushed the doctors into the National Health Service'.

The National Health Service Act — described in the British Medical Journal of 25 January 1947 as 'this infamous and un-English Act' — came into being on 5 July 1948, two years after it had been passed by Parliament. The two years saw both the detailed preparations for setting up the new health service and lengthy and sometimes acrimonious discussions between the medical profession and the Minister of Health.[14]

The BMJ correspondence columns in 1947 and early 1948 were full of opposition and dire predictions about the scheme:

> The spectre of State dictatorship faces us; our freedom is threatened;
>
> ... enter officialdom, exit humanity;
>
> ... doctors will become no more than 'salaried lackeys of a demagogue'.

Figure 4. Aneurin Bevan.

And Punch magazine had its say in the issue of 17 March 1948:

> Mr Bevan denies that as from July 5th all doctors will be required to take the Bureaucratic Oath.

Feelings of the medical profession in particular on the prospect of the National Health Service figured heavily in that magazine and elsewhere in 1947 and 1948 (Figure 5).

Bevan took a firm hand. When he was ready to discuss his proposals, he made it clear that he would consult but not negotiate with outside bodies and professional groups such as the British Medical Association.

He did have some support in the medical press. In the BMJ of 30 August 1947 a correspondent noted that the idea of a national health service had first been mooted by Dr Hugh Chamberlen in his *Proposal for the better securing of health* which he submitted for consideration in 1689.

> It is humbly proposed that a more compleat Constitution of Physick may be established, whereby all sick, rich or poor, shall be advised and visited by approved skilful Physicians and Surgeons; for all diseases except the Pox, Midwifery, and cutting for the stone... and all this (except as before excepted) for a small yearly certain sum assessed upon each house... whereas many at present miserably perish for want of timely and skilful assistance.

And on 6 March 1948, Bevan received robust support in a letter to the BMJ from fellow Labour MP and doctor, Stephen Taylor. Speaking of his colleague Taylor stated:

> In any reasonable attempt to find a solution and make a success of the Health Service, he will play fair; in battle he will neither give nor ask for quarter.

He advised the medical profession to drop their demands for reversal of the law and to approach the Minister again with constructive proposals on particular points of issue. He ended —

> Finally, let me emphasise that the next move is up to you. It is for you to declare war or to make a gesture of peace. If you declare war, you wiD lose. If you make a gesture of peace, you can yet find, in spite of what has passed, the spirit of goodwill.

"Please may I have it—or does it belong to the Government?"

Figure 5. The Spectre of the National Health.
(Reproduced with permission of Punch Ltd.)

In a speech to the National Association of Maternity and Child Welfare Centres about ten days before the inception of the NHS, Bevan said 'the new Health Service has been having a most uneasy gestation and a very turbulent birth but all prodigies behave like that... Before many years are over we shall look back with pride on what we have accomplished'. And in the *BMJ* of 3 July he published a message to the medical profession (Figure 6) in which he referred to the difficulties and outlined his hopes for future partnership.

The Times newspaper in an editorial on 5 July 1948 proclaimed:

> This day makes history - insurance and assistance to help in all the changes and chances of life, a free national health service for all — these are the great landmarks in British social progress which we have reached this month.

PUBLIC HEALTH IN THE NATIONAL HEALTH SERVICE

The introduction of the National Health Service had a major impact on public health.

The strength of public health departments had been evident during the war when the personal authority of Medical Officers of Health proved essential to the organisation of emergency services for civil defence. They ran first aid services, for example, and improvised an ambulance service. Godber[17] quotes two examples of Medical Officers of Health playing key roles. Arthur Massie in Coventry had to handle the casualty services in the first saturation raid on a provincial city, including problems of disrupted water supply and sewage disposal. Stanley Walton, Medical Officer of Health of West Bromwich, was awarded the George Medal for his conduct when that city was attacked.

Godber also points out the great strengths of the Medical Officers of Health just before and during the Second World War when public health was moving on from the sanitary revolution to the development of personal health services. Between the wars, services for mothers, babies and schoolchildren had been greatly improved and broadened through the activities of public health departments,'though with some friction with the general

BRITISH MEDICAL JOURNAL

LONDON SATURDAY JULY 3 1948

A MESSAGE TO THE MEDICAL PROFESSION

FROM THE MINISTER OF HEALTH

On July 5 we start, together, the new National Health Service. It has not had an altogether trouble-free gestation! There have been understandable anxieties, inevitable in so great and novel an undertaking. Nor will there be overnight any miraculous removal of our more serious shortages of nurses and others and of modern replanned buildings and equipment. But the sooner we start, the sooner we can try together to see to these things and to secure the improvements we all want.

On July 5 there is no reason why the whole of the doctor–patient relationship should not be freed from what most of us feel should be irrelevant to it, the money factor, the collection of fees or thinking how to pay fees—an aspect of practice already distasteful to many practitioners. Yet it has been vital, if this is to be the new situation, to see that it did not carry with it either any discouragement of professional and scientific freedom or any unfair worsening of a doctor's material livelihood. I sincerely hope and believe we have secured these things. If we have not we can easily put that right.

The picture I have always visualized is one, not of " panel doctoring " for the less well-off, not of anything charitable or demeaning, but rather of a nation deciding to make health-care easier and more effective by pooling its resources—each sharing the cost as he can through regular taxation and otherwise while he is well, and each able to use the resulting resources if and when he is ill. There is nothing of the social group or class in this and I know you will be with me in seeing that there does not unintentionally grow up any kind of differentiation between those who use the new arrangements and those who, for any reason of their own, do not. Let this be a truly national effort. And I, for my part, can assure you that I shall want vigilantly to watch that your own intellectual and scientific freedom is never at risk of impairment by the background administrative framework, which has to be there for organizing purposes, but in which your own active participation is already secure.

In this comprehensive scheme—quite the most ambitious adventure in the care of national health that any country has seen—it will inevitably be you, and the other professions with you, on whom everything depends. My job is to give you all the facilities, resources, apparatus, and help I can, and then to leave you alone as professional men and women to use your skill and judgment without hindrance. Let us try to develop that partnership from now on.

It remains only to wish you all good luck, relief—as experience of the scheme grows—from your lingering anxieties, and a sense of real professional opportunity. I wish you them all, most cordially.

ANEURIN BEVAN.

Figure 6. Bevan's message to the medical profession on the inception of the National Health Service.

practitioners and not a great deal of help from the paediatric and obstetric hospitals'.

The specialty had expected that the National Health Service would be introduced as part of local government with an expected expansion of the service provided by local authorities. In its comments on the proposals when they appeared, the Society of Medical Officers of Health were alone in recommending control over the service in each area by one single local authority with a chief medical officer in executive authority.

Seeds of antagonism, however, had long been evident in the relationship between local authority and the powerful voluntary hospitals. During the war, the Emergency Medical Service had enabled improved co-operation but the voluntary hospitals still considered themselves superior and made it abundantly clear that they would not tolerate being placed under local authority control in the new service. Clinical medicine as a whole was antagonistic to the idea of health being a local government service and its antagonism extended also to public health which was perceived as a peripheral medical specialty.

Public health, not for the first time or the last, did not grasp the political reality. It expected reason to prevail and grossly underestimated the power of concentrated lobbying by bodies such as the British Medical Association, the Royal Colleges and the voluntary hospitals.

By contrast, the physicians and those concerned with medical education became very interested in the concept of social or community medicine as the specialty was to become called. Both the Goodenough Committee and the Royal College of Physicians emphasised the importance of the subject in the medical curriculum.[18,19]

CONCLUSION

The short time period covered by this chapter saw the most fundamental changes in social and health policy in Britain — changes which were of critical importance for the development and status of public health over the following decades.

References

1) Calder A. *The People's War: Britain 1939-1945.* London: Cape, 1969.
2) Jefferys K. *The Churchill coalition and wartime politics 1940-1945.* Manchester and New York: Manchester University Press, 1991
3) Taylor AJP. *English History 1914-1945.* Oxford: At the Clarendon Press, 1965.
4) Addison P. *The Road to 1945: British Politics and the Second World War.* London: Cape, 1975.
5) Stevenson J. *British Society 1914-45.* Harmondsworth: Penguin Books, 1984.
6) Report on Social Insurance and Allied Services *(Beveridge Report).* Cmd 6404. London: HMSO, 1942.
7) Burnett J. *Plenty and Want. A Social History of Diet in England from 1815 to the present day.* London: Nelson, 1966.
8) Charlton J, Quaife K. *Trends in Diet 1841-1994.* In: *The Health of Adult Britain 1841-1994.* Charlton J, Murphy M (eds). London: HMSO, 1997.
9) Marwick A. *The Deluge. British Society and the First World War.* Houndmills: MacMillan, 1991.
10) Galbraith S, McCormick A. *Infection in England and Wales 1838-1993.* In: *The Health of Adult Britain 1841-1994.* Charlton J, Murphy M (eds). London: HMSO, 1997.
11) Spotlight on Poverty. Economist, 1 May 1943.
12) Abel-Smith B. *The Hospitals. 1800-1948.* London: Heinemann, 1964.
13) Titmuss R. *Problems on Social Policy.* London: 1950.
14) Watkin B. *Documents on Health and Social Services. 1834 to the present day.* London: Methuen, 1975.
15) PEP. *Report on the British Health Services - a survey of the existing Health Services in Great Britain with proposals for future development.* London: Political and Economic Planning, 1937.
16) Honigsbaum E *The Division in British Medicine.* London: Kogan Page, 1979.
17) Godber GE. *Medical Officers of Health and Health Services.* Community Medicine, 8(i): 1-14, 1986.
18) Royal College of Physicians of London. *Planning Committee Report on Medical Education.* (Moran Report). London: Royal College of Physicians, 1944.
19) Report of the Inter-Departmental Committee on Medical Schools *('The Goodenough Report).* London: HMSO, 1944.

4

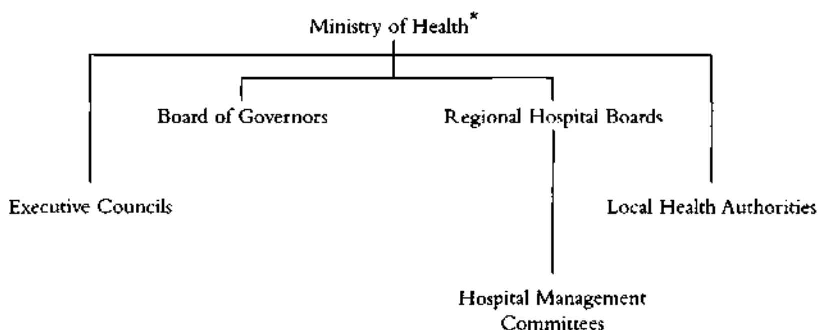
Changing Names
From Public Health to Community Medicine
1948 - 1974

Everyone says that prevention is better than cure and hardly anyone acts as if he believes it, whether he is attached to Parliament, central or local government, or the commonalty of citizens. Palliatives nearly always take precedence over prevention... Treatment — the attempt to heal the sick — is more tangible, more exciting, and more immediately rewarding, than prevention.

Mackintosh 1953 - *Trends of Opinion in Public Health*

THE NATIONAL HEALTH SERVICE ESTABLISHED

The administrative structure of the National Health Service as it was established in 1948 is illustrated in Figure 1. As Ham[1] among others has described, this structure was a product of years of discussion and negotiation by health policy-makers and had thus evolved over a long period of time. It was an example of a structure that was possible and the result of inevitable political compromise rather than one which might have been ideal.



* Superseded by the Department of Health and Social Security

Figure 1. Structure of the National Health Service 1948-74.

(Reproduced from Ham by kind permission of the author and Macmillan Press Ltd.)

It was organised in three main parts. Firstly were the executive councils which replaced the old insurance committees. These were funded directly by the Ministry of Health and members were appointed by local professionals, local authorities and the Ministry. They were not management bodies but administered the contracts of GPs, dentists, opticians and pharmacists, maintained accurate lists of these local family practitioners, as they were called, and considered patients' complaints.

Secondly, came local authorities which were responsible for a range of environmental and personal health services including maternity and child welfare clinics, health visitors, midwives, health education, and vaccination and immunisation. They were also in charge of the ambulance service. The medical officer of health was still the key local authority health officer and funding came from a combination of grants from central government and local rates. Administration of hospitals and tuberculosis and cancer services were removed from local authority control — a substantial reduction in the role of public health.[1,2,,3]

Thirdly, three new bodies were set up to administer hospitals — Regional Hospital Boards, Hospital Management Committees and Boards of Governors. One of the personal concessions that Bevan made to the powerful clinical lobby in the medical profession was to submit to their insistence that both the local authority hospitals and the voluntary or teaching hospitals would be placed under a single administrative structure and not remain under local authority control.

The vast majority of hospitals came under Regional Hospital Boards of which there were thirteen at first and then fourteen in England and Wales and four in Scotland. These Boards were appointed personally by the Minister of Health and they then appointed the members of the Hospital Management Committees of which there were around 400. The old voluntary teaching hospitals were organised under Boards of Governors appointed by the Minister and financed and with direct access to the Ministry of Health. In Scotland teaching hospitals were part of Regional Hospital Boards.

EFFECT OF THE NATIONAL HEALTH SERVICE ON PUBLIC HEALTH

Despite the effective work of medical officers of health and their public health colleagues before, during and immediately after the Second World War, the specialty was thus in effect sidelined with the introduction of the National Health Service. The original White Paper on the National Health Service in 1944 envisaged a system in which counties and county boroughs would still have owned and run their own hospitals and would have had a co-ordinating role with other hospitals.[4]

With the eventual National Health Service Act, however, public health lost control of local authority hospitals and of clinical work since there was now universal access to general practitioner services. In addition, there were moves for hospital and GP services to distance themselves from public health and both social work and environmental health began to assert their rights to be independent departments.

Public health as a medical specialty can with some justification be characterised by its ideahsm — striving to prevent what may happen in terms of illness and disease rather than coping with what has happened. But it has also on occasions throughout its history displayed a stunning naivety. This was certainly the case in the negotiations and manoeuvrings which preceded the introduction of the National Health Service when public health grossly underestimated the political skills and determination both of the Minister of Health and his colleagues and advisers and of the British Medical Association, the Royal Colleges and the clinicians.

PUBLIC HEALTH VIEWS OF ITS STATUS IN THE NATIONAL HEALTH SERVICE

There were varying views about the structure of the NHS and its consequences for public health.

Sir George Godber (Figure 2), Chief Medical Officer of Health from 1960—73, has pointed out that the original structure proposed in 1944 would have led to a very unco-ordinated service because of local competition between

Figure 2. Sir George Godber, Chief Medical Officer of Health from 1960-73. A crucial figure in the development of public health.

hospitals and without effective regional control.[4,5]

Sir Arthur MacNalty, an earlier Chief Medical Officer, writing in the British Medical Journal in July 1948,[6] was lyrical about the promise of the new service and opened his remarks by quoting from John Simon:

> The Profession of Statesmanship, like the Profession of Medicine, must be intent on methods of Prevention no less than on possibilities of Cure and must derive its preventive methods from a genuine science of Causes.

MacNalty saw the establishment of the National Health Service as the:

> culmination of a hundred years of endeavour for the public weal... the beginning of a fresh advance towards the maintenance of health and the conquest of disease and social evil.

Writing in the Lancet in 1949, Brockington,[7] then Medical Officer of Health for the West Riding of Yorkshire, took a reasonably upbeat view of the effect on public health of the National Health Service Act:

> the greatest medical statute since the [Public Health] Act of 1895.

He drew attention in particular to the third section of the Act which set out the preventive duties invested in local authorities and he predicted that health centres would eventually develop into:

> centres of preventive medicine where adequate records and routine health checks become routine procedures... and at some time in the future they will become the focus of medicine.

Brockington saw the removal from public health of many responsibilities directly related to clinical medicine as an advantage, freeing the Medical Officer of Health and colleagues for many aspects of public health which needed close attention. These tasks included the tracing of tuberculosis contacts and the welfare and home care of the elderly and chronic sick. He foresaw new opportunities for working with general practitioners in the care and after-care of the patient at home.

> Part III of the Act can, in fact, be regarded as a minor charter in public

health. Had it been passed into law without the rest of the Act, the world of public health might have acclaimed it without reservation.

By establishing separate authorities to handle medical treatment — largely under State control — the Act placed the emphasis squarely on curative medicine. The work of hospitals and their specialist consultants became the responsibility of the large regional hospital boards who therefore virtually controlled the development of medicine. The members of these boards were appointed, not elected, and about one-third were doctors, almost entirely from the field of curative medicine. Most boards did include a token medical officer of health and a number of the Senior Medical Administrative Officers had a public health background but were charged with clinical administration.

In the previous period, public health had made increasing use of the facilities of curative medicine by using hospital specialists to carry out preventive functions such as immunisation and health education and in setting up special diagnostic screening clinics. After 1948, in all its plans, public health was dependent on another — sometimes less than sympathetic — authority to provide beds or clinics or consultant home visits. Implementation and co-ordination of such preventive activities became more difficult.

The whole public health emphasis on community and health rather than hospitals and illness had changed and health services became increasingly focused once again on treatment and hospitals. Prevention was a vague and seemingly unattainable dream — indeed the 1946 NHS Act went so far as to abolish the legal requirement for smallpox vaccination.

There were those who believed that the regionalisation of curative medicine had swung the balance of power so violently towards cure rather than prevention that to survive successfully public health would have to undergo a similar reorganisation and separate itself from local government. And there were those who argued that, in the interests of a unified service, the remaining health functions should be transferred to the Regional Hospital Boards.

Brockington was eloquent in his opposition to this proposal.[7] 'The outlook of the clinician, who occupies more than a third

of seats on the boards, is centred upon the individual even when he is imbued with the new spirit of social medicine. The outlook of the medical officer of health centres upon society. If then local government in health, after a glorious reign, is now to be deposed, let not the throne be occupied by those who know not'. He was also insistent that the financing of public health activities in part by a local rate was of paramount importance in terms of accountability to the local population.

He argued for the retention of medical officers of health with the freedom to speak their minds and with duties and responsibilities 'in no way subordinated to curative medicine'.

RH Parry, who combined academic and service public health, being both Medical Officer of Health of the City and Port of Bristol and Professor of Preventive Medicine in the University of Bristol, focused on what he saw as the paradox of pubhc health at the beginning of the National Health Service.[8]

Having made such an enormous contribution to the health of the population in the previous 100 years, the specialty found itself once again in the shallows of medicine. 'It is futile to delude ourselves that medical officers of health will play the same kind of part in the country's health services as they have in the past... we must try to find out what tasks lie ahead of us for what really concerns us, in the end, is how best we can serve the community in our own particular sphere.'

Parry emphasised that there would always be important public health problems to be studied and resolved and a change of name to social or community medicine and an Act of Parhament would not alter that. He analysed the new duties imposed on local authorities by the NHS Act and found that at best public health would have an initiating, co-ordinating and supervising role.

All the activities identified in the various sections of the Act had two main components - professional and administrative — and it was here that Parry identified the main danger to public health and the one which many although by no means all in the service sphere did succumb to. Professional activities were clearly mainly the province of specialists and general practitioners in hospital, health centre and home. The medical

officer of health and his public health colleagues would have a liaison function until the services were set up and functioning but not a central role. The administration of these services would be an enormous task, many problems would undoubtedly arise in the practical situation and require solutions. 'If medical officers of health undertake these administrative duties, they will find as much work as they want'.

While there was an excellent opportunity for setting up an efficient administrative system and a unique chance for co-ordination of sound health data systems, Parry had a more powerful picture of the future for public health based on the two main duties and responsibilities defined by the Sanitary Officers' Regulations in 1935. Many medical officers of health had failed to concentrate on these two vital areas and power had been dissipated by attention to too many subsidiary tasks. He strongly advocated a role as adviser rather than executive officer to the local authority and stressed the importance of ensuring free access to medical and social records in the district and adequate staff to fulfil the duties. The greatest need he saw was to protect the expert so that there was freedom to investigate, assess and express an honest view of the position from a public health point of view.

Parry appealed to colleagues in the service sector — 'Once and for all, let us cut the Gordian knot of administration that is strangling our initiative. Let us seek more freedom and more facilities to search for new knowledge regarding the maintenance of health and the prevention of disease.'

FAE Crew, Professor of Public Health and Social Medicine at the University of Edinburgh, was philosophical in his approach to the position of public health at this time.[9] 'The attitude of an elected government should be a reflection of the electorate generally... Fear and pain are great canvassers of curative medicine. That which we have been required to do is all too commonly regarded as an unwarranted and expensive interference with the liberty of the individual, savouring of snooping, restriction and prohibition. The average individual, not being sick, resists all attempts to protect him against the hazards of disease and refuses his cooperation, without which

there is much that must remain undone.'

Since public health has always dealt with environmental, social and bacteriological phenomena in communities rather than symptoms in individuals, its foundations were more scientific than those of most branches of curative medicine. There is a crucial difference between the position of the clinician in charge of the sick, responsible and empowered to take such action as he thinks appropriate to treat an individual patient and the medical officer of health whose role is almost entirely non-executive and advisory — 'he has to mould by convincing argument, commonly in committee, the opinions and decisions of laymen, combatant officers, parliamentarians, magistrates, councillors, the general public'. A difficult and unglamorous remit in any age.

Crew contended that public health had allowed itself to be deflected in 1929 from its progress in preventive medicine and health promotion which was rapidly shaping the organisation and functions of the public health services. Curative medicine at that time — largely based on private practice and voluntary organisations — was badly organised and had been overwhelmed by a rump of stubborn morbidity which had overflowed into the public health services. The medical officer of health was made responsible for the provision of medical and nursing care for a mass of disease, much of it chronic, which had proved unresponsive to available treatment. Public health responsibility towards the sick at this time had been allowed to overtake the previous priorities of disease prevention and health promotion. Although this may have resulted in a short-term enhancement of status for public health, it undoubtedly contributed to the longer-term confusion and reduction in influence of the specialty which has taken so long to resolve.

Despite the variety of views on the effect of the introduction of the National Health Service, the attraction of medical graduates into public health undoubtedly diminished at this time and recruitment into the specialty fell, both in terms of quality and quantity.

HIGHLIGHTS OF SERVICE PUBLIC HEALTH

In this time period, despite the difficulties, many medical officers of health were outstanding and led their colleagues to expand public health activity very productively.[4]

Warin in Oxford, for example, achieved a very high level of success in his programme of immunisation through use of the close relationship which he had built up with local general practitioners and the extended role of health visitors whose responsibilities were widened to include the whole family.[10,11] He also pioneered the attachment of health visitors to group practices. In regard to immunisation, Warin had this to say in his annual report of 1973:

> Oxford has an enviable record of a constant high rate of acceptance of immunisation against infectious diseases. This rate has been maintained by the efficiency and expertise of health visitors and a manual card index system, rather than by reliance on a computer. Immunisation against diphtheria, pertussis and tetanus has been over 90% for the past ten years and is currently 97% of the infant population. Similarly poliomyelitis vaccination has been over 90% for twelve years and is now also 97%. The acceptance of routine vaccination against measles, which was introduced in 1966, has risen from 53% to 82%. Routine vaccination against German measles is now accepted by 94% of girls aged twelve to thirteen years.

In the late 1950s and early 1960s special campaigns of mass radiography were used to good effect in Scotland — first in Glasgow (Figure 3) and later throughout the country, to try to find the unknown and infectious sufferers from tuberculosis.[12] Andrew Semple, Medical Officer of Health in Liverpool from 1953 - 74, set up a very successful MMR campaign in that city during which more than 80 per cent of the adult population was screened. In 1953 he noted that tuberculosis remained a big problem with Liverpool having the highest rates in the country apart from Glasgow. By 1960 Semple was able to report a big reduction in cases resulting from the campaign and by 1966 it was possible to close the Central Chest Clinic.[13]

Other medical officers of health, such as Parry and Wofinden with the William Budd Centre in Bristol, had developed the imaginative new concept of the health centre.[4] Integrated care

Figure 3. The MMR Campaign gets under way in Glasgow, 1957.The Secretary of State for Scotland and the Lord Provost of Glasgow being X-rayed.

for pregnant women from the antenatal period through birth in hospital or at home to care in the postnatal period was beginning in a few places as was more co-ordinated care for the elderly and the chronic sick and mentally ill.

The vexed question of fluoridation of water also raised itself at this time — described by Godber[4] as — 'the classic example of another kind of health promotion in which medical officers of health would lead if the politicians would let them'.

Gwilym Wynne Griffith in Anglesey managed his own authority and public opinion in his county to secure a test period for fluoridation and had a method of dealing successfully with complaints. The start of the scheme was announced pubhcly for a particular day. The following week the usual flood of complaints came in about the taste in the water — the news was then given that the start of the scheme had been postponed for one week! Most Directors of Public Health of today will identify with the frustration of being unable to convince local

councillors and members of water authorities to undertake one of the simplest and safest public health initiatives that remains.

THE NATIONAL HEALTH SERVICE IN ACTION

Beveridge had held the firm view that there was a fixed amount of illness in the population and the introduction of a national health service, free at the point of delivery, would gradually reduce this. His vision was of 'a health service which will diminish disease by prevention and cure'.[14]

It was, therefore, expected that expenditure would level off or even dechne as people became healthier and that the National Health Service would prove to be an investment which would be realised in the increased efficiency shown by a fitter working population.[14] What happened in reality was of course very different. Health service spending spiralled high above parliamentary estimates, thousands of gallons of medicines disappeared down the throats of the British people and there was a rush for free dentures and spectacles.

In an appendix to the Beveridge Report, the government actuary had estimated that a national health service for Britain might cost about £170 million a year. Other government estimates before 1948 were around £180 million gross with a net cost to the Exchequer after various incomings of about 68% of this amount.[14]

In its first full year, the National Health Service cost more than twice what had been expected (Table 1) and, although demand for free spectacles and false teeth was finite and did level off after the initial cascade, the costs of drugs and other services continued to rise. The Minister of Health, Aneurin Bevan, exhorted the medical profession not to prescribe unnecessarily and to use the cheaper drugs rather than the more expensive — a familiar story almost 50 years later.

It was clear that cost *had* operated as a barrier previously and that financial limits and some charges would have to be set. In 1951 the Labour Government introduced charges for spectacles and false teeth and Bevan resigned in protest. Later that year after a general election, the Conservatives imposed further

Table 1
Estimated and actual costs of the National Health Service in Year 1.

Estimated	Actual
NHS as a whole	
£170-£180 million	£402 million
	(£305 falling on Exchequer)
Ophthalmic Service	
Less than £1 million	£22 million
Dental Service	
Less than £10 million	£43 million

Figures from Watkin

charges including £1 for a course of dental treatment and prescription charges with certain exemptions.

The Guillebaud Committee of Enquiry was appointed in 1953:

> To review the present and prospective cost of the National Health Service; to suggest means, whether by modifications in organisation or otherwise, of ensuring the most effective control and efficient use of such Exchequer funds as may be made available; to advise how, in view of the burdens on the Exchequer, a rising charge upon it can be avoided while providing for the maintenance of an adequate service; and to make recommendations.

The Committee heard evidence from more than 100 groups and organisations and also commissioned a study of health service costs from the National Institute for Economic and Social Research (NIESR),[15] the conclusions of which formed the basis of Part I of the final report.

The Guillebaud Report was published in 1956.[16] The NIESR study had shown that once the cost figures were corrected for the fall in the value of money between 1949-50 and 1953-4, the 'real' rise in net cost over the period was only

£11 million rather than a nominal rise of £59 million. Results of the study also showed that the hospital sector was claiming an increasing, and the executive council service a declining, share of total health service resources.

The report stated that:

> the Service's record of performance had been one of real achievement. The rising cost of the Service in real terms during the years 1948-54 was kept within narrow bounds; while many of the services provided were substantially expanded and improved during the period. Any charge that there has been widespread extravagance in the National Health Service, whether in respect of the spending of money or the use of manpower, is not borne out by our evidence.

The Committee concluded that no major change was necessary in the general administrative structure of the NHS and that unification of the three sectors was not a practical proposition at that time, although more could and should be done to strengthen the links between them. It further stated that the service should remain under direct parliamentary control.

They warned that Beveridge's belief that the service would be self-limiting was an illusion and that a realistic aim had to be simply to provide the best service possible within the hmits of available resources. They also suggested that more money was required particularly in respect of the backlog of capital building works on old and neglected hospitals which had built up from the beginning of the Second World War.

The Hospital Plan published by the Ministry of Health in 1962[17] provided for expenditure of £500 million in England and Wales in the ten years up to 1971 and signalled the resumption of major hospital construction and renovation throughout Britain. The key concept in this was the District General Hospital with between 600 and 800 beds providing specialist facilities for all but the most rare diseases for a population of 100,000 to 150,000.

Despite the Guillebaud Committee's plea for better bridges to be built between the three parts of the National Health Service and despite contact maintained by various means, an increasing distance developed between general practitioners and their consultant colleagues at this time. The growth of health

centres and the primary health care team and more equitable distribution of general practitioners throughout the country — the most important developments in general practice — did not happen to any extent until almost twenty years later.

The relationship between general practice and public health was also far from perfect, a reality grounded in historical suspicion between the two specialties. But pockets of good practice — where health centres were being developed and where staff attachments were encouraged and co-operation in areas such as immunisation were bearing fruit — showed that the relationship could work where there was good will and common intent on both sides.

The third branch of the National Health Service — and the one most directly involving public health — developed slowly after 1948 with the provision of ambulances as the main part of the service initially.

In 1963 the Ministry of Health produced a document entitled *Health and Welfare: the Development of Community Care* — intended as an equivalent of the *Hospital Plan* for the local authority health sector.[18] This laid out proposals for the development of local authority health and welfare services. As Ham[1] has pointed out, this was much less of a national plan than the *Hospital Plan* and reflected the greater measure of autonomy in the local authority setting.

There was considerable variation in plans from different authorities and it was the hope that comparisons would provoke revisions of these plans and result in greater uniformity throughout the country. In 1966 the second revision of the Health and Welfare Plan showed that wide differences persisted. There were also interesting tendencies to over or underestimate need for particular groups of staff in many local authorities.[18]

As we have already described, the main services in this sector related to four main client groups — mothers and young children, the elderly, the physically handicapped, and the mentally ill and handicapped — and relied on co-operation between public health and other relevant disciplines such as social work. In the late 1960s the social services were seeking independence from public health and arguing for their own departments.

SEPARATION OF SOCIAL WORK AND ENVIRONMENTAL HEALTH

SOCIAL WORK

The Seebohm Committee on Local Authority and Allied Personal Social Services was set up in 1965 — 'to review the organisation and responsibilities of the local authority personal social services in England and Wales and to consider what changes are desirable to secure an effective family service'.

The growth of various forms of social provision in different departments but the same local authority had led both to gaps in provision and to a degree of overlap and duplication of effort and a growing feeling that a unified family service would help to resolve these problems.[11418] Social workers were also anxious to emerge as a separate professional group, independent of public health control.

Training as well as provision of services had been specialised and there were no less than three national councils of training in social work — Central Training Council in Child Care, the Council for Training in Social Work, and the Advisory Council for Probation and After-Care — as well as a number of specialised professional bodies.

The Seebohm Report was published in 1968 and recommended the establishment of a unified social service department in each major local authority with, as far as was possible, a family or person in need of social work care or assistance served by a single individual. It also suggested the foundation of one central organisation to be responsible for promoting training and a common basic training for all social workers.[19,20] Negotiations for a unified professional organisation were in fact ongoing and well advanced before Seebohm began his enquiry and only formalities remained to be completed. The British Association of Social Workers was thus set up in June 1970.

The Committee saw the new unified social service departments as 'community based and family oriented'. They should include — 'the present services provided by children's departments, the welfare services provided under the National

Assistance Act 1948, educational welfare and child guidance services, the home help service, mental health social work service, social work services provided by health departments, day nurseries, and certain social welfare work currently undertaken by some housing departments'. It was a tall and probably unreahstic order for the newly created departments and, as with so many innovations, an area in which a pilot project might have helped to identify possible pitfalls. They recommended also work with groups and communities to help co-ordination and integration and increase responsiveness to local needs.

It was proposed that social service departments should be run through area offices, serving populations of 50 - 100,000 people with teams of ten to twelve social workers headed by a senior professionally trained social worker with administrative skills and wide delegated powers of decision.

The Report was warmly welcomed by the social work professions as a charter for social work. It was criticised by medical officers of health and other public health professionals mainly on the grounds that it perpetuated the administrative division between health and welfare services and residential care for the elderly, the mentally ill and handicapped and lost another opportunity for integration. The main effect of the reforms, they felt, would be to divorce those local authority services which involved mainly medical skills — vaccination, immunisation and health education — from those which involved mainly social work skills — home helps and residential care — at a time when the two aspects could have usually been more firmly married.
The main recommendations of the Report were accepted almost immediately by the Government and came into force in 1970 in the Local Authority Social Services Act and 1 April 1971 was set as the date for the establishment of the new departments. As early as 1972 a further set often year plans for local authority services was prepared, covering the work of the new established social service departments.[2] Interest in the building of health centres also revived during the 1960s and at this stage was matched by the greater priority attached to this by Government.

Seebohm's broad vision of providing 'a door on which

anyone could knock' was a worthy one. But like the vision of Beveridge previously it contained flaws and tensions that were never to be satisfactorily resolved. As Timmins[19] has pointed out, the main dilemma centred on how to reconcile the interests of the individual and the family with those of the community — often irreconcilable.

Problems in the developing system of health and social services provision persisted. The integration of the three different National Health Service sectors remained poor despite the exhortations of central government and this was intensified, for example, in the care of elderly people being effectively split between the three sectors with, in most cases, inadequate communication between them.

A further problem which came centre stage in the late 1960s was the low quality of care provided to certain patient groups — notably the frail elderly and the mentally ill and handicapped. Public attention was focused on this in 1967 when allegations of low standards and even ill treatment at a number of hospitals in different parts of the country were published.[21] Keith Joseph, Secretary of State for Social Services in the Conservative Government of 1970 — 74, himself said on one occasion 'This is a very fine country to be acutely ill or injured in, but take my advice and do not be old or frail or mentally ill here'.

A third and interrelated difficulty was that of achieving and implementing the admirable policy objectives of improving services for these groups at local level where consultants in the acute specialties of surgery and general medicine generally wielded more influence than psychiatrists and geriatricians.

This then was a period of great uncertainty, change and confusion in the health service as a whole and preventive medicine/public health in particular.

ENVIRONMENTAL HEALTH

Another group anxious for its independence from public health supremacy at this time was environmental health and the Report of the Sub-Committee examining this was published in March 1972[22] and was embodied in the National Health Service Reorganisation Act 1973.

As with social services, this separation was administratively complex since local authority and health authority boundaries were not contiguous. There was a statutory requirement for area health authorities and the corresponding local authorities to set up joint consultative committees to encourage collaboration in the interests of the health and welfare of the population. This was a laudable aim in theory; more variable in its effectiveness in practice.

The Act made provision for health authorities to second a doctor to local councils as adviser and 'proper officer' on environmental health functions. This individual normally worked part-time for each authority and there would be a named alternative officer to act in the event of illness or absence.

The Report emphasised the:

> vital need for the closest co-operation in many fields of environmental health, since health is essentially a single problem for the community as a whole.

MEDICAL EDUCATION

Overall, under both Labour and Conservative governments, the twenty years or so from 1948 saw Britain in a period of gradual and sustained economic growth. 'With growth the Welfare State expanded... more could be afforded, more could be and was done.' And the atmosphere of growth and cautious optimism extended also to the field of education. The 1960s were a time of expansion in education at all stages and higher education in particular.

The call for more universities to match the increasing output from sixth forms increased in volume and influence. Expansion had a powerful and persuasive advocate in Sir Keith Murray who was appointed Chairman of the University Grants Committee in 1953 and used his time in that position to prepare the ground. The Robbins Committee was established in 1961 to 'review the pattern of full-time higher education in Great Britain in the light of national needs and resources and to advise on principles for its long-term development'.

Robbins himself was described by John Carswell, the Treasury civil servant who sat on the committee as 'a bland silver lion.The huge frame and silver mane contained a gentle manner beneath which one sensed a giant paw from which a claw or two would sometimes make a carefully modulated appearance... he intended from the first that his report should mark a great advance'.[23]

The Robbins Report was published in October 1963.[24] Its key recommendation was that:

> courses in higher education should be available for all those who are qualified by ability and attainment to pursue them and who wish to do so.

The Report — with its marathon target of 50 per cent more higher education students by 1967 and a rise of 250 per cent by 1980 — was accepted by the new Conservative Prime Minister, Sir Alec Douglas-Home. The new government thus committed itself to a programme of expansion costing £3.5 billion at a time when total public spending was only £11 billion a year.

As Timmins[19] describes, 'what Carswell has dubbed "the great plastic period" in higher education, and what Robbins had called "a new dawn" had arrived. It was to prove not quite so glorious as it seemed'.

In terms of medical education this was also a time of immense change. In 1948 Crew in Edinburgh had drawn attention to the need for change in medical education.[9] He saw changes in the curriculum for the diploma in public health as essential — it required to be broader, more practical and to take account of wider social and environmental issues. The gap between academic and service public health — more of a gulf at that period — required urgently to be bridged.

As early as the 1950s, those in academic departments of social medicine and public health began to express the view that there was need for considerable change in the education and training of recruits to the specialty. They perceived a collapse of morale and purpose and direction in service public health and a fall in the quality of recruits. There seemed a growing danger that the specialty would be completely sidelined in the face of the

increasing dominance of clinical and curative medicine. The public image of the medical officer of health had — rightly or wrongly — become that of a rather 'dreary and obstructionist'[3] medical administrator remote from the actual everyday practice of medicine.

There were varying and often conflicting views on what the role of public health doctors should be but by the late 1950s academics began to push for courses in medical administration, not in terms of mundane day-to-day affairs but in the overall concept of total health care delivery. There were dissenting voices — notably that of the Professor of Public Health at Leeds, Jervis J Johnstone, who argued that the primary concern of pubhc health was, and should continue to be, the environment and blamed social medicine for diverting the specialty from its correct path.[25]

His was a minority view and most academic leaders of this time considered that the development of medical administration could give the Medical Officer of Health and senior pubhc health colleagues a more specialist and central place in the system of medical care. Wofinden, for example, referred to public health doctors as 'being out of step with this age of medical specialisation' and urged them to 'plan for a future, not in a subservient executive role within social administrations' but as 'broad advisers' to the health service.

In 1966 Warren[26] described in the following way the need to separate the clinical and administrative components of pubhc health:

> For the future we want to graft preventive medicine onto curative medicine (in the shape of the general practitioner), link community medicine with institutional medicine (by relocating the remaining clinic doctors in hospitals) and develop the specialty of medical administration.

In 1962 the Porritt Report[27] on the organisation of medical services recommended that health services should be unified under the area health boards and that the medical officer of health should become a consultant in environmental health to newly established departments of social health based in hospitals. The report was never implemented but its publication

stimulated discussions (and disagreements) about the future direction of public health.[2]

Titmuss[28] added to the increasing controversy by questioning whether there would still be a role for the medical officer of health if the general practitioner became more of a community doctor, focusing on prevention as well as cure.

The then Medical Officer of Health for Northamptonshire, Sir John Reid, was quick to respond.[29] He was convinced of the need for a new training and a new role. Like Wofinden, Reid saw the Medical Officer of Health as a broad adviser to the health service based on his expertise in epidemiology being made available to colleagues in all branches of medicine.

In 1966, the Royal College of Physicians had expressed the hope that senior medical administrators would in future be more clearly equated with consultants.[30] The following year the Nuffield Provincial Hospitals Trust accepted the idea that eventually clinical work would centre on general practice and hospitals and overall medical administration would fall to the medical officers of health and other senior public health doctors.[31]

There remained, however, a failure to clarify the relationship between medical and general health administration and social medicine. This lack of clarity continued for many years to bedevil the broad specialty of pubhc health and to impede progress in defining and developing its role.

Efforts to reform the public health curriculum at the end of the 1960s designated 'epidemiology' firmly as the core element with the intention, previously discussed, of investing Medical Officers of Health and senior public health doctors with the role of broad advisers to the health service. In the University of Edinburgh, for example, the Diploma in Pubhc Health was merged with the Diploma in Medical Administration to create a Diploma of Social Medicine or Community Health and to train Medical Officers of Health to become epidemiologists rather than administrators, and advisers rather than managers.[32] In Manchester the Diploma in Public Health was changed to include epidemiology and statistics, principles of administration and management and advances in medicine.

The growing arguments for reform and revitalisation of public health education and training put forward at this time by academic public health coincided with the publication of the Seebohm Report and the implementation of its main recommendation to establish independent departments of social work to develop the idea of community care. This provided a further threat to service public health by the removal of social work from MOH control.

A Government Green paper on further proposals for reorganisation of the National Health Service, published the same year as the Seebohm Report, tried to reassure public health doctors of a new expanded, though unspecified, role as community physicians.

CHANGING NAMES: A SYMPTOM OF CONFUSION

Morris, the only medically qualified member of the Seebohm Committee, first defined the role of the community physician as the individual responsible for community diagnosis and as such providing the information required for efficient and effective administration of health services. He argued that the barriers between prevention and cure were being eroded — 'public health needs clinical medicine — clinical medicine needs a community' — and emphasised the importance of co-operation.

Morris's ideas were fed into two crucial policy documents of 1968 — the report of the Seebohm Committee of which, as we have seen, he was a member and the report of the Todd Commission on Medical Education of which he was not, although his friend Titmuss was.

The Todd Commission's definition of community medicine as 'the specialty practised by epidemiologists and administrators of health services' endorsed Morris's ideas that the community physician should move away from clinical work to find a new role in the reorganised National Health Service.

As Lewis makes clear,[33] Medical Officers of Health took to the idea of community medicine mainly because they understood it to mean a substantial rise in status for the specialty

— a move at last away from public health with its undertones and drains and sewerage. They accepted the problems of coming into central government control and building up working relationships with other doctors in the health service but they had little influence over any decisions as to the final shape of the reorganised NHS.

This was important because of the way in which policy makers appeared to differ in emphasis from academics on the actual role of the community physician. The Faculty of Community Medicine stressed the complementary nature of community and clinical medicine while the policy makers stressed the importance of changes in management and in the use of resources.

The Hunter Report[34] was the first publication to spell out the actual role of the community physician in the new NHS — the community physician was seen as central to successful integration of health services and was recognised as a specialist adviser with epidemiological expertise. Hunter and his colleagues, however, felt that he had to be more than an adviser if his skills were to be put to proper use and a substantial number of community physicians were to be given management responsibilities in the new consensus management teams.

Three roles for the community physician were defined in a report on management arrangements for the reorganised National Health Service which was published in 1972 — the same year as the Hunter Report — specialist, adviser, manager.[35]

> As a specialist, the community physician would stimulate integration and link the various parts of the service; as an adviser he would liaise with the local authorities; and as a manager he would be responsible for planning, information, evaluation of service effectiveness, and co-ordination of preventive care services. The roles of specialist/adviser and manager formed the core of subsequent definitions of the community physician's role.

In reality, the changes made for even more confusion within the specialty. Medical Officers of Health moved into the role of community physicians as ostensibly the pivot of the new National Health Service. But there was, in practice, little idea on the ground as to what they were actually meant to do within the

new management structure or indeed how management was intended to function.

FOUNDATION OF THE FACULTY OF COMMUNITY MEDICINE

Another very important strand to the development of the specialty at this time was the foundation of the Faculty of Community Medicine in 1972. This has been fully documented by Warren.[36]

Preliminary and informal discussions on establishing one body to represent the medical specialties of public health, medical administration and social and preventive medicine had begun five years previously and continued through what proved to be another period of reform of central and local government and of the National Health Service of detailed discussions on medical education and the place of social/preventive/community medicine in the curriculum.

In 1968 the Todd Report[37] stated that -

> In community medicine there is a great need for a professional body which can bring together all the interests, academic and service, and which has the support and strength to undertake all the assessment needed during and at the end of general professional training.

Lengthy negotiations and discussions on this topic began both within the specialty and within the broader medical profession. There were questions as to whether such a body should be associated with the Royal Colleges and strongly held views either way. There were concerns from other related bodies such as the Society of Medical Officers of Health and the Society for Social Medicine. There were issues about who should be eligible for membership and contention about the right name for the professional body.

A Working Party was set up, with membership as shown in Table 2 and had its first meeting at the London School of Hygiene and Tropical Medicine on 14 October 1969.

A press statement was issued on behalf of the three Royal Colleges on 14 May 1971 and was reported thus in *The Lancet:*

Table 2
Members of the Working Party.

Body represented	**Name of representative**
Society of Medical Officers of Health	Dr WG Harding Professor RC Wofinden
Society for Social Medicine	Professor R Doll Professor JN Morris (Chairman)
Senior Administrative Medical Officers	Dr FJ Fowler Dr RHM Stewart
Scottish Association of Medical Administrators	Dr W McGinness
Scottish Branch of Society of Medical Officers of Health	Dr Maud Menzies
Department of Health and Social Security	Dr H Yellowlees (Observer)
Scottish Home and Health Department	Dr JHF Brotherston

> The Royal Colleges of Physicians of the United Kingdom have agreed to found a joint Faculty of Community Medicine (Figure 4). The provisional council, which includes the presidents of the three colleges, has met twice under the chairmanship of Dr Wilfred Harding; its executive committee has met several times to consider by-laws and administration. A provisional education committee has also been set up. It is hoped that the provisional Faculty will be in position later in the year to receive applications from those wishing to become founder members.

The following week a leading article in the British Medical Journal welcomed the creation of the Faculty and the emergence of the community physician.

> Without a medical man committed to the measurement, planning and development of all services for the prevention and treatment of disease in each administrative area an integrated health service cannot be achieved.

Figure 4. Among the founders of the Faculty of Community Medicine, now the Faculty of Public Health Medicine are, clockwise from top left, Professor Archie Cochrane, Dr Wilfrid Harding, Professor Jerry Morris and Professor Michael Warren.

The proposal was put forward that for a period of two years in the first instance, registered medical practitioners practising in the United Kingdom and fulfilling the three conditions shown in Table 3 would be eligible for consideration by the Provisional Council of the Faculty for immediate election to Membership without examination.

Table 3.
Three qualifying conditions for consideration by the Provisional Council of the Faculty for immediate election to membership without examination.

1)	Appropriate higher postgraduate qualification
2)	Five years' experience in community medicine
3)	Promotion above the basic grade in the relevant field of community medicine

In October 1971, a letter signed by the Presidents of the three Royal Colleges was published in the *British Medical Journal* and *The Lancet* setting out the background to the formation of the Faculty and drawing attention to an invitation printed in the advertisement columns of both journals for those eligible to apply for foundation membership of the Faculty. In addition to the criteria shown in Table 3, the invitation added

> Other medical practitioners of comparable qualifications and/or experience who are engaged in the practice of Community Medicine, including those engaged in research and those who have made notable contributions to Community Medicine may also apply.

There was to be an admission fee of *£15* and an annual subscription in the region of £20 per annum in the first instance. By the end of that year, 1,400 applications had been received of which about 800 had been dealt with or were under consideration, At the inauguration of the Faculty 900 members were elected, of whom 144 were elected Fellows.

The Inaugural Meeting was held at the London College on 15 March 1972 and the first officers and board members of the Faculty were elected as shown in Table 4. Lord Rosenheim, chairing the meeting, expressed confidence that — 'This Faculty •will bring together and weld together all those who work in the field of Community Medicine and that the Faculty will work most intimately with the three Colleges'.

Table 4.
First members of the Board of the Faculty of Community Medicine

Sir John Brotherston	Professor CR Lowe
Professor AL Cochrane	Dr WJ McGinness
Dr W Edgar	Dr Maud P Menzies
Dr AJ Essex-Cater	Dr JR Preston
Dr FJ Fowler	Professor TA Ramsay
Dr TMcL Galloway	Dr RHM Stewart
Dr WG Harding	Dr H Yellowlees
Dr MA Heasman	Dr GD Forwell
Professor WW Holland	Professor T Anderson
Dr JD Kershaw	Lord Rosenheim
Dr JF Kirk	Professor MD Warren

CONCLUSION

The period under scrutiny in this chapter was in the main a time of major uncertainty and confusion for public health, symbolised perhaps by the concern and discussion about names and by the undoubted conflict between academic and service practitioners of the specialty. In this so-called golden age of academic public health, the academics created social and community medicine in a bid to make public health the centre of health services.

There have been many themes running through twentieth century public health training and practice. Above all there is the tendency for public health to have defined itself in terms of the functions it undertook at any one time. The major change in 1948 with the introduction of the National Health Service led to a catastrophic fall in morale that was to have far-reaching effects and from which the specialty is only now beginning to recover. Social medicine did not dominate the medical

curriculum and community medicine did not become the lynchpin of the National Health Service.

Despite many honourable exceptions and excellent pockets of work, and the optimistic end to the period with the foundation of the Faculty, the giants of service public health had been largely overcome by confusion and ambiguity.

References

1) Ham C. *Health Policy in Britain.*Third edition. Macmillan Press Ltd, 1992.
2) Lewis J. *What Price Community Medicine?* Wheatsheaf, 1986.
3) Webster C. *The Health Services since the War.Vol* I. Problems on Healthcare. The National Health Service before 1957. London: HMSO, 1988.
4) Godber GE. *Medical Officers of Health and Health Services.* Community Medicine 1986,8: 114."
5) Godber GE. *The Health Service Past, Present and Future.* Athlone Press, 1975.
6) MacNalty Sir A. *Medicine and the public health.* BMJ, 1948, 2:6-9.
7) Brockington CE *The difficulties of public health. Past, present and future.* Lancet 1949, 2: 759-763.
8) Parry RH. Some thoughts on the future of Public Health and of the MOH. Public Health, March 1948.
9) Crew FA. The scope of public health after 1948. J Roy Sanitation Inst,1947, 67:235-242.
10) Warm JE *Annual report for the City of Oxford,* 1973.
11) Parfit J. *The Health of a City: Oxford'1770-1974.* Oxford: The Amate Press, 1987.
12) Hawthorne VM. *Mass radiography in an ecological approach to respiratory disease.* Scot Med J 1964, 9:115-124.
13) Semple A. *Annual reports for the City of Liverpool,* 1953, 1960 and 1966.
14) Watkin B. *Documents of Health and Social Services. 1834 to the present day.* London: Methuen, 1975.
15) Abel-Smith B, Titmuss R. *Study of health services costs from the National Institute for Economic and Social Research.* London, 1952.
16) *Report of the committee of inquiry into the cost of the National Health Service.* (The Guillebaud Report) Cmnd 9663. London: HMSO, 1956.
17) Ministry of Health. *A Hospital Plan for England and Wales.* Cmnd 1604. London: HMSO, 1962.
18) *Health and Welfare: the Development of Community Care. 1966.*
19) Timmins, N. *The Five Giants: a biography of the Welfare State. London:* Harper Collins, 1995.
20) *Report of the Committee on local authority and allied personal social services* (Seebohm Report). Cmnd 3703. London: HMSO, 1968.
21) Robb B (ed.) *Sans Everything: A Case to Answer?* London: Nelson, 1967.

22) Reorganisation of the NHS and Local Government in England and Wales. (Environmental Working Group chaired by MA Bains) Cmnd 5055. London: HMSO, 1972.
23) Carswell J. *Government and the universities: progress and performance 1960-1980.* Cambridge University Press, 1986.
24) *Report of the Committee on Higher Education appointed by the Prime Minister under the Chairmanship of Lord Robbins 1961-63.* Cmnd 2154. (Robbins Report). London: HMSO, 1963.
25) Johnstone JJ. *Tlie teaching of medicine and public health.* Public Health 1958, 73:123-133.
26) Warren MD. *Possible developments in training for community medicine.* Medical Care 1966,4:170-180.
27) Medical Services Review Committee. *A Review of the Medical Services in Great Britain.* (Porritt Report). London: Social Assay, 1963.
28) Titmuss R. *The role of the family doctor today in the context of Britain's social services.*The Lancet 1965, i:2.
29) Reid Sir John. *A new public health — the problems and the challenge.* Public Health 1965,79:183-196.
30) Royal College of Physicians of London. Committee on Medical Administration. *Report 4.* London: Royal College of Physicians, 1967.
31) Nuffield Provincial Hospitals Trust. *Vocational Training in Medicine.* Report of three working parties on vocational training for the general practitioner, psychological services and the administration of hospital and public health services. Oxford: Nuffield Provincial Hospitals Trust, 1967.
32) Morrison SL. *Postgraduate training for a career in public health.* Public Health 1965, 79: 280-290.
33) Lewis J. *The Public's Health: philosophy and practice in Britain in the twentieth century.* In Fee E, Acheson RM (eds). *A History of Education in Public Health.* Oxford: Oxford University Press, 1991.
34) DHSS. *Report of the Working Party on Medical Administrators.* (The Hunter Report). London: HMSO, 1972.
35) *Management arrangements for the reorganised NHS.* London: HMSO, 1972.
36) Warren MD. *The Genesis of the Faculty of Community Medicine of the Royal Colleges of Physicians of the United Kingdom.* University of Kent at Canterbury: Centre for Health Services Studies, 1997.
37) *Report of the Royal Commission on Medical Education* (The Todd Report) Cmnd 3569. London: HMSO, 1968.

5

Community Medicine in turmoil 1974 -1989

There is a certain relief in change, even though it be from bad to worse; as I have found in travelling in a stage-coach, that it is a comfort to shift one's position and be bruised in a new place.

Washington Irving - *Tales of a Traveller*

The age-old function of the medical officer of health has been criticised... and community physicians everywhere have been displaced under Griffiths. The zenith of epidemiological reductionism in the academic field has coincided with the nadir of fortunes of service community physicians in the NHS and local government. Yet the greatest paradox is that from this lowest point may arise the opportunity to rebuild the 'bare ruin'd choirs' of the public health tradition.

Huw Francis 1987

THE REORGANISED NATIONAL HEALTH SERVICE

During the 1960s, as we have seen, it became clear that some fairly fundamental reorganisation of the National Health Service was essential.

ENGLAND AND WALES

The Labour Government published a Green Paper in 1968 putting forward for consultation a proposal for the health services in England and Wales to be administered by between 40 and 50 health authorities - a suggestion originally recommended in the Porritt Report.[1,2] One suggestion was that local government, itself undergoing reorganisation at the time, should be the unit of administration.

A second Green Paper, published in 1970 suggested 90 area health authorities as the main units of local health services administration, regional health councils to deal with planning and around 200 district committees to promote local

participation.

The Conservative Government's consultative document of 1971 strengthened the regional planning tier and proposed the establishment of local community health councils and the subsequent White Paper stressed the importance of improving the efficiency of management. The resulting National Health Service Act came into force on 1 April 1974 and the new structure is shown in Figure 1.[2]

The reorganisation had three main objectives.

The first was to unify health services under one authority instead of the three separate entities for different parts of the service. As Ham points out, this aim was not achieved in full. In practice, general practitioners retained their independence with family practitioner committees taking over the functions previously carried out by executive councils, although theoretically they were subcommittees of the area health authorities. In addition, a small number of postgraduate teaching hospitals retained separate boards of governors.[2]

The second objective was improved co-ordination between health authorities and related local government services. The boundaries of the new Area Health Authorities were mainly made to match those of one or more of the local authorities providing personal social services — the county councils and the metropolitan district councils or London Boroughs. The two types of authority were also required to establish joint consultative committees to enhance collaboration in development of services. As a deliberate policy decision from the centre, however, coterminosity was not achieved for all areas. This was to prevent or at least complicate any future plan to move the National Health Service to local authority control.

The third main objective of reorganisation was to improve the management of services. Ham[2] deals with the background to this and the detailed functions of each of the three tiers and job descriptions for health authority officers were published by the government.

Central ideas included working in multidisciplinary teams and consensus management. A key principle was to be 'maximum delegation downwards, matched by accountability

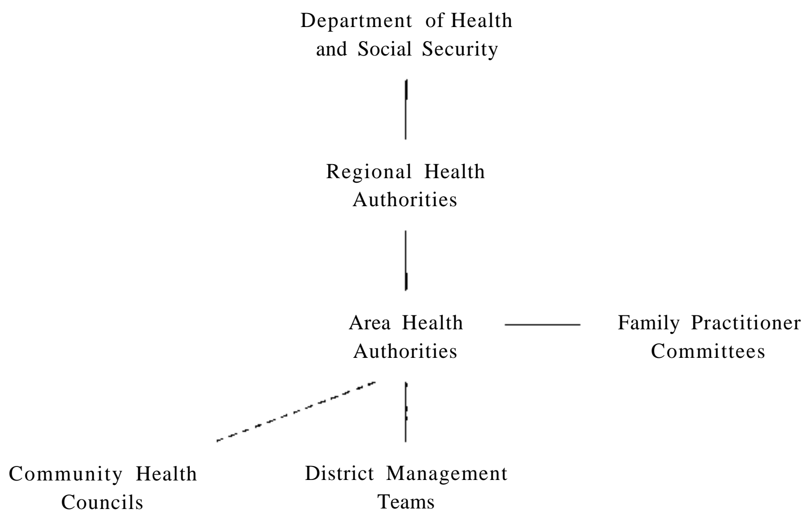


Figure 1. Structure of the NHS in England 1974-1982.
(Reproduced from Ham" by kind permission of the author and Macmillan Press Ltd.)

upwards' with government looking to the private sector and management consultants for ideas about how to run the National Health Service more efficiently. There was also a concern to locate national priorities more appropriately in local settings and to shift resources to more disadvantaged groups both in terms of socio-economic status and disease and disability.

There was undoubtedly a need for improvement in how the National Health Service was run, both in 1974 and later in 1982, and much of what has been achieved was both essential and laudable.

The fundamental flaw on both occasions has been a failure to acknowledge three truths — the importance of personalities, at all levels, in making any organisation move smoothly, the untidiness of reality however many flawless diagrams and flow

charts there are to illustrate how things should work, and the fact that health or its absence is such an important commodity to everyone that it cannot be run absolutely on cost-effective or management efficiency grounds without the intrusion of flexibility and humanity.

SCOTLAND, WALES AND NORTHERN IRELAND

There were slightly different arrangements for other parts of the United Kingdom after reorganisation.

The National Health Service (Scotland) Act[3] did not allow for a regional tier of administration but established fifteen health boards dealing directly with the Scottish Office. There was no separate system of administration for family practitioner services and the Scottish equivalent of community health councils were called local health councils.

The Welsh reorganisation was the most similar to England but the Welsh Office combined the functions of a central government department and a regional health authority. In Northern Ireland, four health and social services boards were established, in direct contact with the Department of Health and Social Security (Northern Ireland). Each of these boards was divided into a number of districts and dealt with personal social services as well as health. There was no separate administrative mechanism for family practitioner services and district committees fulfilled the functions of community health councils.[2]

EFFECTS OF REORGANISATION

From the start there were problems with the reorganised health service from various points of view — delays in decision-making, top-heavy administration with too many tiers, high cost of the whole process both financially and in terms of staff morale.

The Merrison Royal Commission was set up in 1976 with the following remit:

> To consider in the interests both of the patients and of those who work in the National Health Service the best use and management of the financial and manpower resources of the national health service.

The report — the first comprehensive review of the service for nearly a quarter of a century — was published in 1979 and made various recommendations.[4] It found that the 1974 reorganisation had had the worthy objective of trying to integrate all health services for patients in hospital and community into one administration. Sir Keith Joseph, Secretary of State at that time, had planned a unified structure in which the area health authority would provide comprehensive health care for the population of a defined geographical location, and where in theory coterminosity of health and local authority boundaries would facilitate collaboration in planning the delivery and continuity of health care.

As Kember and Macpherson point out,[5] the Royal Commission found that serious flaws had hindered the implementation of this worthy concept. There had also been industrial action during the 'winter of discontent' in various groups of health workers and staff morale was low. The Commission summed up its criticisms thus:

> Too many tiers, too many administrators in all disciplines, failure to take quick decisions, money wasted.

On the election of the Conservative Government in May 1979, public expenditure was immediately targeted to try to reduce the inflation rate and the national debt. With regard to the National Health Service, the aim was to limit the rising costs, increase efficiency, introduce management and structural reforms, and encourage other means of providing health care such as the private and voluntary sectors.[5]

In December 1979, the government published a consultative paper in response to the Merrison Commission's Report[6]. It accepted the basic criticisms and most of the recommendations and stated its intention to simplify the services in such a way as to 'avoid wholesale upheaval' and 'minimise turbulence'.

RE-REORGANISATION

The final decision on the main aspects of amendments to reorganisation were published in July 1980. The main measures applying to England are summarised from the Royal Commission Report by Kember[7] and shown in Table 1.

Table 1.
Main recommendations of the Royal Commission's Report on the National Health Service.

1) Strengthen management arrangements at local level with greater delegation of responsibility to those in hospital and community services.
2) Simplify the structure of the service in England by removing the area tier in most of the country and establishing district health authorities.
3) Simplify the professional advisory machinery so that the views of clinical doctors, nurses and other professions would be heard by the health authorities.
3) Simplify the planning system to ensure that regional plans are fully sensitive to district needs.

One hundred and ninety-two District Health Authorities were created and came into existence on 1 April 1982 with an emphasis on delegation of power to units of management. Detailed management arrangements varied greatly with some units covering a single large hospital and some covering specific services — such as psychiatry — throughout a district as a whole. Administrative costs were certainly reduced by the changes — Ham[2] quotes an estimate that the amount spent on management fell from 5.12 per cent of total budget in 1979-80 to 4.44 per cent in 1982-83, a saving of £364 million. But the principle of coterminosity between health authorities and local authorities was lost by the changes.

In November 1981, it was announced that Family Practitioner Committees were to be given the status of employing authorities in their own right. This measure was incorporated in the Health and Social Security Act 1984 and came into effect on 1 April 1985. At the same time a number of Special Health Authorities were established with the responsibility of running the postgraduate teaching hospitals in London. The structure of the National Health Service in

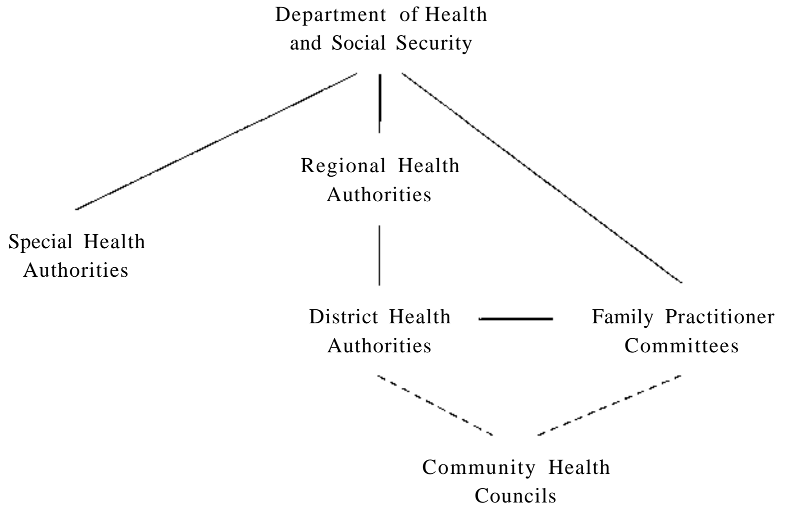


Figure 2. Structure of the NHS in England 1982-1990.
(Reproduced from Ham[2] by kind permission of the author and Macmillan Press Ltd.)

England after 1982 is illustrated in Figure 2. In Wales the main change was the abolition of the district level of management and its replacement by a system of unit management similar to that in England. In Scotland there was initial variation with some health boards abolishing and some retaining the district tier — all districts in Scotland were, however, replaced by a system of unit management from 1 April 1984. The existing arrangements applied in Northern Ireland where the basic structure of health and social services boards was retained.[2]

The mission of the 1982 and 1984 changes was to try to achieve 'greater devolution and clearer personal accountability' in an attempt to get the best value for money in a situation where an ever increasing share of public money was being spent on health.[7] The main emphasis was on simplification of the management and structure, planning and collaboration. The 1974 reorganisation had been very radical and the service was

understandably reluctant to undergo a second major upheaval in such a short space of time. The second aim was therefore to achieve the changes with the minimum of disruption to those involved and because of this an opportunity may have been missed to create a 'genuinely new pattern of local health authorities, with new roles, new levels of delegated authority, and with new and close relationships with clearly defined communities'.[7]

COMMUNITY MEDICINE AFTER TWO REORGANISATIONS

This was then a period of general upheaval and unrest in the National Health Service and for the medical profession and public health under its new name of community medicine in particular. So many changes in such a short period of time created a feeling of instability and job insecurity. There was also the problem of falling recruitment into community medicine - in terms both of numbers and quality — mentioned in the previous chapter.

There was tremendous general confusion about the role of the community physician within the local structure, and the actual meaning of the title in practice. There were constraints of limited staff, budgets and power and a general feeling of inferiority and loss of status. Once again community medicine displayed its inability to master the power play used so skilfully by general practitioners and hospital clinicians since 1948 in protecting their interests.

The change of name from public health to community medicine and the abolition of the post of Medical Officer of Health had added to the confusion and lack of confidence in the specialty. Sir John Brotherston expressed the view of many when he stated that community medicine was merely 'the latest name for that ancient, honourable and essential responsibility which is concerned with the medicine and health of the group. This is public health with a new name and new responsibilities.'[8]

In 1975, a former MOH of Kilmarnock with over 30 years experience published an account of the changes in the health of

that community during his years in office and the improvements in conditions that had taken place.[9]

He quoted the original advertisement which had appeared in the British Medical Journal for the post:

> The Town Council invite applications from duly qualified and registered Medical Practitioners holding the Diploma in Public Health or an equivalent qualification for the appointment of Medical Officer of Health for the Burgh. Candidates must not exceed 45 years of age.
>
> The person appointed will be required to carry out all the duties pertaining to the position of Medical Officer of Health under the Scottish Burgh Police, Infectious Diseases, Notification of Births, Public Health, Housing, Milk and Dairies, Food and Drugs, Blind Persons and Local Government Acts and all other relative Statutes and Orders. The appointment will include the duties of Medical Officer of Kirklandside Infectious Diseases Hospital, Kaimshill Tuberculosis Sanitorium, the Maternity Home and Child Welfare Centre, and the Clinic for the Treatment of Venereal Diseases; the duties of Tuberculosis Officer, Police Surgeon and Medical Officer of the Model Lodging House; and from 15 May 1930, the duties of Medical Officer under the Scottish Poor Law, Lunacy and Mental Deficiency and Vaccination Acts; and all other relative Statutes and Orders. The appointment will also include generally any other responsibilities or works (including work in connection with medical inspection and treatment of schoolchildren and hospital facilities for the sick poor that may be assigned to the Medical Officer of Health by the Town Council either by themselves or in conjunction with any other Public Authority or Body).

The author commented that — 'it will be seen that no-one undertaking these duties was likely to be idle!'. He had also pointed out that the Medical Officer of Health of a Burgh at that time was a well-known figure locally, in touch with the community, easy to approach and ready to address relevant problems. The duties were very clearly defined. He expressed confidence that under the new arrangements this close contact would be maintained — since 'each district will be provided with a community physician whose job it will be to maintain the local contact and be easily available to the public'. His confidence was to be disappointed.

Two issues were important in this context. Firstly, the community physician became an independent consultant

without a team — a major loss for those used to having a department. Secondly, the major concern of the administrative bodies was with hospital services, except in a few places, and the idea for hospital and public health to work closely together did not become a reality for various reasons, including financial difficulties caused by the world-wide increase in oil prices. Pressures of acute illness were as always a priority and, on committees at local level, community physicians without clear authority were outnumbered by around five to one by hospital physicians.

The new emphasis on management was fine rhetoric but there was no clearly defined management function within the National Health Service to support it. Shortly after the 1982 reorganisation, Roy Griffiths, the Deputy Chairman and Managing Director of Sainsburys was appointed chairman of a small team to give the government advice on the effective use of management and manpower and related resources in the National Health Service.[2]

The Griffiths Report was published in 1983[10] and recommended that general managers should be appointed at all levels in the NHS to provide leadership, introduce a continual search for change and cost improvement, motivate staff and develop a more dynamic management approach. Doctors should also:

> accept the management responsibility that goes with clinical freedom

and become more involved in management. The report also proposed that a Health Services Supervisory Board and an NHS Management Board be established within the Department of Health and Social Security and that the Chairman of the Management Board should be appointed from outside the health service and the civil service. It concluded:

> Action is now badly needed and the Health Service can ill afford to indulge in any lengthy self-imposed Hamlet-like soliloquy as a precursor or alternative to the required action.

After debate and discussion, the government asked health authorities to appoint general managers at all levels by the end of 1985[11] and, although the report did not cover Scotland, Wales

or Northern Ireland, similar changes were introduced there although not quite so quickly.

RESOURCE ALLOCATION

Another issue that came to the forefront during this period was allocation of resources for health services. Until the 1960s, the resource allocation policy tended to be based on the somewhat brutal description by Maynard and Ludbrook[12] — 'What you got last year, plus an allowance for growth, plus an allowance for scandals'.

There then followed various initiatives to put allocation of resources on a more professional footing which culminated in the Crossman formula of 1971-72 where each Regional Hospital Board's target allocation was derived from three elements.[13]

1) Population — weighted by the national bed occupancy for different age and sex groups and adjusted for net patient flows.
2) Beds — in each specialty weighted by the national average cost per bed per year.
3) Cases — inpatient, outpatient and day cases weighted by the national average cost per case.

The formula failed in implementation mainly because of the second element on number of beds.[14] This element meant that Regions with adequate resources in terms of beds were rewarded while those with fewer beds who needed support were penalised. Another factor was the component to cover the cost of capital schemes (RCCS — Resource Consequences of Capital Schemes) which covered the total cost of the new revenue required to meet the costs of new hospitals — always greater than the old. Since the new hospitals were mainly in the south of England, the inequalities increased.

The Resource Allocation Working Party (RAWP) was appointed in May 1975 with the following remit:

> To review the arrangements for distributing NHS capital and revenue to RHAs, AHAs and Districts respectively with a view to establishing a

> method of securing, as soon as practicable, a pattern of distribution responsive objectively, equitably and efficiently to relative need and to make recommendations.

An interim report was published in August 1976 and this interpreted the underlying objective of the terms of reference as being:

> to secure, through resource allocation, that there would eventually be equal opportunity of access to health care for people at equal risk.

This was a Herculean, some might say impossible, task.

The final RAWP Report appeared in September 1976[15] and acknowledged that demand for health care world-wide:

> is rising inexorably... And because it can also be shown that supply of health care actually fuels further demand, it is inevitable that the supply of health care services can never keep pace with the rising demands placed upon them. Demand will always be one jump ahead.

The Working Group also acknowledged that supply of health facilities everywhere was variable and very much influenced by history. They, therefore, sought criteria broadly responsive to relative need rather than supply or demand to try to establish and quantify the differentials of need between different geographical locations. The criteria selected were size of population, population make-up, morbidity, cost, health care across administrative boundaries, medical and dental education and capital investment.

The general recommendations of the final summary chapter were four-fold.

1) New arrangements for flexibility between capital and revenue should be introduced in addition to the retention of the existing arrangements.
2) A review of the interaction between expenditure of family practitioner services and all other health expenditure should be undertaken.
3) Data requirements should be kept under review.
4) Research requirements should be considered by a group of Departmental officials and expert advisers from outside the Department and should command reasonable priority.

The RAWP Report attracted a great deal of comment and criticism. As Paton[16] has stated, the whole area of resource allocation is:

> a minefield of conflicting ideologies, proposals and alternatives: made more complex frequently by conflicting methodologies and general principles, which require to be brought into the general perspective.

Paton saw RAWP as a central mechanism of allocation, based on criteria of need which could be more or less effectively translated into health services and facilities at a pace dependent on how quickly targets had to be met. But local authority expenditure runs on a different system and there is local definition of need, subject to national constraints. Systems for matching local and national revenue are as imperfect as those for reconciling local and national objectives for housing, education and social welfare.

> The NHS itself lives with an uneasy but probably creative tension between centralism and localism, professionalism and politics. Yet the consequences for a resource allocation or reallocation policy are that even more when one looks at the 'big picture' of overall public policy, pragmatism is called for.

One of the major problems in this area has always been this tension between local and central control — a political though not necessarily party political tension. As with so many other aspects of health service management, a rigid formula for resource allocation, while looking good in theory and matching up to the increasing emphasis on better management, is unlikely to work well in practice. As ever a certain untidiness — more respectably described as flexibility and pragmatism — is the reality. As conventional wisdom puts it 'When confronted with an elephant to eat, all you can do is walk up to it and take the first bite'.

Mays and Bevan, in their review of the RAWP methods and report,[13] concluded that RAWP stands out as a 'signal success' in public policy initiatives, particularly when compared with other failed attempts to apply rational approaches in public policy. They identified four particular areas for further research in the resource allocation area. The first was to develop a constructive

approach to measuring and coping with social deprivation. The second was to refine RAWP's remarkably durable working hypothesis that standard mortality ratios are adequate proxies for morbidity. The third was to develop skills in regional strategic management. And the fourth concerned the financing of teaching hospitals which was important in terms of the conflict between bed requirements for teaching and the equitable distribution of resources but not always perceived by most health authorities as a priority.[17,18]

Mays and Bevan conclude that the RAWP Report fundamentally altered resource allocation to health authorities. 'Its underlying objective and chosen methods of measuring an appropriate distribution of resources are likely to be profoundly influential for the foreseeable future.'

It is important, however, to note also that while health service resource allocation between Regions has been largely equalised as a result of RAWP, differences between districts within a Region have persisted.

RAWP noted that it was essential to include general practitioner and other resources in the equation as well as hospital resources. Twenty years later this has yet to happen. The Working Party also emphasised the resource implications for the health service of environmental, economic and social factors and this is another issue that remains to be addressed.

WHAT'S IN A NAME ?

One of the calamities for public health, which had had its origins much earlier, was the change of name to social and preventive medicine and then officially to community medicine. It was in Britain in the 1940s that a distinction started to be drawn between public health and social medicine.[19] In 1948, FAE Crew, the Professor of Public Health (later social medicine) in Edinburgh said that 'it should be acknowledged frankly that public health, the forerunner of social medicine, has steadily lost status during the last twenty years or so...'.[20] John Ryle, the first professor of social medicine in the United Kingdom, writing in 1948, drew a clear distinction between social medicine and

public health.[21-22]

> Public health, although in its modern practice attaching an ever-increasing importance to the personal services, for a long time and at first for very sufficient reasons, placed the emphasis on the environment. Social medicine, deriving its inspiration more from the field of clinical experience and seeking always to assist the discovery of a common purpose for the remedial and preventive services, places the emphasis on man and endeavours to study him in and in relation to his environment.

Although Ryle himself seemed to see his notion of social medicine as a broad concept of the extension into the community of the holistic attitude he had applied to individual disease, others had a more narrow concept of social medicine as applying essentially to the methods of epidemiology.

McKeown and Lowe, for example, used the term to describe 'a body of knowledge and methods of obtaining knowledge appropriate to a discipline. This discipline may be said to comprise a) epidemiology and b) the study of medical needs of society.

Alwyn Smith took the exclusion of public health from the field of social medicine further, arguing that 'all medicine is now generally accepted as being involved with the public health, and provision of all kinds of health and medical care is accepted in most communities as a general social concern.'[24] In 1985 he expressed the opinion that medical officers of health had been wrong to forsake 'since the early years of the century... their consultative roles as community physicians in order to assume the responsibility for the day-to-day direction of extensive personal services'.[25]

Whatever the truth about definitions, there is no doubt that the multiplicity of names in use and the lack of uniformity, indeed ambiguity, in how they were used, added to the general confusion and demoralisation of the specialty. Other medical specialties, such as paediatrics, cardiology, psychiatry, have not been subject to such difficulties and while their responsibilities may change slightly according to scientific development and political whim, the substance and focus of their work as doctors remains clearly on a particular age, body system or patient group. No other specialty has been subjected to the same

changes in status and responsibility as public health.

Francis[26] saw the reorganisation of local government and the health service in 1974 as hugely significant and far-reaching in its effects. 'The future of the Medical Officer of Health and of the public health service, however important in itself, was not central to the restructuring of local administration, but was a problem that resulted from it. The effects on the public health services have been severe and can be traced in the change from the Medical Officer of Health to the community physician, the break-up of the public health team and the downgrading of the public health tradition... all in all, 1974 was a crisis for the Medical Officer of Health in 'which almost all elements of the structure which supported his unique role disappeared.'

What was seen by many at the time as a crisis of confidence in community medicine contained within it the seeds of recovery. The Medical Officers of Health who were involved with senior academics in the foundation of the Faculty of Community Medicine were people of outstanding stature and the syllabus for membership of the faculty included much that was relevant to the public health function.

THE ACHESON REPORT

Towards the mid to late 1980s, the term 'public health' began once again to be used in thinking about future directions. In 1986, the Secretary of State set up an inquiry team under the chairmanship of Sir Donald Acheson, the Chief Medical Officer at that time "to consider the future development of the public health function, including the control of communicable disease and the speciality of community medicine, following the introduction of general management into the Hospital and Community Health Services...".

In announcing the establishment of the Committee in Parliament, the Secretary of State said 'The Inquiry will be a broad and fundamental examination of the role of public health doctors including how such a role could best be fulfilled'. It was the first general review of the public health function in England since the Report of the Royal Sanitary Commission in 1871.

The Committee adopted a broad definition of public health as 'the science and art of preventing disease, prolonging life and promoting health through organised efforts of society'.

The Committee took evidence from a wide variety of individuals and organisations with an interest in public health and its report was published in 1988.[27] It identified five main problems.

The first was a lack of co-ordinated information on which to base policy decisions about the health of the population at national and local levels. The second was a lack of emphasis on the promotion of health and healthy living and the prevention of disease. Thirdly, there was widespread confusion about the role and responsibilities of public health doctors — both within the health service and in the public perception. Fourthly, there was confusion about responsibility for the control of communicable disease and poor communication between the various agencies involved. Finally, there was weakness in the capacity of health authorities to evaluate the outcome of their activities and therefore to make informed choices between competing priorities.

The Committee recognised the overwhelming support for the need for a well-trained, medically qualified public health specialist as a key figure in the health service working with a wide range of non-medically qualified practitioners in the field. They made 39 recommendations of which 31 could be implemented without delay, 29 of them at very low or minimal cost.

Their first recommendation was crucial to ending the prevailing confusion on names and roles of which the Committee had considerable evidence from a wide range of opinion.

> We recommend that the specialty of community medicine should in future be referred to as the specialty of public health medicine and its qualified members as public health physicians. Those appointed to consultant career posts in the NHS should be known as consultants in public health medicine.

The final paragraph of the report expresses the belief that the recommendations as a whole represent a significant package of

proposals which will clarify and strengthen the discharge of the public health function.

CONCLUSION

The period under consideration in this chapter was one of almost constant turmoil and uncertainty for all involved in the National Health Service and perhaps in particular for community medicine. But as we have said, the period ended with some glimmers of hope for the re-creation of a revitalised and modern public health service.

One of the major public health issues during the 1980s was that of inequalities in health and the beginning of the decade saw the publication of the Report on *Inequalities in Health* (the Black Report) which was presented to the Secretary of State in April 1980.[28]

This was followed in 1987 by publication by the Health Education Council of a review of studies on the same subject under the title *The Health Divide: Inequalities in Health in the 1980s.*[29]

This politically sensitive and absolutely central health issue was thus thrust once again to the forefront of the public health agenda for the present decade and presented opportunities to be grasped by the public health physicians of today.

References

1) Medical Services Review Committee. *Review of the medical services in Great Britain* (The Porritt Report). London: Social Assay, 1962.
2) Ham C. *Health Policy in Britain.* Macmillan, 1992.
3) NHS (Scotland) Act. 1974.
4) Report of the Royal Commission on the National Health Service. Cmnd 7615 (Merrison Report). London: HMSO, 1979.
5) Kember T, Macpherson G. *The NHS. A Kaleidoscope of Care - Conflicts of Service and Business Values.* London: Nuffield Provincial Hospitals Trust, 1994.
6) Department of Health and Social Security, Welsh Office. *Patients First.* Consultative paper on the structure and management of the NHS in England and Wales. London: HMSO, 1979.

7) Kember T. *The 1982 Reorganisation - Slimming Down.* In: Kember T and Macpherson G. *The NHS. A Kaleidoscope of Care - Conflicts of Service and Business Values.* London: Nuffield Provincial Hospitals Trust, 1994.
8) Brotherston Sir John. *The specialty of community medicine.* J Roy Soc Hlth 1973, 93: 203.
9) Nisbet BR. *The Medical Officer of Health.* Health Bulletin 1975, xxxiii: 6-10.
10) NHS Management enquiry (Griffiths Report). London: DHSS, 1983.
11) Implementation of the NHS management inquiry report. HC84(13). London: DHSS, 1984.
12) Maynard A, Ludbrok A. *The allocation of health care resources in the United Kingdom.* In: Williamson A and G (Eds). *Health and Welfare States of Britain: an inter-country comparison.* London: Heinemann Educational, 1983.
13) Mays N, Bevan G. *Resource Allocation in the Health Service.* London: Bedford Square Press, 1987.
14) Bennett AE, Holland WW. *Rational planning or muddling through? Resource allocation in the NHS.*The Lancet 1977, 1: 464-466.
15) Department of Health and Social Security. *Sharing Resources for Health in England* (The RAWP Report). London: HMSO, 1976.
16) Paton C. *The Policy of Resource Allocation and its Ramifications: a Review.* London: Nuffield Provincial Hospitals Trust, 1985.
17) Holland WW. *Teaching hospitals in crisis: expensive luxury or vital asset?* The Lancet 1984, 2:742-743.
18) Holland WW. *The RAWP review: pious hopes.The* Lancet 1986, 2: 1087-90.
19) Holland WW. *Changing Names.* Scand J Soc Med 1994, 22(1): 1-6.
20) Crew FA. *The Scope of Public Health after 1948.)* Roy Sanitory Inst. 1947; 67: 235-242.
21) Ryle J. *Social medicine: its meaning and scope.* Br Med J 1943,2:633-636.
22) Ryle J. *Changing disciplines.* In: Chave S (ed) London: Oxford University Press, 1948.
23) McKeownT, Lowe CR. *An introduction to Social Medicine.* Oxford: Blackwell Scientific Pulbications,1966.
24) Smith A. *Tlie Science of Social Medicine.* London: Staples Press, 1968.
25) Smith A. *The epidemiological basis of community medicine.* In: Bennett AF. (Ed). *Recent Advances in Community Medicine* Vol 3. Edinburgh: Churchill Livingstone, 1985.
26) Francis H. *Towards community medicine.* In: Bennett AE (Ed). *Recent Advances in Community MedicineVol* 3. Edinburgh: Churchill Livingstone, 1978.
27) *Public Health in England.The* Report of the Committee of Inquiry into the Future Development of the Public Health Function (Acheson Report). London: HMSO, 1988.
28) *Inequalities in Health* (The Black Report). London: DHSS, 1980.
29) Health Education Council. *The Health Divide:* Inequalities in Health in the 1980s. London: HEC, 1987.

6

The Health of the Nation 1989 -1997

The relation of poverty to disease is so great and inseparable that it is astonishing legislators should not ere now have acknowledged it.

The Lancet 1 April 1843

There are rich and poor and if diseases are to be combated, these inequalities must be made good.

Bernet 1935

The crude differences in mortality rates between the various social classes are worrying... it is a major challenge for the next ten or more years to try to narrow the gap in health standards between different social classes.

David Ennals 27 March 1977

If (any) government is to give itself a chance of making an appreciable impact on inequalities in health or any associated social problems, it must overcome its fear and encourage more imaginative intersectoral approaches to policymaking.

BMJ 4 November 1995

HEALTH SERVICE FUNDING

During the 1980s, health pohcy was dominated by questions of finance.[1] As the decade wore on, the gap between the money provided by the government for the National Health Service and the funding required to meet ever-increasing demand grew wider.

The cash crisis came to a head in 1987 when the presidents of the Royal Colleges of Surgeons, Physicians and Obstetricians and Gynaecologists took the unprecedented step of issuing a

joint statement claiming that the NHS was almost at the point of breakdown and that additional or alternative sources of funding would have to be found.

The government response had two strands. First, ministers announced in December 1987 that an extra £101 million was to be made available in the United Kingdom to help tackle immediate problems. Secondly, in January 1988 the Prime Minister announced a far-reaching review of the future of the National Health Service, the results of which would be published within a year.

When the Prime Ministerial Review was announced, it was widely suggested that the government would use the opportunity of the crisis in health service funding to put forward radical alternatives to the NHS.[1]

In reality, a working party had been set up in the early years of the Conservative Government to examine alternative ways of financing health services. Its report, which was never published, had been submitted to ministers early in 1982 and in July of that year Norman Fowler, then Secretary of State for Health and Social Security, had announced that the government had no plans to change the system of financing the NHS largely from direct taxation.

Ham[1] quotes the conclusion of the working party that:

> every country in Europe was facing an explosion in demand for health care; every country in Europe was spending substantial public resources upon health, and in many ways our centrally run, centrally funded system was the most effective in controlling costs. There was no inherent cost advantage in moving over to an entirely new financing system and it was also clear that whatever system was chosen, taxation would still have to finance a giant share of the service.

PRIME MINISTERIAL REVIEW OF THE NHS

At the beginning of the review process, the main emphasis was quite naturally on the financing of health services. It became clear, however, that there was little support for a major change in this area and the focus moved quite quickly towards how to achieve more efficient use of resources through changes in

health care delivery.

The idea that hospitals should compete for resources in an internal market gained credence and there were also proposals that doctors should be made more accountable for their performance and become more involved in management. Proposals were put forward on how to strengthen the overall management of health services with the introduction of general management.

In 1988, the Department of Health and Social Security was divided into two separate departments. In 1989, a government White Paper, entitled *Working for Patients,* confirmed that the founding principles of the National Health Service would be preserved and funding would continue to be provided mainly out of taxation.[2] Similar White Papers applied to other parts of the United Kingdom.

The main changes related to the delivery of health services and were designed to create competition between hospitals and other service providers with the separation of responsibility for purchasing and providing health services. Thus, health authorities would purchase services on behalf of their local populations from a range of public, private and voluntary providers. Large general practices would also be able to purchase some hospital services for their patients.

> By introducing market principles, the government hoped not only to make services more responsive to patients, but also to stimulate greater efficiency in the use of resources. Ministers argued that competition would be carefully managed or regulated to ensure that appropriate services continued to be available in each locality.

The White Paper also tried to strengthen management arrangements. Centrally the Department of Health would have a Policy Board and a Management Executive instead of a Supervisory Board and Management Board. Locally, the composition of health authorities, or health boards in Scotland, would be revised along business lines.

There were also various ideas aimed at encouraging doctors to become more accountable for their performance and more involved in management.

As Ham[1] has pointed out, *Working for Patients,* while it did

include important recommendations affecting primary care, was concerned mainly with hospital services, particularly acute services. But the government also developed radical proposals for primary care and community care.

The White Paper, *Promoting Better Health,*[3] proposed changes to raise standards of health and health care, to place greater emphasis on health promotion and disease prevention, and to offer wider choice and information to patients with new contracts for general practitioners and dentists introduced in April and October 1990 respectively. The new GP contract included provision for new patient health checks, annual checks for patients aged 75 years or over, targets for vaccination, immunisation and cervical screening, encouragement for the development of health promotion clinics, pre-five child health surveillance and the provision of minor surgery. Another important feature was extra payment for GPs practising in areas of deprivation.

In responding to the proposed new contract, a senior general practitioner summarised the duties of general practice.[4] These include:

i) responding to new requests for care from patients by identifying their problems and taking action;
ii) providing continuing care for those with chronic conditions, the elderly, the terminally ill and the bereaved;
iii) undertaking appropriate screening and health education;
iv) primary, secondary and tertiary prevention.

Morrell[4] also lists five requirements for good quality primary care:

i) provision of adequate premises and appropriate equipment;
ii) maintenance of good records of care provided;
iii) accurate age and sex registers of the practice population;
iv) provision of services for patients with particular needs;
v) development of a team approach to primary care to make the best use of non-medical health professionals.

The general practitioner should not be expected to be responsible for controlling people's health-damaging behaviour — described by Ivan Illich[5] as the medicalisation of social

behaviour — or with the provision of routine medical examinations for healthy adults. Morrell's reservations about some aspects of the proposed contract and in particular about unrealistic targets were widely shared in the profession. 'Certain standards of performance have been determined that are concerned almost entirely with preventive care — some of which is of questionable benefit. Some of these standards seem to ignore the rights of patients to accept or reject care.' The emphasis on income derived from capitation fees would, he felt, encourage the development of practices with large lists of patients to the detriment of sometimes time-consuming consultations with individual patients.

Morrell[4] suggested ways in which general practitioners could be encouraged to provide care sensitive to quality of services with basic clinical care monitored through audit of records and prescribing.

> The overemphasis on prevention in the new contract, which is just a part of the general practitioner's normal services, could largely be delegated to nurses and would be balanced by good general care and not constrained by unrealistic targets related to unreliable denominators.

In December 1986, Sir Roy Griffiths had been asked to suggest a solution to the problems of community care. He presented this in the form of a report entitled *Community Care: An Agenda for Action* in March 1988.[6] In it, he assigned to local authorities a pivotal co-ordinating role for community care services with a Minister of State in the Department of Health to have responsibility for community care. His report did not examine funding in detail but he proposed that central government should arrange 'for the necessary transfer of resources between central and local government to match the defined responsibilities' and emphasised that the review was about 'cost improvements not cost cutting'.

The report did not meet with the approval of a government which was critical of what it saw as the wastefulness and inefficiency of local government. As *The Lancet* reported, Sir Roy's pedigree was 'not sufficient to win support for an idea which is heresy to the present administration'. The Royal College of Nursing argued that nursing provided a much better

base from which to recruit and train the right staff.

Others were more positive. Local government organisations were, not unnaturally, enthusiastic about the core role proposed for social service departments and the National Association of Health Authorities and Trusts (NAHAT) also welcomed the proposals. There were fears that without political commitment to the reforms they would fail and there was also criticism of the proposal to use means testing.

The BMA broadly supported the proposals and emphasised the importance of adequate and properly directed funding and the perils of over hasty implementation. An editorial in the British Medical Journal expressed concern as to:

> whether local authorities have the ability or the will to implement the recommendation... an appreciable minority have elected members whose priorities are concerned largely with the advancement of an ideology.

Sir Roy himself summed up the response to his proposals as 'two cheers for Griffiths'.

The government finally responded to the report in July 1989. They had failed to provide a sensible alternative to making local authorities and social service departments the central players but rejected the idea for a minister of state for community care and the proposal to ring-fence funds for this specific purpose within the annual grants to local authorities, with the inevitable consequences, although the latter proposal was implemented in 1992.

Government plans for the future of community care were formalised in a White Paper, *Caring for People,* which was published in November 1989:[7]

> Local authorities would be given the lead responsibility in the planning of community care and would be required to prepare community care plans in association with NHS authorities and other agencies. It was expected that local authorities would become enablers and purchasers, co-ordinating the provision of care in different sectors, and providing some services directly themselves.

NHS AND COMMUNITY CARE ACT

The proposals set out in *Working for Patients* and *Caring for People* were included in the NHS and Community Care Act which received the royal assent in June 1990 and came into force in April 1991 in England and Wales. Similar changes with variations in the composition of health authorities were planned for Scotland and Northern Ireland although the timing of the reforms was slower.

Parliamentary debate had focused particularly on the government's proposal to introduce competition into the National Health Service and a fundamental fear of the beginning of an attempt at privatisation. As the debate developed, it was suggested that the reforms should be tested in a series of pilot projects in view of their radical nature. In the event the only concession made by the government during parliamentary discussion was to agree to the establishment of a Clinical Standards Advisory Group to help ensure that the quality of care did not suffer as a result of competition and there was eventual agreement to implement the reforms more slowly than had been intended.

Outside Parliament, there was considerable opposition to the proposals for the health service. This was led by the British Medical Association who took particular exception to the new GP contract. There was greater support for the reforms from managers and health authorities although there was concern about the timetable for implementation. The changes proposed in community care evoked concern both about financial resources and timing, particularly in view of the changes to local government finance with the replacement of domestic rates with the community charge in 1990. The reforms were eventually phased in over a three year period with local authorities finally taking responsibility for the new funding arrangements in 1993.

The structure of the National Health Service from April 1991 is illustrated in Figure 1.

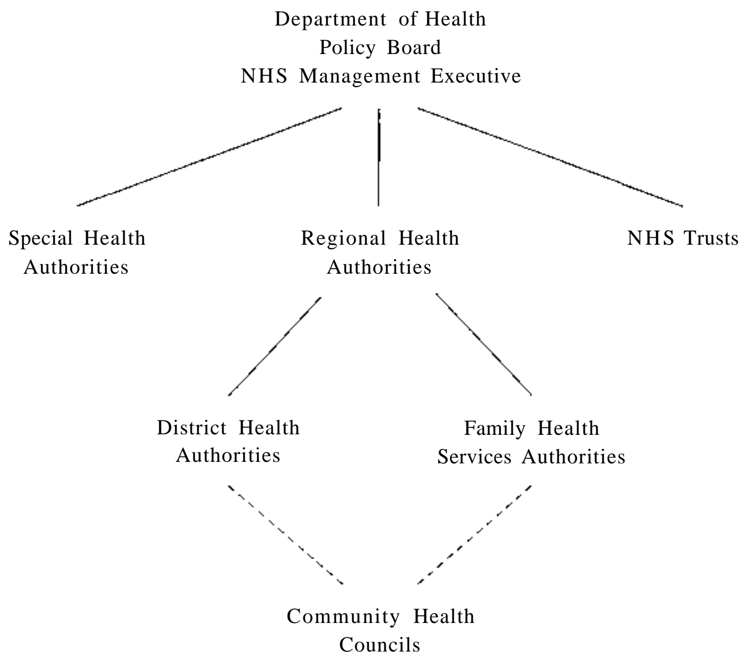


Figure 1. Structure of the NHS after 1990.
(Reproduced from Hani by kind permission of the author and Macmillan Press Ltd.)

PUBLIC HEALTH IN THE NHS AFTER 1991 - HEALTH OF THE NATION

An unexpected by-product of the radical reforms on the National Health Service at this time was the clear and important role that became available for public health.

In June 1991, the then Secretary of State for Health, William Waldegrave, presented a consultative document entitled *The Health of the Nation* to Parliament and the final report was published in July 1992.[8] The strategy behind the report was to promote health rather than concentrating mainly on clinical

services and had been the subject of much discussion and amendment under successive Secretaries of State for Health.

The final document acknowledged that health authorities had been preoccupied for too long with the — very real — problems of day-to-day management of clinical services to the detriment of their strategic role of maintaining and improving the health of their local populations. A key feature of the health reforms was the creation of a clear strategic role for health authorities. The reforms were also intended to refocus the Department's attention on the broader public health issues which often go beyond the responsibilities of the National Health Service.

In his foreword, the Secretary of State had this to say:

> It is often forgotten that the Department of Health's predecessor Ministry was established in 1919, long before the creation of the NHS. Its origins lay in the great public health reforms of the second half of the 19th century. The 1919 Act required my predecessor the Minister of Health to 'take all such steps as may be desirable to secure the preparation, effective carrying out and co-ordination of measures conducive to the health of the people'. ...The exercise of these central Government responsibilities has not been in abeyance, but their importance and the attention we pay to them need now to be brought into a better balance with the attention we rightly pay to the National Health Service. ...The strategic role of the Department is clear. Its task is to monitor and assess the health of the nation and take the action necessary, or ensure that the action is taken, whether through the NHS or otherwise, to improve and protect health.

Mr Waldegrave acknowledged the part that a variety of public authorities, such as those concerned with water and sewerage, housing, pollution control and so on, have to play in any national health strategy and urged the development of co-ordination overall.

He emphasised three points in particular. Firstly, the need to find the right balance between what Beveridge identified as the three key areas of prevention, treatment and rehabilitation. Secondly, the need for a proper balance between individual responsibility and government action. Many of the main current causes of premature death and avoidable disease are related to lifestyle but it is not possible to force people into good health.

'Government must ensure that individuals have the necessary information with which they can exercise informed free choice.' Thirdly, setting objectives and targets for health improvements is an essential discipline and these targets must be sufficiently challenging without being unachievable. 'Resources which can be devoted to health care will always be finite in the face of infinite demand.' Setting priorities, however difficult and contentious, is therefore essential.

There was a major difference in approach to the improvement of health between the Department of Health and the Faculty of Public Health Medicine. The Faculty and many others actively concerned with improving health wanted the targets and activities to focus on the factors that led to ill health — smoking, poverty, inadequate housing, for example, rather than on the diseases and conditions that resulted. The Faculty, therefore, identified sixteen priority areas where public health action could have a significant impact on important causes of morbidity and mortality in the United Kingdom.[9]

Within each cause, objectives were further sub-divided into improved health status, risk factor reduction, improved services and protection, surveillance, and data needs.

The objectives were ambitious both in terms of risk factor reduction as well as in the services to be provided or action to be taken — for example, no tobacco product advertising other than small point-of-sale notices, the inclusion in GP health records of a patient's smoking habits in order to identify those at risk, the provision of condoms free of charge on prescription, access to a female doctor or nurse for women when being examined or fitted with a contraceptive device. These proposals identified both the inadequacies of current services and policies, as well as the need to develop appropriate data systems to provide the information necessary to assess both needs and whether objectives were being approached.

The *Health of the Nation* approach was somewhat different. Objectives were limited to five key areas — i) coronary heart disease and stroke; ii) cancer; iii) mental illness; iv) HIV/AIDs and sexual health; v) accidents. The reasoning behind this was two-fold. Firstly, it recognised that the lead role was played by

the Department of Health and secondly that the focus was on disease containment rather than risk/behaviour modification. An inter-departmental committee at Cabinet level, chaired by the Leader of the House of Commons, ensured some co-ordination of pohcies. But in the crucial area of reduction of harm from tobacco, the Government refused to introduce any measure which would limit tobacco advertising, in spite of the repeated and unanimous advice of all the advisory bodies which had been established to help in designing the *Health of the Nation* policy.

These bodies were partly successful at least in persuading Ministers to include sub-objectives on smoking and alcohol although many of the controversial proposals from the Faculty of Public Health Medicine were omitted.

Although health authorities were required to report progress in achieving the *Health of the Nation* targets, and the prime role of public health in doing this was recognised, both the means of tackling the problems and the methods of surveillance were flawed. The targets, for example, were expressed in national terms — but they obviously required to be translated to local level in view of the wide variation in the United Kingdom of both disease and risk factor incidence. As the targets set were not very challenging, districts often needed to do little to achieve them.

No resources were allocated to this initiative — and since performance of health authorities was judged on process measures, such as waiting lists, or fiscal measures such as savings made, there was little incentive to develop new programmes or change current ones concerned with disease reduction and health promotion. Public health effort was also dissipated by the need to be involved in contracting for services rather than in promoting health.

In 1992, the British Medical Association published a report entitled *Priorities for Community Care* in which it called for community care planning to include input from all relevant branches of the medical and nursing professions. It argued that the public health physician was 'probably the doctor who would have the most continuous input into the needs assessment and

service planning of an area, taking advice from appropriate specialists and liaising with... social service departments and the voluntary sector'.[10]

The failure of the public health speciality to rise to the challenge of linking medical management with planning and developing services for local populations, which could have been such a positive consequence of the 1974 reorganisation, was disappointing and resulted in a crisis of confidence and a drop in recruitment, both in quality and quantity.

The new focus on the central importance of public health offered by the Acheson Report,[11] the NHS and Community Care Act 1990,[12] and *The Health of the Nation*[9] should have begun what Acheson described as a renaissance of the specialty with medically qualified directors of public health being part of the decision-making machinery of health authorities or boards. But once again the specialty failed to grasp this clear opportunity as wholeheartedly and universally as it could and should have done.

PUBLIC HEALTH RESEARCH AND TRAINING

In 1987 the House of Lords Select Committee on Science and Technology became concerned with the state of medical research. A sub-committee was set up to determine how priorities were established and research stimulated. Although much of the evidence dealt with whether medical research should be science led or problem led, the committee concluded that there was a need for a balance between the two. The committee was, however, particularly concerned with the difficulties experienced by public health research. They regarded the mechanisms put in place by the Department of Health as inadequate, both in asking those dealing with their research policy to consider what research was required and in applying the research findings. This has been fully described by Kember and Macpherson.[13]

Although the Department of Health responded by creating a Research and Development Directorate which has forged closer links with those responsible for health policy and management,

it has continued to neglect the needs for public health research, concentrating for the most part on the research needs underpinning clinical policies.

This failure to develop a public health research agenda to tackle some of the underlying causes of ill-health and the lack of career development for those required to undertake such research has unfortunate consequences. When longstanding problems, such as inequalities in health, require to be addressed, new research has to be commissioned. This will take some years to yield results and thus policy is made without the benefit of sound research findings or not at all.

One outcome of the Acheson Report was the acceptance of the need for more public health physicians. There was an increase in the number of trainee positions in all Regions with ring-fenced funding available to recruit about 50 more trainees per year for four years.

This had a marked and very welcome effect on recruitment to the specialty. But one fundamental problem was not tackled. No provision was made for the training or career development of non-medical individuals who are essential for the performance of some public health tasks.

With the changes in National Health Service structure, public health physicians in some places began to perform more and more tasks that could be defined as managerial — for example, negotiating clinical contracts. With the inevitable concern with managerial costs once the 1991 changes had been in place for a number of years, public health physicians were regarded as 'grey suit managers' and were subject to managerial 'downsizing'. This has had two effects. Firstly, authorities restricted the expansion of consultant public health posts to take on the new trainees and this caused frustration and disappointment among many who were motivated to become involved in public health. Secondly, the authorities recognised that some of the public health functions could be performed by non-medically qualified individuals such as nurses, statisticians and social scientists who were cheaper to employ. Since no training scheme for such individuals had been established, however, there could be no assurance of the quality of work performed. Many public health

physicians also saw this as a threat and there is, as yet, no resolution of the dilemma.

One result of the concern with managerial costs after the 1991 changes has been a reduction in the number of tiers of management. The regional tier was abolished and incorporated in the NHS Executive in the form of Regional Offices. The Regional Directors of Public Health have thus become employees of the government and are civil servants. In this way, their abihty to provide a critical voice on the effects of government policy on regional health needs has been constrained. And their freedom to produce independent annual reports — a crucial public health function — has been compromised.

A very beneficial consequence of Acheson's enquiry on the public health function has been the control of infectious disease. Each district or board has established a mechanism for communicable disease control and has usually appointed a properly trained consultant responsible for this. Close co-ordination has been achieved with the Communicable Disease Surveillance Centre of the Public Health Laboratory Service and with appropriate Public Health Laboratories. Thus, although there have been several major outbreaks of communicable disease in recent times, these have been handled with greater expertise than sometimes in the past. The lack of an adequate legal framework of responsibility for the control of infectious disease remains a major difficulty.

INEQUALITIES IN HEALTH

One of the most obdurate public health problems which has been reported since social class analysis of mortality was first published by the Registrar General in 1921 has been that of inequalities in health and the link between deprivation and health.

Alwyn Smith and Jacobson, in their report of an independent multidisciplinary committee on *The Nation's Health,*[14] are among many who have drawn attention to the continuing social disparities in death rates at every stage in life.

The Black Report on *Inequalities in Health,* published by the Department of Health and Social Security in 1980, and later updated, concluded that the observed disparities in health were real and had widened continuously among adults since 1951.[15]

This report was the outcome of the work of a Research Working Group which was appointed in 1977 by the Secretary of State for Social Services in the Labour Government to assess national and international evidence on inequalities in health and assess the implications for Britain.

The Group was chaired by Sir Douglas Black, formerly Chief Scientist at the Department of Health and at the time of the inquiry President of the Royal College of Physicians. The other members of the group were Professor Jerry Morris of the London School of Hygiene and Tropical Medicine, Dr Cyril Smith, Secretary of the Social Science Research Council and Professor Peter Townsend, then Professor of Sociology at the University of Essex.

The Working Group completed its review in 1980. It concluded that the poorer health experience of lower occupational groups applied at all stages of life. The class gradient appeared to be greater than in some comparable countries — although data for the United Kingdom were almost invariably fuller — and were becoming more marked. During the twenty years up to the early 1970s, mortality rates for both men and women aged 35 years and over in occupational classes i and ii had steadily decreased while those in classes iv and v had changed very little or deteriorated.

The Working Group felt that much of the problem lay outside the scope of the National Health Service itself. Economic and social factors - such as income, work or unemployment, environment, housing, education, transport, diet — all influence health and are better handled by the more affluent members of society. National health pohcy did not, but should, involve itself in these factors and different departments of government should work more closely together to influence policy for the benefit of the health of the whole population.

In view of the continuing importance of the issue almost twenty years later, the summary and recommendations of the

Black Report are reproduced as Annexe 2 to this book.

There were two main policy thrusts which are described in the introduction to the 1992 edition of the report.

1) A total and not merely a service-oriented approach to the problems of health.
2) A radical overhaul of the balance of activity and proportionate distribution of resources within the health and associated services.

In April 1980, the Black Report was submitted to the Secretary of State of the new Conservative administration to what must truthfully be described as a lukewarm reception. It was released to selected journalists on the Friday before the August Bank Holiday of that year. No official press release or press conference was organised and only 260 copies of the duplicated manuscript were made available rather than the usual DHSS or HMSO method of publication and distribution of an official commissioned report.

In his foreword to the document, the Secretary of State for Social Services, Patrick Jenkin, made clear the government's position on the recommendations:

> The Working Group on Inequalities in Health was set up in 1977, on the initiative of my predecessor as Secretary of State, under the chairmanship of Sir Douglas Black, to review information about differences in health status between the social classes, to consider possible causes and the implications for policy, and to suggest further research.
>
> The Group was given a formidable task, and Sir Douglas and his colleagues deserve thanks for seeing the work through and for the thoroughness with which they have surveyed the considerable literature on the subject. As they make clear, the influences at work in explaining the relative health experience of different parts of our society are many and interrelated; and while it is disappointing that the Group were unable to make greater progress in disentangling the various causes of inequalities in health, the difficulties they experienced are perhaps no surprise given current measurement techniques.
>
> It will come as a disappointment to many that over long periods since the inception of the NHS there is generally little sign of health inequalities in Britain actually diminishing and, in some cases, they may

> be increasing. It will be seen that the Group has reached the view that the causes of health inequalities are so deep-rooted that only a major and wide-ranging programme of public expenditure is capable of altering the pattern. I must make it clear that additional expenditure on the scale which could result from the report's recommendations — the amount involved could be upwards of £2 billion a year - is quite unrealistic in present or any foreseeable economic circumstances, quite apart from any judgement that may be formed of the effectiveness of such expenditure in dealing with the problems identified. I cannot, therefore, endorse the group's recommendations. I am making the report available for discussion but without any commitment by the government to its proposals.

Not surprisingly, this was followed by prolonged and angry correspondence in the medical press and efforts were made by many health related bodies to increase coverage and discussion of the evidence and arguments in the report.

The government, however, continued to defend its reaction to the report on grounds of lack of knowledge of the precise causes of inequalities in health, new evidence claimed (although later discredited) to disprove the thesis that the deprived had poorer access to the health services, and financial constraints.

In 1986, the Health Education Council commissioned an update of evidence on inequalities and health since 1980 and to assess progress made on the Black recommendations (Annexe 2).

This was published as an HEC Occasional Paper, under the title of the *Health Divide,*[16] in March 1987 and confirmed clearly the main conclusions of the Black Report. A press briefing was cancelled by the Chairman of the Council shortly before it was due to begin with a statement to the effect that it was necessary to postpone the briefing until the full Council was able to consider 'this important and possibly controversial document'.

Press interest was naturally heightened by this move and inequalities in health thus became even more of a political issue than it already was in what was also an election year.

In a saner world, this should never have become a political issue. It is a long-standing problem of health and its fair distribution throughout society. It remains very much with us in 1998 and has to be addressed by politicians, health and other relevant professional experts and the public themselves. It will

not be capable of solution easily or quickly but a start must be made.

In 1994, the Government did set up a working group under the Chief Medical Officer's wider Health of the Nation Working Group to 'make the best use of any existing information to tackle ethnic, geographical, socio-economic and gender variations in health status, with particular reference to the strength of skewed relationships and evidence about the effectiveness of interventions'.

Discussion was limited to what the NHS and the Department of Health could do to reduce inequalities in health — or what were somewhat coyly described as 'variations' in health. Other relevant issues, such as poverty, housing and unemployment were not within the remit.

An editorial in the *British Medical Journal* saw the report of the Chief Medical Officer's group, which was published in 1995,[17] as 'a welcome opening of negotiations'. It regarded the report's recommendations as worthwhile.

> As well as saying that health authorities should monitor health variations, target resources, ensure equal access, and evaluate interventions, the report also says a little (not enough) about the responsibilities of the NHS as the country's largest employer and - most crucially — emphasises the Department of Health's responsibility for informing the government of the impact of other aspects of policy on health.

But the editorial goes on to say that, as well as influencing the content of the report, political constraints risked starting the discussion off on the wrong foot. It pointed out that there were both expensive and inexpensive ways of tacking inequalities of health, and the former are unlikely to be the best.

> What is expensive is to leave the underlying causes intact while establishing new services for those 'at risk' in an attempt to repair continuing damage.

Another commentator lamented yet another missed opportunity.

> What is remarkable, in view of the evidence presented of current inequalities - and apparent trends in these - is that the prescription

> offered is 'more research'... That the report was commissioned is undoubtedly an advance. It is a pity that such an important intellectual challenge had to succumb to ideology.

Over the past 100 years or more, as we have seen in earlier chapters, there have been challenges of the day to which public health practitioners have sometimes responded magnificently, sometimes adequately and sometimes scarcely at all. It remains to be seen how the specialty of today responds to what is almost certainly today's greatest challenge.

CONCLUSION

Other medical groupings, such as general practitioners and clinical specialties, have a clear-cut purpose to provide the best forms of diagnosis, treatment and care for individual patients. Public health, as a medical specialty, is in a different and more complex position. It is concerned with populations which can seem rather more remote than individuals. It has the further problem of the heterogeneity of the composition of a population. It has to influence and guide a wide variety of other agencies and establish multidisciplinary networks to achieve its objectives. And as a medical specialty it has to retain credibility with its parent profession.

The establishment of a new post within the Department of Health — Minister for Public Health — is a sign that the Labour Government elected in May 1997 regards public health as one of its priorities. It is an unprecedented position in British central government and one of immense potential influence and importance.

Acheson has given us a perfectly appropriate definition of what the specialty is or should be about. What we need now in the health service of the late twentieth century is to acknowledge the importance of public health at the centre of the National Health Service. There is recent evidence that the Government is preparing to do just this.

In the recent Green Paper *Working Together for a Healthier Scotland*[20] the following quote signals the Government's approach.

> True public health policies are embedded in action to improve our quality of life and protect our environment, in improving housing and educational achievement, as well as in addressing poverty and unemployment and in the restructuring of the National Health Service as a public health organisation with health improvement as its main aim.

There is also an imperative for public health to forget its past disappointments and deficiencies and to provide the expertise and strong leadership of some of the previous giants of the specialty. The complexion of some of the public health problems of today may have changed. But 'new plagues' are as important as old and the crucial issue of inequalities and variations in health has been waiting for too long to be addressed.

References

1) Ham C. *Health Policy in Britain.* Third edition. Macmillan Press Ltd, 1992.
2) *Working for Patients.* Cmnd. 555. London: HMSO, 1989.
3) *Promoting Better Health.* London: HMSO, 1987.
4) Morrell D. *The new general practitioner contract: is there an alternative?* BMJ 1989, 298: 1005-7.
5) Mich I. *Limits of medicine. Medical Nemesis. The Expropriation of Health.* London: Marion Boyars, 1995.
6) Griffiths R. *Community Care: An Agenda for Action.* Report to the Secretary of State for Social Services. London: HMSO, 1988.
7) *Caring for People.* London: HMSO, 1989.
8) *Health 'of the Nation.* Cmnd. 1523. London: HMSO, 1992.
9) HoUand WW (ed). *UK Levels of Health.* First Report June 1991. Second Report July 1992. London: Faculty of Public Health Medicine.
10) British Medical Association. *Priorities for Community Care.* London: BMA, 1992.
11) *Public Health in England.* Cmnd. 289. (Acheson Report). London: HMSO, 1988.
12) NHS and Community Care Act 1990. London: HMSO, 1990.
13) Kember T, Macpherson G. *Research and Education.* In: *The NHS - A Kaleidoscope of Care.* London: Nuffield Provincial Hospitals Trust, 1994.
14) Smith A.Jacobson B. *The Nation's Health. A Strategy for the 1990s.* London: King Edward's Hospital Fund for London, 1988.
15) *Inequalities in Health* (The Black Report). Harmondsworth: Penguin Books, 1992.
16) Whitehead M. *The Health Divide.* Harmondsworth: Penguin Books Ltd, 1992.
17) Department of Health. *Variations in Health.* 1995
18) Wilkinson RG. *"Variations" in Health. The costs of government timidity.* (Editorial) BMJ 1995, 311: 1177-78.

19) Holland WW. *Comment on Variations in Health.* Health Economics 1996, 5: 275-278.
20) Scottish Office Department of Health. *Working Together for a healthier Scotland.* Cm 3584. Edinburgh: HMSO, 1998.

7

A Perspective on Public Health Past

Public health slowly commits suicide; for as it is successful, it progressively removes the reason for its own being. But although society today is vastly different from what it was when public health began, there is as yet no lack of work; all that has so far happened has resulted only in a widening horizon and a shifting emphasis.

Fraser Brockington: *The Lancet* 1949,2:759 - 763

Looking back at public health concerns over the past 100 years, two central points become clear — the changes and the similarities. Firstly, and most importantly, there have been dramatic changes in terms of the improvements in health, in health services, in the environment and in quality of life during that time. The changes have been most dramatic in terms of the increase in life expectancy and the reduction in some of the previous hazards to health.

Secondly, there is much that remains similar. Many of the problems that were important in the past, still bedevil us today, sometimes in a less serious way or in a slightly different form. They are ignored at our peril. And new public health problems have also emerged.

The improvements can and have been linked to changes in expectation. People are no longer willing to accept conditions that were once commonplace — crowded, badly heated living accommodation, dirty towns, indifferent medical treatment, decrepit hospitals and unsafe working conditions. In many aspects, life at the end of the twentieth century is much easier and safer than it was 100 years ago. Telecommunications and air travel are two examples of radical changes in the way of life of much of the population that have shrunk the world and, theoretically at least, improved the quality of life.

In health services people have become unwilling to tolerate 'poor house' conditions in hospitals, badly organised and often delayed outpatient appointments or the stark waiting rooms of

past general practice. Education in all spheres, including medicine and public health, has improved greatly. There is better access to advice on health problems for the population and an increased ability for health professionals to maintain and increase their knowledge base and provide high quality up-to-date services.

That is the positive side. But in many ways too, life is more complicated and less safe. Although Beveridge's five giants of Want, Disease, Ignorance, Squalor and Idleness have had their influence much reduced, problems persist, although in ways that are less immediately obvious. Homeless people continue to live rough on the streets and, although the proportion of people working in heavy and dangerous conditions such as coal mines, iron foundries, and cotton mills is much lower than it was, other problems of unemployment, job insecurity and increased stress exist.

With all the changes that have taken place in recent times, it is worth considering some of the main issues that have been and remain important in public health.

ISSUES AFFECTING HEALTH

HOUSING

Housing as a health issue first claimed public attention in the mid-1880s at the time of Edwin Chadwick's report on public health conditions throughout the country[1] In the mid-nineteenth century, both urban and rural poor lived generally in overcrowded and insanitary housing. Many of the public health reforms of the latter part of that century were concerned with improving living conditions and consequently health.

In recent times, the issue has once again come to the forefront of concern with a renewed acknowledgement of the link between poor housing and poor health. Acheson[2] has listed some of the housing factors contributing to illness — faulty design, for example, can cause falls and fire, inadequate heating and lighting, dampness which leads to the growth of moulds and mites which are linked to chest diseases, and lack of safe amenities for recreation.

There are numerous recent studies linking aspects of poor housing to poor physical and mental health.[3] And Hunt[4] provides a clear account of the links between housing and health over the past 150 years and reiterates the concern that 'dampness, inadequate heating and overcrowding are among the factors affecting general ill health and respiratory disorders, heart disease, accidental injury and emotional problems'.

The Ministry of Health, created after the First World War, recognised the importance of housing in influencing health and the Minister of Health was for a number of years also responsible for housing. After both World Wars, albeit for different reasons, there was a pressing need to re-build and re-house the population.

In the 1920s the need was to demolish the insanitary slum houses still so prevalent in town and country. As discussed previously, few houses at this time had inside lavatories or running water and middens and open sewers were common. The Garden City movement, spearheaded by Ebenezer Howard, among others,[3] was a clear expression of this need for improved housing and hving conditions. In many rural areas, the living conditions of farm workers, while they may have been less overcrowded than those of town dwellers, were appallingly primitive.

After the Second World War housing need was again paramount in view of the destruction wreaked by the war and the need to rebuild and improve. Politicians and administrators recognised the importance of housing and that it was central to successful reconstruction. In 1925, Neville Chamberlain, when offered the post of Chancellor of the Exchequer by Baldwin, preferred instead to become Minister of Health with responsibility for housing which he considered of central importance.

Macmillan, among other politicians of the later era, spent a great deal of his energy in increasing the numbers of houses being built. But in both post-war periods the drive to increase the number of homes and their quality was thwarted by economic events — the Great Depression, for example, after the First World War and balance of payment difficulties. Bad

mistakes in housing were made in both periods. In spite of the models of Letchworth and Welwyn Garden City, planners and builders produced inadequate houses — strip developments with too little space and no amenities after the First World War; high tower blocks and system built houses with appalling standards after the Second.

In spite of a great deal of effort in more recent times, major problems in housing stock remain, both in terms of quality, availability and affordability. The right-to-buy policy of the 1980s, for example, resulted in a shortage of good quality accommodation for those on low incomes and the figures for homelessness are rising.[4]

NUTRITION

One of the major influences on the health of any population was and remains how and on what it feeds itself. Nutritional status can be influenced by illness and other factors and is not solely determined by diet. In turn it can influence resistance to infection and health and growth, especially in children.

Before 1939, under-nutrition was the main problem. M'Gonigle, among others, in his impeccable study in Stockton-on-Tees demonstrated without doubt the deleterious effects of an inadequate diet on health, despite improved living conditions.[6] Vitamin deficiencies and rickets were not uncommon in schoolchildren. With the beginnings of the school medical service and better surveillance of health in school children, improvements were made, including the provision of free school milk.

The major impetus to change, however, was without doubt the introduction of rationing early in the course of the Second World War. As already described, the system of rationing in Britain was fair and well organised and improved further with the introduction of the points system. The scheme provided a cheap and nutritious diet for all and communal feeding schemes in factories and the so-called 'British Restaurants' were also successful and well used. By the end of that war, under-nutrition and vitamin deficiencies, whether in young or old, had become extremely rare.

In more recent years our nutritional status has changed — as

has been shown by the increase in both height and weight of schoolchildren[7] — and the need for free school milk and meals has lessened.[8]

The effect of nutrition on health, however, has not disappeared. It has rather changed direction. As Britain has become increasingly affluent, the emphasis has switched from problems of under-nutrition to those of over-nutrition and consequently overweight and obesity. A consensus conference in the United States in 1985[9] concluded that obesity is 'undoubtedly associated with hypertension, hypercholestero-laemia, non-insulin-dependent diabetes mellitus, certain cancers, and has adverse effects on health and longevity'. The proportion of the population who are obese increases with age.[10] However, the National Study of Health and Growth has also noted a marked increase in obesity in children of primary school age.[11]

'Over-nutrition' is greater among the poorer sections of society — as was its predecessor under-nutrition — and greater in women than men.

As Charlton and Quaife point out,[12] 'in the modern, affluent, consuming Britain, attention is now being focused on the problems of over-consumption.... We are getting taller and heavier, even though we are eating less, and the increase in obesity, which carries with it increased risk of heart disease and stroke, is worrying'.

They add that there remain vulnerable groups in the population who eat less or less well and have poor nutritional status and conclude that 'although the British diet is improving, it still has some way to go'.

MORBIDITY AND MORTALITY

During the twentieth century, the decline of infectious disease mortality has been the most important cause of increased life expectancy. Infectious disease as a cause of illness and death in the 1920s and 1930s was of huge importance. Tuberculosis was common and was more feared than cancer is today. Special hospitals and sanitaria were built and voluntary efforts in helping victims of the disease and promoting prevention were

well developed. The introduction of streptomycin and Bacillus Calmete-Guerin Vaccine (BCG), although of great value, was not the major reason for the decline in this disease.[13] Improvements in housing, nutrition and sanitation were of far greater importance in this context. But even now, with effective agents for treatment and prevention, tuberculosis still causes more than 1,000 deaths per year and the emergence of multiply-resistant organisms has re-awakened interest in the condition and concern.

Similarly, although the introduction of sulphonamides and antibiotics has had a major impact on the incidence of previously common infections such as scarlet fever, acute otitis media, rheumatic fever and acute nephritis, other factors, such as the reduction in pathogenicity of the streptococcus and improved nutrition leading to increased resistance to infection, have contributed to a considerable reduction in the toll exacted by streptococcal infections. Immunising agents, particularly for diphtheria, polio and measles have had a profound effect on mortality from these diseases — the change in the pattern of illness in childhood is perhaps one of the most remarkable achievements of the period. Infectious diseases now account for only around 0.5 per cent of all deaths.

The decline in respiratory disease mortality was second in importance. There have also been major declines in death rates from diseases of the digestive, genitourinary and nervous systems.[14] As against these declines there have been increases in mortality from circulatory diseases and cancers, especially in men.

One of the most dramatic changes over the years in question has been the reduction in maternal and child mortality. Undoubtedly this is attributable in part to the general improvements in living conditions and standards of living but it is also in part the result of a recognition of the need to provide effective safe health services. The reduction in maternal mortality is perhaps one of the best examples of how, by concerted action, bad obstetric practices have been largely eliminated.

THE ENVIRONMENT

The most dramatic environmental change has been the improvement of air quality. Until the Clean Air Act of 1956, most of our urban areas were covered by a pall of dirty black smoke in the winter months. This resulted in many episodes of so-called 'smog'. The most famous of these was the London smog of 1952. This was implicated in more deaths in London over a period of three weeks than was caused by German bombs dropped on London throughout the Second World War.[15] In the early years of this century, chronic bronchitis was an extremely common condition; now it is relatively rare.

But in spite of this major improvement in air quality and thus in the frequency of respiratory illnesses in both young and old, problems of air pollution are still a matter for considerable concern. Although levels of smoke and sulphur are much lower, there have been increases in levels of pollution from increased road traffic giving rise to an increase in other air pollutants, notably nitrogen dioxide and carbon monoxide. While these pollutants have far less effect on health than those of the past, there is legitimate concern about their effects on the exacerbation of asthma and related symptoms.

Past problems with both domestic and public hygiene in terms of adequate sanitation, sewerage and water supplies, described earlier, have largely been rectified. In more recent years, however, other environmental issues have become prominent — for example, lead in the environment, in paint, in petrol and in food or in the soil; the impact of the use of pesticides in farming and the content of some animal feeds on the food chain; the siting of waste dumps or the building of houses on sites formerly used for industrial waste disposal.

THE CONS OF PROGRESS

Not all the changes that have occurred during the course of this century have been good for health.

The most obvious of the health-damaging behaviours that have shown an increase is cigarette smoking. Tobacco smoking was well established by 1941. It increased up to the end of the

Second World War when it fell slightly before stabilising. Use by women began in the mid-1920s. It increased rapidly during the Second World War and continued to increase until the 1970s when it began to fall.

Scientific evidence of the harmful effects of cigarette smoking was first provided in 1950 by Doll and Bradford Hill.[16] The overall proportion of smokers has gradually diminished over time. It now stands at about 30% of the population but cigarette smoking is now much more common in women than in the early part of this century and in those in the less affluent sectors of society who can least afford it. Schoolgirls are now more likely to smoke than schoolboys. Smoking is much the most important cause of lung cancer and although mortality from this disease is diminishing in men, it is continuing to rise in women.

Changes in society with improved transport systems, more advanced information and industrial technology, increased leisure, and very widespread possession of televisions and videos in homes, have created another behavioural problem. Most jobs and leisure activities in the past entailed a certain amount of physical exercise and effort; fewer do so now. The lack of exercise, whether it is the result of a change of type of activity at work or in leisure, has meant that risk factors associated with chronic conditions such as coronary heart disease, stroke and arthritis, have increased.

There has been a major change too in the causes of illness and death. With the reduction in the incidence of infectious disease there has been an increase in the chronic diseases — coronary heart disease, stroke, diabetes, arthritis, cancer. This is not the context in which to discuss evolving methods of treatment for these conditions but it is fair to say that reduction in mortality from them offers the best scope for increasing life expectancy in the foreseeable future.

But it is important from the public health point of view to recognise that these changes have not been uniform or consistent. Thus although there was a marked rise over the years, for example, in deaths from cancer of the lung and coronary heart disease, the mortality rates for both these conditions have been falling in recent years, possibly because of changes in

smoking habits or other environmental or behavioural factors.

Abortion and fertility are also issues of public health as well as ethical concern.

In the past abortion was illegal and practised illicitly with undocumented consequences. It was legalised in April 1968 when notifications of termination of pregnancy had to be made to Chief Medical Officers within seven days. The sharp increase in terminations between 1968 ad 1972 seems likely to have been due in part at least to transfer from the illegal to the legal sector. Whether it is actually now more or less common than in the past is difficult to ascertain because of the paucity of rehable data but at least it is now carried out under regulated conditions. Other methods of contraception, such as the Pill, have been introduced and have revolutionised this area of health care.

Recent advances in reproductive medicine too have opened possibilities in the treatment of infertility which have vast ethical imphcations yet to be fully addressed by the profession, politicians and society at large.

Both these areas run the risk of becoming over politicised as in the two opposing abortion lobbies of a woman's right to choose versus the rights of the unborn child — the former emphasising the right to choose but ignoring the responsibility of choosing to avoid conception — and in recent controversy on the issue of surrogacy. The public is now much more informed and concerned about these issues, partly because of the intensive media interest in and coverage of health matters which in some quarters is less than responsible and prepared to sacrifice scientific veracity in favour of sensationalism. It is imperative that detailed attention is given at a most senior and informed level to both these issues to look at ethical and social aspects.

Although there has been an improvement in the quality of life and in reduction of the incidence of many diseases, new ones have appeared in their stead — AIDs, Legionnaires Disease, BSE (and CJD) — and existing organisms such as salmonella and E.coli, have resurfaced in new and arguably more dangerous forms. Although the total number of deaths for these conditions is a fraction of the past toll, they do appear to cause far more public and professional concern and attract more than their fair

share of media attention.

Throughout the period covered by this book, mental illnesses have been a continuing concern. Whereas in the early years, most mental patients were cared for in institutions, often situated deep in the countryside in virtual isolation, few of these large 'asylums' now exist and most patients are looked after in the community. The trend is now changing back — and the need for some places of safety to care for the minority of patients who cannot safely or acceptably live in the community has been accepted. The advent of drugs such as largactil has completely changed the methods of treatment in this field in particular but there remains a great deal to be done in terms of, for example, the diagnosis and treatment of depressive illness in primary care and adequate care and help for patients with mental illness trying to cope with life outside hospital.

Along with the reduction in infections and other potentially fatal diseases has come an increased life expectancy with a rapidly growing population at the upper end of the age spectrum. And it seems indisputable that the composition of the population will continue to change, with the proportion of older people increasing especially at higher ages.[17] This has coincided with increased mobility of the population and a weakening of the bonds of family life with fewer families able to provide care for elderly and infirm relatives. The types of care required for those in this age group have changed and there has also been a substantial increase in the resources required to treat illness at this stage of life. Issues of long-term care, dementia, arthritis requiring hip replacement and multiple diseases have to be considered alongside other priorities in the health service budget.

Violence, including child abuse, has been present over the years and there is little evidence of any profound change in incidence or effective methods of prevention.

With the increase in the availability and use of effective drugs, there has also been a rise in the side-effects they can cause. One of the most dramatic of these was the occurrence of phocomelia in babies after the administration of thalidomide to mothers during pregnancy. These episodes have led to much more

stringent safety testing before new drugs are introduced and, from the public health point of view, have underlined the need for adequate systems of surveillance.

Poverty stands out as a factor of major impact on health throughout the whole period. There has been an indisputable improvement in standards of life and in state provision for those in greatest need. The change from the old Poor Law provisions to our current welfare and benefits system has improved life for many. But even with these changes in welfare, inequalities in levels of health between the various social groupings have remained to the detriment of the more deprived and are unacceptable at the end of the twentieth century.

ORGANISATIONAL ISSUES

For public health, organisational concerns have loomed large in this time period. Perhaps the most important of these has been the relationship of public health to clinical practice, both in hospitals and general practice.

In the Victorian era public health tasks were clearly defined. Most public health practitioners combined clinical practice with part-time public health duties. In the one capacity, they earned fees; in the other they were salaried employees of local authorities.

The change from the Poor Law administration of hospitals to local authority control was the first major change in this arrangement. Local authorities naturally gave public health practitioners authority to manage and control these newly acquired facilities. Medical Officers of Health responded to this challenge in varying ways. Many saw this as a major opportunity to improve the clinical hospital care of their population and persuaded their councils to build new and better facilities and improve services. Others took a more laissez-faire attitude and did relatively little to change the facilities or services.

It would be wrong to blame individual members of the profession for these deficiencies - they were often dependent on the initiatives of individual councils and councillors and available resources. In general, however, public health as a

discipline was able to improve hospital services despite fluctuations in its level of influence at different stages of the time period.

The major drawback to this new responsibility for public health was that those involved became more concerned with the problems and minutiae of clinical/hospital administration — many became medical superintendents and thus directed clinical care. In all cases those working in local authority hospitals were ultimately accountable to the Medical Officer of Health and the council. This was in contrast to the voluntary hospitals where the consultant staff did not have accountability to another doctor but worked essentially as independent practitioners.

In many instances, this gave rise to feelings of unease and animosity. Consultants, on the one hand, did not like or respect Medical Officers of Health or local authority physicians whom they considered were divorced from clinical practice or 'real medicine'. Medical Officers of Health and public health physicians on the other hand saw this new responsibility as a means of acquiring power and authority and gaining status which they had not had as employees of a local authority before.

At the same time public health was charged with developing community services for pregnant women, infants, children and school health services. Many of these developments started in poor areas where individuals in the various categories could not afford to use general practitioners since payment was expected either by the 'panel' or by the individual. Public health and general practice thus found themselves in competition and friction was inevitable.

The introduction of the National Health Service in 1948 changed this picture radically, as we have seen. Public health was separated from clinical practice and remained under local authority control. This was a profound disappointment to many public health practitioners who had expected that all hospitals and general practice would come under local authority control and that they would remain in charge.

Mutual suspicion and dislike between clinicians of all varieties and local authority medical officers of health flourished. Some Medical Officers of Health became full-time medical

administrators in Regional Hospital Boards and essentially lost their public health responsibilities and much of their credibility.

Between 1948 and 1974, public health in many areas began to acquire new roles and to identify the gaps that had occurred as a result of the radical changes in health and local government. Perhaps the most important of these was the co-ordination of services in situations where some were delivered in hospital and others in general practice. Some areas developed co-ordinated maternity and child health services which illustrated the need for change in the structure of the National Health Service.

There were also some outstanding co-operative developments between public health and general practice in building innovative health centres, in Bristol and London to quote two well-known examples, owned by local authorities but providing both clinical and preventive services.

Throughout the period, public health remained responsible for preventive services such as immunisation, health education, communicable disease control and environmental protection. A few authorities led the way to using modern technologies, such as computers, in these fields and achieved remarkable results despite the curious action of the 1946 NHS Act which abolished compulsory vaccination for smallpox — implying that immunisation was not essential.

Despite some positive collaboration and progress in particular parts of the country, however, the period from 1948 to 1974 was one of great turmoil and uncertainty for public health — a specialty which seemed to many to have lost its way. Differences in standards and performance between public health departments in counties and urban areas that had existed previously became even more marked.

In general Medical Officers of Health in the county areas were treated as professionals and, within their agreed policies, given complete freedom. In more compact urban areas, day-to-day control of pubhc health activities by elected councillors was far more obvious and tended to be influenced by party political issues.

At the same time two groups of employees responsible to Medical Officers of Health became restive.

Social workers sought their independence and the Seebohm Report[18] recommended the creation of unified social service departments under their own directors who would be given generic training. This was a total change from the previous specialised bodies of social workers with specific responsibility for different groups, such as children, hospital patients, young offenders, and psychiatric patients.

Environmental health inspectors also aspired to independence and the Bains Report[19] accepted their representations and recommended the creation of separate environmental health directorates responsible for such matters as food hygiene, housing standards, and sanitation.

As we have previously described, all these forces helped to promote the integration of the three main services concerned with pubhc health — general practice, hospitals and public health — and this was one of the things achieved by the 1974 reorganisation.

For public health, both new and old roles were created in the structure of Districts, Areas and Regions. The report of the Todd Royal Commission on Medical Education[20] had already recommended that all branches of public health — that is, those in academic departments, local authorities, and medical administration in Regional Health Boards, as well as hospitals in Scotland — be brought together under one umbrella.

In an attempt to achieve this aim, the name of the specialty was changed to community or social medicine and the Faculty of Community Medicine of the Royal Colleges of London, Edinburgh and Glasgow created.[21]

But this has not been the end of the organisational issues affecting public health up until the present time. Further reorganisations occurred in 1982 and again in 1989-91 and 1995. The first of these abolished the area tier of authority, the second reduced the number of districts and regions from fourteen to eight. The last made Regional Directors of Pubhc Health and their staff civil servants and employees of the NHS Management Executive in England although not in Scotland.

All these many changes have undoubtedly had an influence on public health over the past 80 years. But throughout this

period, the one issue referred to earher was of constant and central concern — the relationship between public health and clinical medicine. At the beginning, the problem focused on competition and earnings, an area of continuing tension. Public health practitioners were in the main salaried employees; clinicians depended on fees earned by the provision of services. The role of pubhc health practitioners as administrators — or managers and directors as they would now be termed — was also resented by hospital clinicians, particularly those working in voluntary hospitals where their clinical activities were only lightly monitored, usually by a colleague or lay person.

Some of these tensions disappeared with the introduction of the National Health Service but reappeared after the 1989-91 reforms when public health practitioners generally became employees of health authorities and responsible for the purchasing, commissioning and monitoring of clinical services. They were then more in control of clinical matters than in the intervening period and this was viewed with suspicion by the clinicians.

A further common organisational concern over this period has been the difference in working patterns between public health doctors and those in hospital or general practice. In the latter context, once an individual has been trained and acquires a position as consultant or partner, their practice is essentially controlled only by themselves, except in extreme circumstances. Historically, by contrast, public health has worked within a hierarchy, with the Medical Officer of Health or Director of Public Health as leader. One of the results of the 1974 reorganisation was the disappearance of this clear hierarchical relationship. This has reappeared to some extent with the creation of the posts of Directors of Public Health in health authorities or boards.

In addition, consultants and general practitioners — even if working within organisations — have complete clinical freedom to prescribe drugs or treatments they consider appropriate for a particular patient. Although 'guidelines' to practice are now issued, their freedom of action remains almost unimpaired. Public health practitioners, while protected by statute for certain

functions and nominally free to express their views on public health matters, do work within the constraints of corporate governance with all that that entails.

This difference in culture and practice is of particular concern in the production of an annual report by each Director of Public Health. Before 1974, each public health department was bound to produce and publish an annual report on the health of the local population. Although many were no more than humdrum lists of statistical data, some were hard hitting and did not shrink from commenting on local or national problems. The annual report for Gloucester in 1923, for example, was admirably frank about the mistakes made by the Medical Officer of Health in identifying and controlling a major smallpox epidemic. The Chief Medical Officer's reports of 1931 and 1932 contained extracts of local reports on the impact of unemployment on health in particular areas.

The requirement for public health reports to be produced was abolished with the 1974 reorganisation, perhaps because many or most had become dull accounts of what was already on record and were not perceived as useful. In 1988 Acheson, in his report on the functions of public health[22] recommended the re-introduction of annual reports.

After a variable start, these reports have improved greatly, partly as a result of guidelines produced by the Faculty of Public Health Medicine[23] on what they should contain. One produced by a Senior Registrar in the Bassetlaw Health Authority in 1990, for example, described in clear terms the inadequacy of the range of services for women in her district — from contraception, abortion and maternity care to screening and treatment of breast and cervical cancer screening.[24] The fears of some politicians and administrators that these reports could highlight deficiencies in provision in a very public manner were realised on this occasion.

One major organisational issue involving public health as a key player continues to demand skilled attention — how to allocate limited resources within the context of exploding demand for health care. The improvements in health and health services described earlier in this book have led to increased life

expectancy in both sexes. Men and women who would previously have died in their 50s, 60s and early 70s are surviving into their eighth and ninth decades in increasing numbers, with important implications for organisation of services and for allocation of finite resources.

In all health systems, resources are limited. In view of their training in population medicine and their ability to look across the whole spectrum of health care, public health physicians must have a key place in discussions on how priorities can best be decided and we will return to this theme in the final chapter.

EDUCATION, RESEARCH, MANPOWER

One of the difficulties that has bedevilled public health over the past 80 years has been a search for its sense of identity as illustrated by its change of name to community medicine and the subsequent change back again. Until the late 1930s the term Public Health was commonly used, although some academic departments used the term Hygiene or Preventive Medicine. In the United Kingdom at the beginning of the 1940s, the term Social or Community Medicine came to the fore in academic circles although Public Health continued to be used by the service.

The history and meaning of the term social or community medicine has already been described;[25] but it has to be acknowledged that part of the reason for its emergence at that particular time was a wish on the part of the academic wing of the specialty to dissociate itself from the service side. One of the stated recommendations of the Report of the Todd Commission was, as we have seen, to unify all branches of the specialty — service and academic public health and medical administration and the terms community or social medicine were suggested.

After some discussion, this nomenclature was adopted but it was by no means ideal or universally accepted and in 1988, the term Public Health became, quite rightly, once again the description of choice. This bewildering variation in title epitomises one of the central problems of the disciphne.

In the nineteenth and early part of the twentieth centuries

the types of problem facing pubhc health were unambiguous — water, air, rapid and unregulated industrial growth, poor housing and nutrition, poverty, inadequate or non-existent sanitation. The achievements of pubhc health in tackling these problems were acknowledged and appreciated and it was recognised as an important specialty in the field of health and health services.

By the second half of the present century, the major achievements of medicine were the result of treatment with various new and more effective types of drug such as antibiotics or of improvements in medical technology. The specialty of pubhc health was perceived both by the profession and by society in general as searching for a role in some confusion, tending towards bureaucracy and administration and not a part of 'real' medicine. Perceptions do not have to be true to be powerful and public health in a changing medical world allowed itself to become something of a second class citizen.

Over this time span too the teaching of public health in medical schools and elsewhere had gradually deteriorated. In most places it was undertaken as a part-time activity by Medical Officers of Health — who naturally had more immediate demands on their time — or by some other uninvolved individuals outside the speciality. In some places, notably London, there was no teaching of the subject at all.

The Report of the Goodenough Committee in 1944[26] and the Royal College of Physicians of London[27], recognised the need for improvement in education in social medicine and advocated its expansion but little happened. Only postgraduate education, for the statutory Diploma in Public Health, continued at all — and only the London School of Hygiene and Tropical Medicine had comprehensive full-time regular courses in the subject.

The foundation of public health — epidemiology — was considered to be a pre-clinical subject, largely concerned with infective conditions. It flourished in a very few universities but in particular at the London School of Hygiene. There were a few notable academic public health giants before 1948, such as Major Greenwood and Topley, who maintained standards. After the Second World War and with the emergence of chronic

diseases as a dominant problem, the need for research became manifest. The London School of Hygiene provided perhaps the premier stage for this with Bradford-Hill, Doll and Donald Reid as the major players. Jerry Morris, with his Social Medicine Research Unit at the London Hospital, Archie Cochrane in South Wales, Alice Stewart in Oxford and Tom McKeown in Birmingham were the main supporting figures and were supported largely by the Medical Research Council but also by the Nuffield Provincial Hospitals Trust. These academic figures established a tradition of rigorous research discipline which has since served the specialty well. But significant also was their desire for separation from mainstream service public health.

Gradually since the 1960s, the teaching of the subject has been firmly established and incorporated into the curriculum of all medical undergraduates and some of the postgraduate teaching has also been expanded. Research has also increased, partly because of the recognition by the National Health Service of the need for reputable data on which to base health policies and changes in provision. In the first place a programme of research was funded by the Office of the Chief Scientist both north and south of the border, and, since the publication of a House of Lords report on the subject in 1988, the Research and Development Directorate of the NHS Management Executive has also provided funding.

The full story of the development of research and education in public health in the United Kingdom is a long and complicated one which needs to be told but which cannot be covered in detail here.

With the establishment of recognised academic departments in every medical school and of the Faculty of Community Medicine, or Public Health Medicine as it has become, it has also been possible to develop a structured training and development programme for those in service positions. Before 1939, few, if any, authorities paid individuals to take the postgraduate and essential Diploma in Public Health; by 1974 several had become willing to second their staff for postgraduate training.

Since 1974 the funding for specialist training in public health

has been the same as in all other medical specialties — that is, individuals are seconded for part or full-time training by their employing authority which meets the academic fees.

The problems of training, the standing of the subject, and the earnings of public health physicians have all had an effect on recruitment and the ability of those in the specialty.

Between the two World Wars, public health physicians were paid salaries. These — although not over-generous — were comparable to those of other professionals employed by local authorities and comparable to or better than most general practitioners or consultants. Furthermore they provided a stable income, a most desirable feature at a time of great economic depression.

After the Second World War, ex-servicemen with their gratuities and paid education were also attracted to the specialty which they had seen as being of relevance and importance during their service careers.

With the separation of public health from clinical medicine, however, the situation changed rapidly. Salaries of local authority staff, except for the most senior, were no longer as good as those in the National Health Service which also ensured that all staff received regular increments.

The attraction of clinical medicine with its potential for curing people with up-to-date drugs, high tech equipment and reasonable facilities seduced many from what they saw as the dull, bureaucratic tasks of public health. Recruitment fell off rapidly, both in numbers and quality. One of the great attractions of the 1974 reorganisation was that public health physicians would be paid the same salaries as other hospital medial staff and be eligible for distinction awards.

Properly structured, demanding postgraduate courses were introduced, first in 1970 at the London School of Hygiene with others following shortly thereafter. The effect on recruitment was dramatic. Many of the new entrants were the 'children of 1968', self-assertive and idealistic in their aspirations. Some became frustrated; others scorned or neglected the academic traditions of their teachers. Many had problems with their senior colleagues who were versed in another tradition.

Only in the past ten years has recruitment properly settled down. In general, public health is now able to attract many of the brightest medical graduates again and in sufficient numbers to sustain the specialty and develop it in excellence. It now contains an encouraging number of potential public health giants of the future.

Many entrants to the specialty have come with good clinical experience but having realised the limitations of clinical practice and the huge potential of public health. Many of the current new recruits too are women, attracted by the ability to combine an important professional role with family life.

OTHER ISSUES

WORKING IN TEAMS

Public health has traditionally worked in a multidisciplinary way with other health professionals such as social workers, statisticians, environmental health officers and so on. This has not always been easy. Before 1968, except perhaps in some academic departments, it was always accepted that the leader of any multidisciplinary team would be a medical practitioner and thus in this context the public health physician. With the emergence of independent directorates of social services and environmental health, public health physicians have had to come to terms with a different type of non-hierarchical multi-disciplinary activity. This has bedevilled many working relationships and limited many promising projects and requires continuing patient and sensitive resolution.

SPECIALISATION

There is also the question of specialisation. Over the years the practice of medicine, like much else, has changed and become more complex. Public health has hitherto, except in the field of communicable disease control, adopted a generic method of training to fit its recruits to work in any field of pubhc health concern. Whether this can continue has to be carefully considered.

This is relevant, for example in the maintenance of standards,

an issue that has only been considered seriously by the specialty in the past fifteen or so years. There is now a system in place, not only for training, but for auditing the satisfactory performance of the public health function. In the past, reports of the mishandling of outbreaks of infection, the unwillingness to accept blame for maladministration in mental or mental handicap hospitals, for example, were too frequent. Problems still occur and mistakes in any complex task are inevitable, but for the most part, standards of work appear to be high.

There is still room for improvement in a number of areas including the assessment of health in populations, for example, and the provision of satisfactory information systems.

Public health's main function is to be concerned with the improvement and maintenance of health, as defined somewhat idealistically but constructively by the World Health Organisation in 1979 — 'Health is a state of complete physical, social and mental well being and not merely the absence of disease or infirmity'.[28]

But it is striking to consider how few academic or service public health practitioners have yet become involved in trying to evaluate progress with this concept. The measurement of mortality and morbidity is of course much easier and most have been content to confine their activities to this.

In regard to information systems and data — the life blood of public health — there is much room for progress. Despite the pioneering work in this field by Major Greenwood, Donald Reid and Bradford Hill in defining some of the main information needs, only in the field of infectious disease have appropriate systems yet been developed.[29]

TECHNOLOGY- ITS ASSESSMENT AND APPUCATION

Public health physicians have always been in the forefront of introducing novel technologies — be they vaccines, immunising agents, mass X-ray or screening. In the past, with academic collaboration they developed rigorous methods of assessment, often using randomised controlled trials — examples of this include trials of the efficacy of streptomycin and various vaccines, for example, for polio and measles. Their role in the

current evaluation of new techniques such as PET scans and minimally invasive surgery still requires to be resolved. In terms of screening, where the specialty has an important role at local level in monitoring the national programmes for cancers of the breast and cervix, there is certainly likely to be a role in assessing any proposed new screening programmes before rather than after introduction, preferably by means of pilot studies.

WHERE NOW?

In the past, as we have seen, most public health effort was devoted to the control of infectious disease and the improvement in the practical environment. Public health practitioners have more recently become deeply involved in the planning, provision and evaluation of services for acute disease as well as research on such conditions as cancer of the lung, chronic bronchitis and coronary heart disease. Throughout the period under review, the needs and problems of the elderly, the mentally ill and handicapped and disabled have come gradually into clearer focus but, with some notable exceptions, have received much less attention, either in terms of research or practical action.

This is partly because of the complexity of the measurements required and the difficulty of contacting and communicating with these populations. We hope, despite the undoubted obstacles, that as we approach the twenty-first century, the public health spotlight will focus determinedly on these areas.

As with any such practical specialty, the relationship between research and practice has been somewhat cloudy. Much good research has been carried out but translating sound results into practice has been notoriously difficult. Effective methods of immunisation, for example for diphtheria, were introduced only ten years after their effectiveness had been demonstrated. The national screening programme for cervical screening was introduced without adequate evaluation. It would be a huge advance if research and practice could in some way be more closely related.

Communication in the modern world is a crucial

management task and nowhere more so than in the field of health and pubhc health. The medical profession has in the main had an uneasy relationship with the media and with much good reason in terms of inaccurate reporting and sensationalism. In the past few years this has been recognised and the Faculty of Pubhc Health Medicine set up a Working Party to look at these issues. Public health physicians have to report on health risks and outbreaks and they need to be able to convince their populations and authorities to modify behaviours or to change services or introduce new ones. Communication skills are therefore of the utmost importance in the specialty. There is a need to interpret findings and communicate these to a non-professional audience cogently and convincingly. These skills are still in scant supply in public health.

Finally, the ambiguity of the role of the public health physician must be resolved once and for all. The clinician's role is clear — the responsibility here is to his or her patient. The public health physician's patient is the population or community. But he or she is a member of a corporate team and the role is multiple — as official, enabler and advocate. The balance of these roles has been difficult since the time of John Simon.

But we do have a clear and acceptable definition of public health:

> Public health is the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society."

It is not only desirable but vital for the specialty that this definition becomes its focal point and is enshrined in every public health department, academic or service, and every public health practitioner. The time for continuing ambiguity is long past.

References

1) Chadwick E. *Report on the Sanitory Condition of Labouring Population of Great Britain.* 1842. Edited with an introduction by MW Flinn. Edinburgh: Edinburgh University Press, 1965.

2) Acheson R. *Edwin Chadwick and the world we live in.* Lancet 1990, 336-385.
3) Whitehead M. *The Health Divide.* London: Penguin Books, 1988.
4) Hunt S. *Housing-related disorders.* In: Charlton J, Murphy M (eds). *The Health of Adult Britain.* London: HMSO, 1997.
5) Howard *B.Garden Cities of Tomorrow.* London: Faber and Faber, 1900.
6) M'Gonigle GCM, Kirby J. *Poverty and Public Health.* 1936.
7) Chinn S, Rona RJ. *Trends in weight-for-height and triceps skinfold thickness in English and Scottish children* 1972-82 and 1982-90. Paediatric and Perinatal Epidemiology 1994, 8: 90-106.
8) Rona RJ, Chinn S. *School meals, school milk and the height of primary schoolchildren in England and Scotland in the eighties.]* Epidemiol Comm Hlth 1989,43:66-71.
9) NIHCDP Consensus Conference. *Health Implications of Obesity.* Annals of Internal Medicine 1985, 103: 1073.
10) Bennett N, Dodd T, Flatley J, Freeth S, Boiling K. *The Health Survey for England 1993.* London: HMSO, 1995.
11) Hughes JM, Li L, Chinn S, Rona RJ. *Trends of growth in England and Scotland 1972-1994.* Arch Dis Childhood 1997, 76(3): 182-189.
12) Charlton J, Quaife K. *Trends in Diet 1841-1994.* In: Charlton J, Murphy M (eds). *The Health of Adult Britain.* London: HMSO, 1997.
13) McDonald JC, SpringettVH. *The decline of tuberculosis mortality in Western Europe.* Br Med Bull 1954, 10:77-81.
14) Charlton J, Murphy *M.Trends in causes of mortality: 1841-1994- an overview.* In: Charlton J, Murphy M (eds). *The Health of Adult Britain.* London: HMSO, 1997.
15) Holland WW, Reid DD. *The urban factor in chronic bronchitis.* The Lancet 1965, 1:445-448.
16) Doll R, Hill AB. *Smoking and carcinoma of the lung — a preliminary report.* BMJ 1950, 2:739-748.
17) Charlton J. *Trends in all-cause mortality: 1841-1994.* In: Charlton J, Murphy M (eds). *The Health of Adult Britain.* London: HMSO, 1997.
18) *Report of the Committee on Local Authority and Allied Personal Social Services* (Seebohm Report). CMND 3703. London: HMSO, 1968.
19) Reorganisation of the NHS and Local Government in England and Wales. (Environmental Working Group chaired by MA Bains). Cmnd 5055. London: HMSO, 1972.
20) *Report of the Royal Commission on Medical Education* (Todd Report). Cmnd 3569. London: HMSO, 1968.
21) Warren MD. *The Genesis of the Faculty of Community Medicine.* University of Kent at Canterbury, 1997.
22) *Public Health in England. The Report of the Committee of Inquiry into the Future Development of the Public Health Function* (The Acheson Report). London: HMSO,1988.
23) Bussey A (ed). *Faculty Guidelines on Annual Reports.* London: Faculty of Public Health Medicine. 1990.

24) *Annual Report on the State of the Public Health of the People of Bassetlaw.* 1990.
25) Holland WW. *Changing Names.* Scan J Soc Med 1994: 22:1-6.
26) *Report of the Inter-Departmental Committee on Medical Schools* (The Goodenough Report). London: HMSO, 1944.
27) Royal College of Physicians of London. *Planning Committee Report on Medical Education* (Moran Report). London: Royal College of Physicians, 1944.
28) World Health Organisation. *Measurement of Levels of Health.* European series no.7. Copenhagen: WHO, 1979.
29) Holland WW. *Achieving an ethical health service: the need for information.* Journal of the Royal College of Physicians of London 1995, 29: 325-334.

8

Where now for Public Health? The Art of the Possible

The most important aspect of modern medicine is unquestionably Public Health, embracing as it does the four historical functions of the physician: to heal, to know, to predict, to organise.

Marti-Ibanez, 1958

Good health is more than the absence of disease. It has to do with the way we live, the quality of our life and our environment. That is what public health... is all about.

Secretary of State for Scotland, 1998.

INTRODUCTION

Acheson's definition of public health, quoted at the end of chapter seven, emphasised that public health was concerned with more than sanitary hygiene and epidemic disease control.[1]

The Acheson Committee considered that public health must be involved not only in 'efforts to preserve health by minimising and where possible removing injurious environmental, social and behavioural influences', but also 'in the provision of effective and efficient services to restore the sick to health, and where this is impracticable, to reduce to a minimum suffering, disabihty and dependence'. Public health's major functions must, therefore, be:

1) to improve the surveillance of the health of the population centrally and locally;
2) to encourage policies which promote and maintain health;
3) to ensure that the means are available to evaluate existing health services.

In this review of public health, it is clear that these elements have been the constant aim of the specialty over the past 130 years, with differences in focus and emphasis at different times.

In this final chapter, it is our intention to try to bring all this together, to look at the major issues confronting public health now, and to suggest how the application of public health knowledge can be applied more effectively to improve the health of the population. To understand public health as it is today, it is essential to take account of the vision of previous pioneers and giants of the specialty and to confront with confidence and imagination the challenge it faces in the future.

TERMINOLOGY

The terminology used in the context of public health has often led to misunderstanding — the difference between private and public health, for example, requires clarification, especially for those unfamiliar with the subtleties of the English language. The term clinical services describes more aptly those health services that focus on the cure or care of individual patients, whether these are privately or publicly financed. An effective public health service must identify and respond to major public health problems involving populations and individuals within populations — such as, for example, the recent outbreaks of E.coli food poisoning in Scotland — and promote strategies to combat them. If no well-tried solution is available, the service must ensure that an investigation is mounted in order to develop the body of knowledge and define means of solving that particular problem, and thus to identify suitable methods of protecting the public health more effectively in future. The intelligence system maintained by the service should provide relevant information on which to base these public health tasks.

TENSIONS

Over the years, the tension between those practising clinical medicine and those concerned with public health has been undiminished.

Until 1974, some public health practitioners also practised clinical medicine. Some part-time medical officers of health, for example, were also general practitioners. Public health clinical

medical officers looked after infant and child welfare clinics, school services and outbreaks of infectious disease. But while the latter were usually responsible for diagnosis and advice in these contexts, patients had to be referred to their general practitioner or to a hospital consultant if they needed any drugs or other treatment.

This dual function of clinical and population responsibilities disappeared with the emergence of Community Medicine and the Faculty of Community Medicine in 1974. This change created tension, confusion and controversy within the medical profession in general and the specialty of public health in particular. There was a view that the clinical functions performed by public health clinical medical officers were important and that public health should retain this managerial responsibility. The health care and surveillance of infants, children, mothers, the elderly, the disabled and handicapped, particularly in deprived areas, it was felt, could best be provided by dedicated, salaried practitioners under the direct professional and operational control of public health consultants. A small group of academic practitioners were also anxious that, by losing clinical responsibilities for patients, those practising epidemiology would lose also the necessary clinical knowledge to underpin their research.

Most public health practitioners, however, considered the clinical functions unimportant within the context of public health work. With improvements in medical education and training, in general practice in particular, the need for dedicated medical staff to look after these 'at risk' population groups was lessening. Increase in knowledge and new methods of diagnosis and treatment available to specialist physicians, also diminished the ability of non-specialist individuals to provide up-to-date care. A number of organisational proposals helped to define more clearly the boundaries between the medical disciplines.

The medical profession generally also became more aware of the importance of preventive services, such as immunisation, screening, health promotion and family planning. This came about partly by improvements in medical education and partly by incentive payments to general practitioners for specific

preventive services such as family planning or for the achievement of set objectives such as the proportion of children immunised. The needs of academic practitioners were met by ad hoc arrangements. Public health physicians involved in the control of communicable disease and toxic hazards still required to maintain their clinical skills of diagnosis in order to fulfil adequately their functions in the identification and control of outbreaks of disease. They were not responsible for treatment of individual cases although they were expected to advise on measures to be taken with contacts. This remains the case today.

The tension between public health and clinical medicine was not, however, concerned only with the delivery of services to the individual patient. The change from Poor Law administration to local authority control of hospitals other than sanatoria and those for infectious disease was also a major factor. Until 1929 the administration of institutions was under the control of the Poor Law Commissioners. After this date, hospitals were administered by local health authorities who appointed the appropriate clinicians. The head of this hospital administration system was the Medical Officer of Health.

Between 1929 and 1939 there was some rivalry, for financial reasons, in some areas, between the voluntary hospitals and those under local authority control[2] Most of the public health/clinical medicine conflict up to this time was between general practitioners and public health; then hospital clinicians entered the fray. Many resented the fact that their 'boss' was a public health doctor usually, in their view, with little clinical training. The contrast between local authority and voluntary hospitals was also marked — in the latter, the clinicians normally had to deal only with lay administrators or governors, and most did not have out-patient departments.

Medical Officers of Health were now responsible for large budgets and institutions with many employees — a huge administrative burden but for some a powerful and attractive role. Although, as we have emphasised, public health should properly be concerned 'with the provision of effective and efficient services to restore the sick to health', this should not necessarily involve responsibility for the management of

institutions. Responsibility for such a complex task inevitably reduces the time available for other, perhaps more relevant, public health work. The demands of institutions and staff are always great, the needs of individual patients are far more evocative of public sympathy than those of population groups. And since local authorities are political entities the requirements of institutional management often took precedence over other pubhc health issues.

On the positive side, responsibility for large budgets gave pubhc health practitioners control of resources which could, and often were, used for public health purposes. The period 1929-39 saw these powers used by Medical Officers of Health in both a positive and negative way. In some towns and counties there was great improvement in health facilities — for example, new hospitals and better services. But there were also problems that were not properly tackled. Diphtheria immunisation, for example, was sporadic and was not introduced as a universal requirement until 1941, although evidence of its effectiveness was available in 1930.[3] As a result there were in one decade, some 20,000 avoidable deaths from the disease.

A major problem during the 1930s was under-nutrition. Although there was good evidence available of its effect on health in terms, for example, of rickets and excess mortality,[4] there were few examples of public health interventions in attempting to correct this problem.

The separation of pubhc health functions from institutional management with the introduction of the National Health Service in 1948 was welcomed by some and opposed by others. As we have illustrated, during this period some Medical Officers of Health greatly expanded community care services and promoted the integrated care of patients through the development of links between general practice and hospitals to provide continuity of care — for example during and after childbirth. It was not until 1974, however, that an attempt was made to introduce greater clarification of the division between public health and clinical responsibility. It failed. Pubhc health physicians (District Medical Officers) joined a hospital clinician and a general practitioner as members of the District

Management Team (DMT) which was given a 'consensus' decision-making role and consequently lacked clear lines of accountability and responsibility for management of services. This system persisted until the mid-1980s when general management was introduced.

CURRENT CONCERNS

More recently, the 1989-91 reforms in the National Health Service have again caused disturbance.[5] The changes have separated providers — that is the hospitals (NHS Trusts) and community clinical services (Community NHS Trusts) — from purchasers — the Health Authorities, or Boards in Scotland. These retain public health practitioners among their staff. The general practitioners, still independent contractors in 1998, can now be both providers and purchasers of clinical services. These recent changes and the problems they have created have been fully described elsewhere and we do not intend to deal with them in detail here, except in so far as they impinge on the public health function.

The first concern is the role of public health in the control of communicable disease. The law currently lags behind the recent reforms of both the health service and local authorities. No one body or person has a clear legal duty to control infectious disease. Current legal powers lie with local authorities but need decisions by public health physicians who are employed, in the main, by the National Health Service. As a result of such ambiguity, there have been a number of incidents — for example, recent outbreaks of Legionella, food poisoning in a long stay hospital, and E. coli in Lanarkshire[6] and Lothian in Scotland — which have had serious consequences and caused public concern. Such events highlight the need for practitioners with field as well as laboratory experience and good working relationships. Because of the lack of unambiguously clear responsibilities for notification, investigation of patients and their contacts, and for appropriate control measures, unnecessary deaths and illness have occurred.

As public health is principally situated in the purchaser

authority, relationships also have to be established with providers, be they general practitioners or NHS trusts, in a similar way to arrangements before the National Health Service, but with one major difference. There now exists a Public Health Laboratory Service and the micro-biologists in these and other laboratories are no longer under the direct control of local authorities. Although co-ordination is possible and occurs in many instances, clear understanding of responsibility, accountability and relationship needs to be established and sustained if proper control and prevention of infectious disease is to be possible.

The second major problem is that usually the only medically qualified executive director of a Health Authority or Health Board is the Director of Public Health. He or she is able to offer advice and provide knowledge of clinical matters which the other executive and non-executive directors do not have. This is a powerful role. Directors of Public Health now have authority not only in matters concerned with public health but also in areas of clinical concern in which they cannot be expert, such as establishing clinical priorities and monitoring services. Health Authorities or Boards also have fiscal responsibility for disbursement of resources to hospitals, general practitioners and other clinical services.

The public health function is frequently labelled as 'health policy' with public health practitioners made responsible for the process of contracting for clinical services. Some authorities also have executive directors of primary health care development and this too can increase tensions because so much primary care activity now impacts on public health functions.

Once again, therefore, public health is being seduced into assuming responsibility for large budgets which must be spent on clinical services and, once again, public health practitioners believe that they can use this power to improve health. Where this is linked to appropriate means of considering the total expenditure and development of preventive, curative and rehabilitative services, as for example in the Health Care Programme developed by O'Brien and his group for the Medical Royal Colleges,[7] this is to be welcomed. In this

programme — so far developed only for coronary heart disease — the need and cost of the effective programmes to prevent, cure, and rehabilitate patients with coronary heart disease are assessed together. Realistic funding decisions can then be made. This contrasts with the usual contracts — for example, for personnel or for diagnostic services — since it focuses on a specific disease rather than a non-specific service. It can, therefore, be better targeted. To develop this programme, close co-operation is needed between the relevant clinicians and services and public health practitioners. Examples of such clearly formulated methods of working are still relatively rare.

As employees of Health Authorities or Boards, public health practitioners are accountable to their Chief Executive or General Manager who in turn is accountable, hierarchically, to both the Authority or Board and to the Chief Executive of the National Health Service. National Health Service Authorities and Boards are accountable to the Secretary of State but Chief Executives or General Managers are also personally answerable to the NHS Chief Executive for stewardship of funds and assets. They thus have dual accountability. In England, if an Authority is contemplating a course of action that its Chief Executive considers 'would infringe the requirements of propriety and regularity,' he or she is required to 'set out in writing to the chairman and authority your objection to the proposal and the reasons for it. If the authority decides nonetheless to proceed, you should seek in writing instruction to take the action in question...You should also inform the NHSE, if possible before the authority takes its decision or in any event before the decision is implemented so that the Executive can, if necessary, intervene with the authority and inform the Treasury... The accountable officer, should, as a member of the authority vote against the course of action rather than merely abstain from voting.'[8]

This ambiguity and potential for conflict extends also to public health practice. Although Directors of Public Health are theoretically independent and are required to produce annual reports, they are inhibited by nature of the structure within which they work from enunciating and propagating messages

contrary to the views of management or the employing health authority. Their independent role was covered previously by the special protected position of the Medical Officer of Health.

Currently, the Director of Public Health's position as an Executive Director and delegated budget-holder has tended to become a major constraint to freedom to speak freely and deliver, if necessary, a critical, unpopular or controversial public health message. The doctrine of the collective responsibihty of the whole executive team can also be an inhibiting factor in plain speaking. Although medically qualified consultant grade public health physicians have the same security of tenure as other NHS consultants, they are bound by similar rules of public disclosure.

Annual reports, which had largely disappeared with the 1974 reorganisation, were re-introduced with the 1990 reforms. Directors of Public Health within each District and Region in England or Boards in Scotland are again required to publish annual reports. From indifferent beginnings, their quality has improved gradually and, in some authorities, these are considered as the most important publication to direct the programme of work and as a positive opportunity to progress. Over time, however, the impact of many of these reports has diminished. This may be because of a waning of enthusiasm for the task, or because of the lack of resources — both human and financial — available for production, or because it is difficult to avoid being repetitive year after year. Public health messages, on smoking, exercise, overweight, for example, do not change much, nor does environmental advice. For Directors of Pubhc Health to review progress and highlight deficits and deficiencies annually is a daunting task. Furthermore, some see an irreconcilable conflict between their roles as independent advisers and as members of executive teams with collective responsibility.

Many health authorities and boards now publish their own reports concentrating heavily on their achievements and service to patients. Some might consider independent, impartial reports from Directors of Public Health as detracting from these if they reveal problems and deficiencies. Many authorities now

combine the two types of reports with the real possibility that any criticisms can be muffled.

In addition, the performance of health authorities or boards is judged on the basis of a complex formula involving largely fiscal and process measures, such as changes in waiting lists, which are open to manipulation. Potentially, lip service is paid to the achievement of Health of the Nation and similar national targets in terms of judging the performance of health authorities or the use of resources allocated to them; but little account is taken of public health matters and attention to the outcome of services is still at an early stage.

The relationship between the Director of Public Health and public health physicians and the Chief Executive of a Health Authority or Board also contains subtle potential for conflict and tension. The salaries of the Director of Public Health and of consultants in public health medicine are based on a nationally agreed scale; those of the Chief Executive, and other non-medical senior staff, are assessed annually and depend on a performance review which considers achievements in the past year against a set of agreed objectives. These objectives are usually concerned with the development of services, financial control, waiting lists and other process measures. Chief Executives in Health Authorities are personally accountable to the Executive of the National Health Service and will not wish to report any deterioration in the health services, the health status or the risk factors of their population. The Director of Public Health is a member of a corporate health authority team and will prefer not to undermine the Chief Executive. Thus, although in theory the Director of Pubhc Health is free to publish an honest and, if necessary, critical annual report on the health of the local population or on deficiencies in particular services, there are many human and career factors working against complete candour.

Since 1974, service public health practitioners have had to reapply for their positions with each reorganisation — that is, in 1974, 1981, and 1989 — and also on other occasions when districts have been amalgamated or boundaries changed. This continuous turmoil and insecurity has not been conducive to

the development of the properly critical attitudes of the public health professional nor to the willingness of individual practitioners to speak out on issues of clear public health importance.

PUBLIC HEALTH RESPONSIBILITIES TODAY

Major public health problems have tended to recur over the years, sometimes in slightly different guises or with modifications. There are four broad types of problem:

i) outbreaks of disease caused by infective or toxic agents — for example, smallpox, typhoid, food poisoning, BSE, radiation and so on;
ii) problems arising from social and environmental issues such as inadequate housing, unemployment, poverty, abortion, fluoridation of water;
iii) behavioural concerns such as smoking, excessive consumption of alcohol, drug-taking, and insufficient exercise;
iv) health service issues including assessment of health care needs and outcomes, and the effectiveness and efficiency of particular services. Given that these types of problem will continue to be faced in the future, how can the practice of public health be improved to address them directly and try to find solutions for the modern age?

Public health, as a discipline, should not become directly involved in the management of clinical services whether in the community or within institutions — it lacks the expertise essential for this task. Its prime responsibility is to promote health and to prevent and control disease. It should thus have responsibility for surveillance and for the planning and co-ordination of measures which promote and maintain health. It should be involved in the planning and distribution of clinical services in accordance with measures of need and demand and the assessment of effectiveness.

The major academic disciplines of public health, epidemiology, medical statistics and some aspects of the social

sciences including economics, are uniquely combined in training public health practitioners. Their contribution to the inter-disciplinary work needed to develop clinical services in accordance with criteria of need, effectiveness and resource availability has added value because of this breadth.

Public health practitioners must develop and sustain their skills in handling outbreaks of disease and the law must be updated to clarify these responsibilities fully and ensure that these responsibilities are accompanied by the necessary powers to act. Training in epidemiology is crucial to this activity. Public health practitioners need to develop the essential links with microbiology and toxicological laboratories, so important in control of outbreaks, but they must also be appropriately knowledgeable in these disciplines to be able to assess and use this expertise to best effect. Defined responsibilities for this require explicit organisational links and adequate powers to investigate and control any outbreak. For this function, relevant methods of disease surveillance, including notification, are essential.

Thus public health has key needs in the collection, analysis and dissemination of accurate information. It follows that it should have a major role in the design and implementation of appropriate supporting information systems. Public health expertise and needs are related to demographic, social, and environmental data — essential for the measures of utilisation and of outcome — and it must have an understanding of economic principles. It should not, however, be involved in financial, or other purely administrative data, such as those relating to manpower.

It is important for the effective monitoring of health needs and outcome that data collected about patients are linked to individuals, and not merely based on events. Methods of record linkage which respect confidentiality pioneered in Oxford and Scotland should become the norm, as they are in countries such as Sweden and Denmark. Unique patient numbers are central to more effective use of data systems in health care. They were promised for introduction in the United Kingdom in 1996 but have yet to become a reality, apart from in Scotland where

linked data in the form of community health index numbers are now in routine use.

Responsibility for the assessment of health and its maintenance implies the requirement to determine the factors responsible for ill-health. Public health must be involved in appropriate studies, whether epidemiological, sociological, psychological, or statistical, which enable hypotheses to be tested and solutions implemented for the control of ill-health. Its major role is in the identification and planning of appropriate methods of intervention to correct deficiencies and prevent the occurrence of disease. This must be a multidisciplinary activity. In purely medical terms, however, roles can and should be distinguished. The role of public health in the surveillance, identification, planning and co-ordination of measures to prevent, if possible, the occurrence of disease, and to deal with it if it does occur, is central to the specialty. The actual implementation of appropriate preventive, curative and rehabilitative measures is the responsibility of clinicians, in both hospital and general practice.

Screening services may serve as an example of how this can work in practice. As we have stated previously,[9] screening is merely one aspect of health care provision and must be linked to primary prevention including immunisation, health education and adequate easy access to effective treatment. To achieve optimal results, a public health practitioner in each district should be empowered to co-ordinate screening activities. There should be satisfactory population registers with call/recall facilities in every general practice and district, the process of screening must be adapted to the needs of the specific local population, the agreed criteria observed and proper evaluation undertaken of the procedures and results.

Screening programme mishaps can have very high media profiles, as was seen in the review of cervical smear tests in Inverclyde in Scotland in 1993[10] and subsequently elsewhere. Such events naturally cause concern to the public, especially to those personally involved, but they can also result in general improvements to the screening system.

There is a clear distinction in the roles of public health and

clinical medicine in this context. Public health identifies a problem and co-ordinates the service; general practitioners or hospital clinicians provide whatever treatment or management is appropriate. If these distinctions are recognised many of the factors causing friction will be removed or at least modified. The different knowledge and expertise of different medical specialties — and their inevitable overlap — must be acknowledged and respected if effective collaboration is to be achieved.

Screening should also be seen within a national context, introduced routinely only after scientific evidence of benefit, and implemented only when clear aims, objectives and quality standards can be identified and put in place.

HEALTH RISKS

The importance of infectious and toxic hazards in the causation of disease is universally accepted. But not all individuals exposed to a particular hazard succumb. There are a variety of biological, behavioural, social and environmental factors which play a part in the development of these diseases in individuals or populations. In chronic diseases such as cancer of the lung, coronary heart disease, diabetes, or stroke, multiple factors are involved in the development of illness.

Although we accept that certain forms of treatment should be given for particular conditions and certain outcomes expected, there are wide variations within both these parameters.

The main determinants of ill-health are associated with social factors such as unemployment and deprivation, risk-taking behaviours such as cigarette smoking and over-consumption of alcohol, environmental factors such as housing and fluoride — or lack of it — in the water supply, genetic predisposition and the availability and quality of clinical services. The role of public health in finding a way through the jungle of determinants of disease is an extremely complex one. Many of these factors are related inextricably to political, professional and economic realities. Their identification may well antagonise one interest group or other.

Public health physicians, therefore, require diplomatic, political and persuasive skills to achieve the most positive results. These qualities are in short supply in any field of endeavour. Although public health tries to fulfil its role, it has not always been successful either in describing dangers to health clearly and effectively enough or in proposing workable and acceptable solutions. This has become no easier in the past few years when little meaningful attention has been paid to the indisputable relationship between deprivation and ill health.

In this century, most service public health practitioners have been employees of local authorities and of the National Health Service. In terms of local authority employment, 'political' control was variable. In some authorities they were valued as experts providing professional advice; in others their functions were closely controlled by their elected members. In recent years, their freedom has tended to become even more constrained.

If public health is to fulfil its proper function — to improve and maintain health — the specialty must secure the necessary means and freedom both to identify and to disseminate knowledge of the factors that lead to ill health and possible means of solution. This may, on occasion, involve implicating particular groups — for example, tobacco manufacturers, farmers, butchers, and even clinicians. It is obviously of the utmost importance that such knowledge is based on incontrovertible evidence and is presented responsibly — and, where possible, without the hysterical media reportage that has become all too common in recent times. Put plainly, public health must regain an independent voice and use it.

Health authorities have a responsibility to do everything in their power to prevent ill health and to provide clinical services to those who need them. But many of the factors which cause ill health are under the control of other local authority departments or central government and the opportunity for public health to intervene may be limited. Some important public health messages are uncomfortable and unpopular politically and others may have unwelcome resource implications.

RISK COMMUNICATION

Public health's ability to communicate with the media, pressure groups and the pubhc on the concept of health risk also has enormous implications for any future public health structure. Some health risks are the result of deliberate decisions of individuals consciously trying to get the best deal possible for themselves and those important to them, such as the wearing of bicycle helmets and seat belts. Others involve social issues, such as the siting of hazardous waste incinerators, whether to vote for or against fluoridation of pubhc water supplies or whether to support sex education for primary schoolchildren. In some cases, single choices can have a large effect on individual health risk — buying a car with air bags, for example, or becoming pregnant. In others, the effects of individual choices are small but can accumulate over multiple decisions — adding salt to food and using butter rather than margarine. In some cases, choices tend to affect health risks, do nothing at all, or achieve the opposite of what is intended — for example, the adoption of quack treatments.

It is important for individuals to understand the risks and benefits associated with alternative courses of action but balance is vital. If understanding is over-estimated, people may be thrust into situations they are ill-prepared to handle. If understanding is under-estimated, people may be disenfranchised from decisions that they could or should take for their own health benefit. A recurrent obstacle to assessing or improving laymen's estimation of risk is the reliance on verbal qualifiers. Lay people misunderstand when a risk is described as 'very likely' or 'rare' since this means different things to different people or even to the same person in different contexts. Caiman[11] has attempted to develop a scale for this. But estimating the accuracy of risk estimates requires not only an appropriate response mode but also credible statistical estimates against which responses can be compared. Performance is often different for risks with a magnitude which is less readily calculated and people may not see these population risks as personally relevant.

Populations tend to be far more concerned with catastrophic risks rather than life-year expectations of risks. It would appear

that the critical factor in catastrophic potential is not how the deaths are grouped but the possibility of discovering that a technology is out of control.

Thus risk perception and communication of the risks of particular behaviours, environments and events is an extremely complex process. But it is central to any modern public health function and structure and requires greater attention to communication skills than has previously seemed necessary.

POSSIBLE SOLUTIONS

The skills and concerns of public health are generally agreed. However, there remains, at present, confusion between its role in the management of clinical services and its primary role in the management of public health services.

Its present service structure is as part of the corporate team that contracts both public health and clinical services from National Health Service providers for a defined population in a defined geographical area. Public health can thus influence the priorities and distribution of health service resources to improve the health of the population for which it is responsible. However, as the health authorities are appointed by the Secretary of State for Health, they have no direct powers to influence the policies or activities of other departments with responsibilities which impact on health and disease, such as housing, environment, social services or education. These are controlled by locally elected representatives of local councils and their officials. The only way these can be influenced, at local level, is by formal and informal consultative mechanisms or partnership arrangements. Although, theoretically, some transfers of resources between the two types of authority are feasible, they only occur rarely, and the amounts transferred are relatively very small.

At central government level, the Chief Medical Officer of the Department of Health is officially also the Chief Medical Officer to other Departments of State — Education, Home Office, Social Services, Environment. In addition there are formal (and informal) inter-Departmental committees,

including at Cabinet level, to try to develop relevant central governmental pohcies, for example in support of the Health of the Nation targets and programme.

Thus, theoretically, at central government level, the necessary co-ordinating mechanisms for influencing the policies and distribution of resources, to improve health, rather than simply health services, do exist.

But it is at this level that the problem for public health is particularly stark. Although Chief Medical Officers, since the first incumbent John Simon, have been willing to enunciate publicly about health hazards such as inadequate housing or the dangers of cigarette smoking, both their public pronouncements and actions have been circumscribed by their political masters. Recent Chief Medical Officers have had their powers reduced, their resources cut, and their ability to influence policies further constrained.

The difficulties for public health to influence policies or events are even greater at lower levels. We have already referred to the constraints on the annual reports produced by Directors of Public Health and the possibility of influencing resource allocation policies outside the health sector, at local level, is very restricted or non-existent.

Public health, as part of the corporate body responsible for the allocation of funds and development of both clinical care and public health services, should be in a strong position to develop pohcies and services to improve health rather than simply clinical care. But the allocation of resources to any authority, in the United Kingdom, is in the form of block grants. Earmarking amounts for specific purposes is very rare. Thus pubhc health resource needs are always in competition with the needs of clinical services. The latter nearly always take precedence — treatment of individual patients seems far more immediate a priority than changes in health status for the future. The practical needs to maintain buildings, employ clinical staff, buy high technology equipment, for example, also tend to take precedence over more ephemeral public health priorities of teaching children how to live healthily, banning cigarette advertising, or altering road lay-outs to ensure traffic 'calming'

and reduce road traffic accidents.

One solution would be to separate the functions of public health and clinical medicine more clearly and establish an independent public health organisation with its own staff and budget.

POSSIBLE STRUCTURES FOR AN INDEPENDENT PUBLIC HEALTH ORGANISATION

In order to fulfil their role effectively, public health practitioners have to do certain things.

1) They have to be forthright in the advocacy of programmes that improve health and to state clearly and openly the dangers and consequences of some actions, clinical, environmental or political.
2) They have to be able to influence the budget for public health activities and to ensure long-term public health issues are considered on a separate dimension from short-term clinical and practical issues which will otherwise always take precedence.
3) They have to assume a clearly identifiable role in helping to influence and guide the policies not only of health authorities but also of schools, environmental agencies, welfare agencies, housing departments, micro-biological laboratories and practising clinicians in hospital and general practice.

To be able to fulfil these tasks public health must work in close co-operation with other relevant disciplines and must take responsibility for the development, maintenance and operation of the information systems required to maintain first-class intelligence on the health needs of the population, disease control, including prevention and the outcome of public health and clinical policies.[12]

As we have already seen, the present structure does not fulfil these important requirements. Public health practitioners have no control over the required information systems and do not have the practical freedom to report on the health of the

populations for which they are responsible. Their power to influence and guide the activities of bodies other than health authorities is either absent, or rudimentary and informal. Change is needed. The present structure and powers of public health physicians are inappropriate and inadequate to fulfil the essential tasks

There are, in our view, three possible options for a better structure — the return of the Medical Officer of Health, a national Commission of Public Health, or re-creating the Institutes of Public Health within the existing structure.

RETURN OF THE MEDICAL OFFICER OF HEALTH

There is a view that, since many of the factors that influence the health of the population are administered by local government, public health practitioners should be employed by local government, and their co-ordinating and guiding duties to health authorities, hospitals and general practice carried out on an agency basis.

There are two major obstacles to this solution. Firstly, most health information systems are administered by health authorities. Since appropriate guidance has to be based on accurate data and responsibility for information systems is essential if they are to be in a position to deliver that guidance, it is most unlikely that health authorities would be willing or indeed permitted to relinquish these functions. Secondly, although clinical interventions are only one part of the way in which health is maintained and achieved, the role and authority of doctors is vital in understanding, knowledge, and communication. One of the most important roles of public health is in the surveillance, prevention and control of disease, whatever its cause. It is important that highly qualified medical doctors are attracted to public health not only to cope with the public health problems but also to communicate with the public, policy-makers and other practitioners. They play a central role in the planning of health services. If public health were not considered as a mainstream health activity, it is likely that the status of the subject and its attraction for medical

graduates would diminish and public health and the health service in general would be the poorer.

NATIONAL COMMISSION OF PUBLIC HEALTH

This option envisages a Commission which would also encompass the Public Health Laboratory Service, a central Toxicological Laboratory, the National Poison Centre and perhaps even the National Radiation Protection Board. The Commission should have a budget agreed not only for the expenses and staffing of these laboratories but also for the cost of all of the service public health practitioners throughout the country. Although the appointment and payment of public health practitioners would be undertaken by the Commission, most would be located in Districts or Boards. Each health authority would continue to have a Director of Public Health and several consultant posts well as trainees. But all public health practitioners would be on the staff of the Commission and those at local level seconded there for fixed, renewable periods. Directors of Public Health would continue as members of health authorities but would be ultimately accountable to the Director of the Commission and not to the Chief Executive of the District.

The Chairman of such a Commission's Governing Council would be elected for a fixed term by Council members, nominated by appropriate bodies, who would also be elected and serve for a fixed term of office. The budget of the Commission would be set and agreed by the Ministry of Public Health. The Council of the Commission would report to Parliament and thus be independent of the government of the day.

The Director of the Commission would be appointed by the Council and would report to it. The Commission staff centrally would be made responsible for providing strategic direction for public health nationwide, supporting the district and board practitioners and functions, particularly by provision of specialist laboratories and expertise and by collaborating with academic departments in the commissioning and execution of public

health research. The Commission would have responsibilities to develop, monitor and accredit suitable training programmes for public health staff. This should be done in conjunction with the Faculty of Public Health Medicine and with academic departments. The Commission would have responsibility for the development and maintenance of an information system which would satisfy the public health needs as outlined elsewhere.[13]

At all levels of staffing the need for multidisciplinary working would be paramount. Consultant level appointments would be needed not only for those with a medical qualification, but also for statisticians, social scientists, and health economists. For all disciphnes it would be essential to have a proper education and training programme and not merely a university degree. For some posts, for example, communicable disease control, a basic medical training would obviously be essential. For others, this might be helpful but not mandatory. Refresher training and continuing professional development should also be integral to the service.

In order to fulfil better the requirement to consider the public health implications of clinical, social, educational and environmental actions and policies, the locally based public health consultants should have clearly defined appointments to hospital and community trusts, general practice, local authority social service, education and environmental departments. Although the local consultants would be appointed by the Commission, the appropriate local agencies would also be involved in this. The duty of the public health staff in these groups, trusts, or departments would be to advise and encourage the development of policies and practices which promote and maintain health.

This structure and these responsibilities imply that those concerned with public health who are not medically qualified would be working much more closely, and on equal terms, with public health medical officers. This is similar to the position of non-medical scientists working with medically qualified ones in laboratories and university departments. For this to succeed, it would be necessary to ensure that both the periods of training and their supervision and the salaries of all public health staff of

equivalent grade were similar. This would be one of the major and most contentious tasks of the Commission.

The Faculty of Public Health Medicine and the Royal College of Pathologists would continue to be responsible for the maintenance of professional standards of the medical public health practitioners and laboratory staff, in the same way as the Royal Statistical Society, for example, is for statisticians. Both bodies would continue to play a role in the appointment of consultants, and with the Commission, in the recognition, development and accreditation of training.

The obvious advantages of this model are the independence that public health practitioners would have in both their action and reports, the recognition of the importance of a multidisciplinary approach, and an acknowledgement of the clear differences between clinical services and public health services.

There are, however, various problems with this option which effectively preclude its adoption as a practicable proposition. The most obvious of these are firstly that the establishment of a free standing commission, controlling not only action but also staffing and training, might stifle local initiative and secondly it would be a bold and imaginative government who would be prepared to grant the commission the wide remit proposed or meet the full cost implications of the equivalence of salaries of all staff whether medically qualified or not.

The experience of such an organisation for public health in New Zealand has demonstrated how easy it is to relegate public health functions and abolish independence when uncomfortable decisions have to be made. —

> The New Zealand experiment, with a Public Health Commission separate from the Ministry of Health, must be viewed as a failure. The ultimate evidence of this failure is the premature ending of the Public Health Commission because its semi-independent nature was seen as a threat to the Government... Independent public health policy advice to government is desirable, even if not always desired. The New Zealand experience suggests that the institutional base for such advice must be securely supported by all major political parties as well as by the public health community. Without strong support, the existence of semi-independent public health agencies will be precarious.

MODIFICATION OF PRESENT STRUCTURE WITH RE-CREATION OF INSTITUTES OF PUBLIC HEALTH

A more realistic modification of the full Commission of Public Health option might be to reinforce the role of public health at district or board level — whether in health or local authorities — by the re-creation of expert regional institutes with a national institute, including micro-biological and toxicological laboratories. For pubhc health to function effectively it needs access to expertise. This can be provided to a large extent through universities and research units but there is also a need to have an identifiable practical resource with service responsibilities

This option would retain a Director of Pubhc Health and consultant grade public health practitioners in each District or Board. Their function would be that of co-ordinator, with access to and responsibility for all information services and the duty to guide with advice, not to direct, except in special circumstances.

Public health physicians should once again have specially secured positions as Medical Officers of Health had before 1974. Public health physicians should again be involved at both central and local level in the discussions of bodies concerned with the environment, social services, education, nutrition, housing so that the influence, for example, of housing policy on health is fully recognised.

By requiring public health at local level to participate in and influence the decisions which in turn will influence health, the wide diversity of different parts of the country can be recognised and a positive sense of local ownership encouraged.

If this option were adopted local authorities would again need to become involved in the appointment of public health physicians. This option emphasises the fact that public health should be concerned largely with its own issues rather than with clinical service management and contracting. This model could also be used to promote involvement with general practice and hospitals locally and remove or reduce many of the current conflicts and difficulties between different specialties.

At central level, the ability of the Chief Medical Officer to guide policy on tobacco, food, transport, and education should

be strengthened and public health expertise consulted in policy decision-making.

WHERE NEXT?

The last option is the most realistic way forward and the one that, we would argue, is most likely to be both practicable and productive.

If it were were adopted, the boundaries for public health would be more clearly demarcated and the different functions of public health and health and clinical services management properly defined. This should have the added benefit of reducing the tensions that currently exist, enabling the service as a whole to concentrate on the twin objectives of health services of curing or at least helping the currently ill and laying the foundations for future improvement in health for the population as a whole.

The establishment of this modified structure and the better definition of roles, however, would not ensure, on its own, that health is improved. It might, however, lead to more clarity and action to modify the health effects of poverty, reduce the health hazards of behaviour such as smoking, and improve the ability to control and prevent outbreaks of disease, whether infectious or toxicological. It should also lead to clearer messages being given on clinical policies that improve health or do harm, whether it be changing from institutional to outpatient care or the development of screening services.

Any of the options involve strengthening the public health role, giving it clearer focus and ensuring its ability to provide independent advice and strategic direction. But the precise structure to be adopted does require wider discussion between all interested groups. Such discussion would also highlight the problems of local governance. Public health works in relation to defined populations. Health authorities at present also have responsibilities for defined groups but none for some of the major factors responsible for ill health. They are also appointed and may thus be less effective in influencing social and environmental policies. Hospitals do not generally serve strictly

defined populations and are thus inappropriate bases for some public health activities. Local authorities, although elected, now have little interest in health affairs — and certainly their current budgets are quite inadequate to fulfil health requirements. They now have no regional tier to provide the wider expertise and co-ordination required for and by public health. The regional tier of the current health system cannot fulfil the role that we have identified with its rudimentary resources and in view of its incorporation in the central governmental machinery.

An essential ingredient for progress is clarification of the role of individuals required to perform the public health function and thus has implications for staffing and personnel. Many of the interdisciplinary tensions within public health arise from lack of clarity about the nature of expertise and false beliefs about the abilities of different professional groups. As we have already emphasised, to fulfil some of the service requirements medically qualified public health physicians are needed. Medical knowledge and skills are essential, in particular, in the control, surveillance and prevention of diseases, both infectious as well as chronic. Medical expertise is also required in the assessment, evaluation and planning of clinical care requirements and is helpful for the co-ordination of activities and policies with hospital and general practice clinicians.

If public health is to play the wider role envisaged, it is essential that the interdisciplinary nature and working of the discipline is established more firmly than at present. In the investigation of an outbreak of infectious disease, for example, the consultant in communicable disease control has to work with microbiologists and with environmental health officers trained in environmental investigation and control. To devise appropriate programmes of health promotion for a school, public health workers must be trained in education, psychology and sociology. Medical statisticians are important for the successful analysis and interpretation of data.

Only if public health physicians accept fully that they must work on equal terms with other qualified health professionals of similar status will it be possible to achieve the crucial development and application of policies that can improve the

population's health.

The proposals also have implications for the often uneasy interface between service and academic public health. Part of this is a result of the different emphases of these two branches of the specialty. Academics can seem indifferent about the practical application of findings and some appear to consider that some service preoccupations are mundane in comparison with the development of knowledge. Similarly, the service side has sometimes seemed preoccupied with day-to-day problems and unwilling to invest in research efforts without an immediate pay-off.

There are of course many exceptions to these generalisations. One such is the long-running MIDSPAN study in the west of Scotland — an excellent example of multidisciplinary collaboration between Argyll and Clyde Health Board and the medical faculty of the University of Glasgow.[14] A proliferation of examples like this should help the relationship between academic and service public health to become as close as that of an academic department of medicine and those responsible for clinical care.

Public health research has been relatively neglected in recent times.[15] The Research Assessment Exercise has had a regressive effect on public health research, particularly on studies of the most effective and efficient configuration of health services since these are perceived as being unlikely to rank highly internationally. Research on effective intervention strategies has seemed to be given lower priority, partly perhaps because possibilities of implementation of findings have been uncertain. With clear managerial responsibilities, the need to develop effective programmes, for example, to prevent children from taking up smoking, to determine whether particular waste disposal means are safe, or even more importantly what interventions are effective in reducing the damage to health of poverty, may become more relevant. This should also lead those responsible for research fund allocations to give these a higher priority. The future of public health research has been discussed in detail elsewhere.[16]

CONCLUSION

Public health has come a very long way and made massive inroads into disease within the relatively short period covered by this book. It has progressed through the vision and commitment of the pubhc health giants of the past. It has also suffered disappointments, reversals and missed opportunities.

In looking at the three options suggested, we would argue that a return to the era of the Medical Officer of Health would risk another sidelining of the specialty at a time when it must be at the centre of the health scene. The radical option of the establishment of an independent pubhc health commission is of course attractive but it does not seem feasible that any government of whatever political complexion would be willing to support persistently and fund such a body at an adequate level. We, therefore, favour the third option of modifying and extending the present structure of public health within health authorities and boards but with the addition of a national and several regional institutes.

Public health is now, it seems to us, at a crossroads where it can either accept the status quo or confront realistic change and challenge and seek to regain its former independent voice. It is more than time, for example, to nail the 'libertarian' myth that individual freedom and the right to choose are worth more than the improvement in the health of the population as a whole. Pubhc health does not and should not seek to patronise, wet-nurse or coerce the population into 'health', as is sometimes suggested by powerful critics with vested interests.

But the specialty surely has a duty to inform the public responsibly on pubhc health matters, to fight the active promotion of products, such as cigarettes, which have a well proven adverse effect on health, and to seek the introduction of simple public health measures, such as fluoridation of public water supplies, which would provide enormous benefits, particularly in more deprived sectors of the population.

We perceive public health as the central medical specialty of the future — as described in the quotation at the beginning of this chapter. It now has a clear and workable definition of its proper functions and we hope it will find the courage and unity

to face the challenge of realistic change in pressing for the return of its independent voice.

Of course this is a personal view. But the political climate now seems right for such a move to lay the foundations for a real improvement in the nation's health in the next century. The Labour Government, elected in May 1997, has in principle accepted the central importance of public health. It has created the new post of Minister of Public Health and has published a Green Paper earlier this year on *Our Healthier Nation.* In the 1997 White Paper on the NHS,[17,18] it acknowledges the need for a health service that 'does not just treat people when they are ill but works with others to improve health and reduce health inequalities'. And public health has surely learned from the lessons of history the real power of political expediency which combines opportunism and realism.

This we hope will be the new vision and challenge for public health.

References

1) *Public Health in England.The* Report of the Committee of Inquiry into the Future Development of the Public Health Function (The Acheson Report). London: HMSO, 1988.
2) Abel-Smith B. *The Hospitab 1800-1948.* London: Heinemann, 1964.
3) Godber Sir George. Persona] communication, 1997.
4) M'Gonigle GCM, Kirby J. *Poverty and Public Health.* 1936.
5) NHS Act 1990. London: HMSO, 1990.
6) The Pennington Report. Edinburgh: HMSO, 1997.
7) O'Brien M, Halpin J, Hicks N, Pearson S, Warren V, Holland WW. *Health Care Commissioning Development Project.].* Epidermiol, 1996, 6: 589-592.
8) NHS Executive Letter to Chairmen of NHS Trusts or Health Authorities on Accountable Officers. EL(96) 59. 10 July 1996.
9) Holland WW, Stewart S. *Screening in Health Care.* London: Nuffield Provincial Hospitals Trust, 1990.
10) Scottish Office. *Report of the Inquiry into Cervical Cytology at Inverclyde Royal Hospital, Greenock.* (McGoogan Report). Edinburgh: HMSO, 1993.
11) Caiman Sir Kenneth. *CMO Report for England and Wales* London: HMSO, 1996.
12) Holland WW. *Achieving an ethical health service: the need for information.* Journal of the Royal College of Physicians of London 1995, 29: 325-334.

13) Beaglehole R, Bonita R. *Public Health at the Crossroads.* Cambridge: Cambridge University Press, 1997.
14) Hawthorne VM, Watt GCM, Hart CH, Hole DJ, Smith GD, Gillis CR. *Cardiorespiratory disease in men and women in Scotland: baseline characteristics of the Renfrew/Paisley (Midspan) study population.* Scot Med J 1995, 40: 102-107.
15) House of Lords: Priorities for Medical Research, 1988.
16) Holland WW, Fitzsimmons B, O'Brien JM. *The future of public health research.* Journal of Public Health Medicine 16:4-10, 1994.
17) *The new NHS - modern, dependable.* Cmnd 3807. London: HMSO, 1997.
18) *Designed to Care - renewing the National Health Service in Scotland.* Cmnd 3811. Edinburgh: HMSO, 1997.

Annexe 1.

Prime Ministers and Health Ministers of Britain 1919-1997

General Election	Party	Prime Minister	Health Minister
1918 December	Coalition	Lloyd George	Dr Charles Addison Sir Arthur Mond (from April 21)
Local Government Board became the Ministry of Health on 24 June 1919			
1922 November	Conservative Conservative	Bonar Law Stanley Baldwin (from May 23)	Sir Arthur Griffith-Boscawen Neville Chamberlain Sir William Joynson-Hicks (from Aug 23)
1924 January	Labour	Ramsay MacDonald	John Wheatley
1924 November	Conservative	Stanley Baldwin	
1929 June	Labour	Ramsay MacDonald	John Wheatley
1931 August	National	Ramsay MacDonald	Neville Chamberlain
1931 November	National	Ramsay MacDonald	Sir Edward Young
1935 June	National	Stanley Baldwin	Sir Kingsley Wood
1935 November	National	Stanley Baldwin	Sir Kingsley Wood
1937 May	National	Neville Chamberlain	Sir Kingsley Wood
1939 September	National	Neville Chamberlain	Walter Elliot (from May 38)
1940 May	Coalition	Winston Churchill	Malcolm MacDonald Ernest Brown (from Feb 41) Henry Willink (from Nov 43)
1945 May	Conservative	Winston Churchill	Henry Willink
1945 July	Labour	Clement Attlee	Aneurin Bevan (from Aug 45)
1950 March	Labour	Clement Attlee	Aneurin Bevan Hilary Marquand (from Jan 51)
1951 October	Conservative	Winston Churchill	Harry Crookshank Iain Macleod (from May 52)
1955 April	Conservative	Sir Anthony Eden	Iain Macleod Robin Turton (from Dec 55)

General Election	Party	Prime Minister	Health Minister
1957 January	Conservative	Harold Macmillan	Dennis Vosper Derek Walker-Smith (from Sept 57
1959 October	Conservative	Harold Macmillan	Derek Walker-Smith Enoch Powell (from July 60)
1963 October	Conservative	Sir Alec Douglas-Home	Anthony Barber
1964 October	Labour	Harold Wilson	Kenneth Robinson
1966 March	Labour	Harold Wilson	Kenneth Robinson
Department of Health and Social Security was established in April 1968			
			Richard Crossman (from April 68)
1970 June	Conservative	Edward Heath	Keith Joseph
1974 February	Labour	Harold Wilson	Barbara Castle
1974 October	Labour	Harold Wilson	Barbara Castle
1976 April	Labour	James Callaghan	Barbara Castle
1979 May	Conservative	Margaret Thatcher	Patrick Jenkin Norman Fowler (from Sept 81)
1983 June	Conservative	Margaret Thatcher	Norman Fowler
1987 June	Conservative	Margaret Thatcher	John Moore
Department of Health and Social Security was divided in January 1990 and Health restored as an independent department			
			Kenneth Clarke (from Jan 1990)
In November 1990 Margaret Thatcher was replaced as leader of the Conservative Party and thus Prime Minister by John Major. This did not necessitate a General Election.			
		John Major	William Waldegrave (from Nov 90)
1992	Conservative	John Major	Virginia Bottomley Stephen Dorrell (from July 95)
1997 May	Labour	Tony Blair	Frank Dobson

Annexe 2.

Summary and recommendations from the Black Report on Inequalities in Health

1) Most recent data show marked differences in mortahty rates between the occupational classes, for both sexes and at all ages. At birth and in the first month of life, twice as many babies of'unskilled manual' parents (class v) die as do babies of professional class parents (class i) and in the next eleven months nearly three times as many boys and more than three times as many girls. In later childhood the ratio of deaths in class v to deaths in class I falls to 1.5-2.0, but increases again in early adult life, before falling again in middle and old age. A class gradient can be observed for most causes of death, being particularly steep in the case of diseases of the respiratory system. Available data on chronic sickness tend to parallel those on mortahty. Thus self-reported rates of long-standing illness (as defined in the General Household Survey) are twice as high among unskilled manual males and 2.5 times as high among their wives as among the professional classes. In the case of acute sickness (short-term ill health, also as defined in the General Household Survey) the gradients are less clear.

2) The lack of improvement, and in some respects deterioration, of the health experience of the unskilled and semi-skilled manual classes (class V and IV), relative to class I, throughout the 1960s and early 1970s is striking. Despite the decline in the rate of infant mortality (death within the first year of life) in each class, the difference in rate between the lowest classes (IV and V combined) and the highest (i and II combined) actually increased between 1959-63 and 1970-72.

3) Inequalities exist also in the utilisation of health services, particularly and most worryingly of the preventive services. Here, severe under-utilisation by the working classes is a complex result of under-provision in working class areas and of costs (financial and psychological) of attendance which are not, in this case, outweighed by disruption of normal activities by sickness. In the case of GP and hospital in-patient and out-patient attendance, the situation is less clear. Moreover it becomes more difficult to interpret such data as exist, notably because of the (as yet unresolved) problem of relating utilisation to need. Broadly speaking, the evidence suggests that working class people make more use of GP services for themselves (though not for their children) than do middle class people, but that they may receive less good care. Moreover, it is possible that this extra usage does not fully reflect

the true differences in need for care, as shown by mortality and morbidity figures. Similar increases in the use of hospital services, both in-patient and out-patient, with declining occupational class are found, though data are scanty, and possible explanations complex.

4) Comparison of the British experience with that of other industrial countries, on the basis of overall mortality rates, shows that British perinatal and infant mortality rates have been distinctly higher and are still somewhat higher than those of the four Nordic countries and of the Netherlands, and comparable with those of the Federal Republic of Germany. Adult mortality patterns, especially for men in the younger age groups, compare reasonably with other Western industrialised countries: the comparison for women is less satisfactory. The rate of improvement in perinatal mortality experienced by Britain over the period since 1960 has been comparable to that of most other countries. In the case of infant mortality (which is generally held to reflect social conditions more than does perinatal mortality) all comparable countries - especially France - have shown a greater improvement than has Britain. France, like Britain and most other countries considered (though apparently not Sweden), shows significant class and regional inequalities in health experience. It is noteworthy that through the 1960s the ratio of the post-neonatal death rate (between four weeks and one year) in the least favoured social group to that in the most favoured fell substantially in France. Also important, probably, has been a major French effort to improve both attendance rates for ante-natal care and the quality of such care. Very high rates of early attendance are also characteristic of the Nordic countries; so too are high rates of attendance at child welfare clinics, combined with extensive 'outreach' capacity. In Finland, for example, whenever an appointment at a health centre is missed, a health visitor makes a domiciliary call. We regard it as significant also that in Finland health authorities report not on the volume of services provided, but on the proportion of all pregnant women and of all children of appropriate ages who register with Health Centres.

5) We do not believe there to be any single and *simple explanation* of the complex data we have assembled. While there are a number of quite distinct theoretical approaches to explanation we wish to stress the importance of differences in material conditions of life. *In our view much of the evidence on social inequalities in health can be adequately understood in terms of specific features of the socio-economic environment:* features (such as work accidents, overcrowding, cigarette-smoking) which are strongly class-related in Britain

and also have clear causal significance. Other aspects of the evidence indicate the importance of the health services and particularly preventive services. Ante-natal care is probably important in preventing perinatal death, and the international evidence suggests that much can be done to improve ante-natal care and its uptake. But beyond this there is undoubtedly much which cannot be understood in terms of the impact of so specific factors, but only in terms of the more diffuse consequences of the class structure: poverty, working conditions, and deprivation in its various forms. It is this acknowledgement of the *multi-causal* nature of health inequalities, within which inequalities in the material conditions of living loom large, which informs and structures our policy recommendations. These draw also upon another aspect of our interpretation of the evidence. We have concluded that early childhood is the period of life at which intervention could most hopefully weaken the continuing association between health and class. There is, for example, abundant evidence that inadequately treated bouts of childhood illness 'cast long shadows forward', as the Court Committee put it.

6) We have been able to draw upon national statistics relating to health and mortahty of exceptional quality and scope, as well as upon a broad range of research studies. We have, however, been conscious of certain inadequacies in the statistics and of major lacunae in the research. For example it is extremely difficult to examine health experience and health service utilisation, in relation to income and wealth.

7) Moreover, we consider that the *form* of administrative statistics may both reflect and determine (as the Finnish example quoted above suggests) the way in which the adequacy and the performance of a service is understood: hence it acquires considerable importance. We also consider systematic knowledge of the use made of the various health services by different social groups to be inadequate: though this is less the case in Scotland than in England and Wales. While conscious of the difficulties in collecting and reporting of occupational characteristics within the context of administrative returns, we feel that further thought must be given to how such difficulties might be overcome. We argue that the monitoring of *ill health* (itself so imperfect) should evolve into a system also of monitoring *health* in relation to social and environmental conditions. One area in which progress could be made is in relation to the development of children, and we propose certain modifications to community health statistics.

1) *We recommend that school health statistics should routinely provide, in relation to occupational class, the results of tests of hearing, vision, and measures of height and weight. As a first step we recommend that local health authorities, in consultation with educational authorities, select a representative sample of schools in which assessments on a routine basis be initiated.* (Chapter 7, p127)

8) *Aaidents* are not only responsible for fully one-third of child deaths, but show (with respiratory disease) the steepest of class gradients.

9) We should like to see progress towards routine collection and reporting of accidents to children indicating the circumstances, the age and the occupational class of the parents. In relation to traffic accidents there should be better liaison between the NHS and the police, both centrally and locally.

2) *We therefore recommend that representatives of appropriate government departments (Health and Social Security, Education and Science, Home Office, Environment, Trade, Transport), as well as of the NHS and of the police, should consider how progress might rapidly be made in improving the information on aaidents to children.* (Chapter 7, pl28)

10) The Child Accident Prevention Committee, if suitably constituted and supported, might provide a suitable forum for such discussions, to be followed by appropriate action by government departments. Further,

3) *We recommend that the Health Education Council should be provided with sufficient funds to mount child accident prevention programmes in conjunction with the Royal Society for the Prevention of Accidents. These programmes should be particularly directed at local authority planners, engineers and architects.* (Chapter 9, p182)

11) While drawing attention to the importance of the National Food Survey as the major source of information on the food purchase (and hence diet) of the population, we are conscious of the scope for its improvement.

4) *We recommend that consideration be given to the development of the National Food Survey into a more effective instrument of nutritional surveillance in relation to health, through which various 'at risk'groups could also be identified and studied.* (Chapter 7, p128)

12) We have already referred to the difficulties in examining health experience in relation to income and wealth. In principle this can be done through the

General Household Survey in which the measure of income now (since 1979) corresponds to the more satisfactory measure employed in the Family Expenditure Survey. However,

5) *We recommend that in the General Household Survey steps should be taken (not necessarily in every year) to develop a more comprehensive measure of income, or command over resources, through either a) a means of modifying such a measure with estimates of total wealth or at least some of the more prevalent forms of wealth, such as housing and savings, or b) the integration of income and wealth, employing a method of, for example, annuitisation.* (Chapter 1, p41)

13) Beyond this, we feel that a comprehensive research strategy is needed. This is best regarded as implying the need for careful studies of a wide range of variables implicated in ill-health, in their *interaction over time,* and *conducted in a small number of places.* Such variables will necessarily include social conditions (and the interactions of a variety of social policies) as well as individual and behavioural factors. Any major advance in our understanding of the nature of health inequalities, and of the reason for their perpetuation, will require complex research of a multi-disciplinary kind.

6) *The importance of the problem of social inequalities in health, and their causes, as an area for further research needs to be emphasised. We recommend that it be adopted as a research priority by the DHSS and that steps be taken to enlist the expertise of the Medical Research Council (MRC), as well as the Social Science Research Council (SSRC), in the initiation of a programme of research. Such research represents a particularly appropriate area for departmental commissioning of research from the MRC.* (Chapter 7, p129)

14) We turn now to our recommendations for policy, which we have divided into those relating to the health and personal social services, and those relating to a range of other social policies. Three objectives underpin our recommendations, and we recommend their adoption by the Secretary of State:

— To give children a better start in life.

— To encourage good health among a larger proportion of the population by preventive and educational action.

— For disabled people, to reduce the risks of early death, to improve the quality of life whether in the community or in institutions, and as far as possible to reduce the need for the latter.

Thirty years of the Welfare State and of the National Health Service have achieved little in reducing social inequalities in health. But we believe that if these three objectives are pursued vigorously inequalities in health can now be reduced.

15) We believe that *allocation of resources* should be based on need. We recognise that there are difficulties in assessing need, but we agree that standardised mortality ratios (SMRs) are a useful basis for broad allocation at regional level. At district level, further indicators of health care and social needs are called for. These should be developed as a matter of urgency, and used appropriately to reinforce, supplement or modify allocation according to SMRs. *However, a shift of resources is not enough: it must be combined with an imaginative (and in part necessarily experimental) approach to health care and its delivery.*

 7) *Resources within the National Health Service and the personal social services should be shifted more sharply than so far accomplished towards community care, particularly towards ante-natal, post-natal and child health services, and home-help and nursing services for disabled people. We see this as an important part of a strategy to break the links between social class or poverty and health.* (Chapter 8,pl36)

 8) *The professional associations as well as the Secretary of State and the health authorities should accept responsibility for making improvements in the quality and geographical coverage of general practice, especially in areas of high prevalence of ill-health and poor social conditions. Where the number or scope of work of general practitioners is inadequate in such areas we recommend health authorities to deploy or redeploy an above-average number of community nurses attached where possible to family practice. The distribution of general practitioners should be related not only to population but to medical need, as indicated by SMRs, supplemented by other indicators, and the per capita basis of remuneration should be modified accordingly.* (Chapter 8, p145)

16) Moreover, we consider that greater integration between the planning process (and the establishment of priorities) and resources allocation is needed. In particular the establishment of revenue targets should be based not upon the current distribution of expenditure between services, but that distribution which it is sought to bring about through planning guidelines: including a greater share for community health.

 9) *We recommend that the resources to be allocated should be based upon the future*

planned share for different services, including a higher share for community health. (Chapter 8, p142)

17) Our further health service-related recommendations, designed to implement the objectives set out above, fall into two groups.

18) We first outline the elements of what we have called a District Action Programme. By this we mean a general programme for the health and personal social services to be adopted nationwide, and involving necessary modifications to the structure of care.

19) Second, we recommend an experimental programme, involving provision of certain services on an experimental basis in ten areas of particularly high mortality and adverse social conditions, and for which special funds are sought.

District action programme

Health and Welfare of mothers and pre-school and school children

10) *A non-means-tested scheme for free milk should now be introduced beginning with couples with their first infant child and infant children in large families.* (Chapter 8, p134)

11) *Areas and districts should review the accessibility and facilities of all ante-natal and child-health clinics in their areas and take steps to increase utilisation by mothers, particularly in the early months of pregnancy.* (Chapter 8, p143)

12) *Savings from the current decline in the school population should be used to finance new services for children under five. A statutory obligation should be placed on local authorities to ensure adequate day care in their area for children under 5, and that a minimum number of places (the number being raised after regular intervals) should be laid down centrally. Further steps should be taken to reorganise day nurseries and nursery schools so that both meet the needs of children for education and care.* (Chapter 8, p146 and Chapter 9, pl74)

13) *Every opportunity should be taken to link revitalised school health care with general practice, and intensify surveillance and follow-up both in areas of special need and for certain types of family.* (Chapter 8, pl47)

20) Some necessary developments apply to other groups as well as children and mothers.

14) *An assessment which determines severity of disablement should be adopted as a guide to health and personal social service priorities of the individual, and this should be related to the limitation of activities rather than loss of faculty or type of handicap.* (Chapter 8, p147)

21) Though we attach priority to the implementation of this recommendation in the care of disabled children, we believe that it must ultimately apply to all disabled people. We recognise that such assessments are now an acknowledged part of'good practice' in providing for the disabled — we are anxious that they should become standard practice.

The care of elderly and disabled people in their own homes

22) The meaning of community care should be clarified and much greater emphasis given to tendencies favoured (but insufficiently specified) in recent government planning documents. (See Recommendation 7.)

15) *A Working Group should be set up to consider:*

i) the present functions and structure of hospital, residential and domiciliary care for the disabled elderly in relation to their needs, in order to determine the best and most economical balance of future services; (Chapter 8,p151) and

ii) whether sheltered housing should be a responsibility of social service or of housing departments, and to make recommendations. (Chapter 8, p149)

16) *foint funding should be developed and further funding of a more specific kind should be introduced, if necessary within the existing NHS budget to encourage joint care programmes. A further sum should be reserved for payment to authorities putting forward joint programmes to give continuing care to disabled people —for example, post-hospital follow-up schemes, pre-hospital support programmes for families, and support programmes for the severely incapacitated and terminally ill.* (Chapter 8, p152)

17) *Criteria for admission to, and for continuing residence in, residential care should be agreed between the DHSS and the local authority associations, and steps taken to encourage rehabilitation, and in particular to prevent homeless elderly people from being offered accommodation only in residential homes. Priority should be given to expansion of domiciliary care for those who are severely disabled in their own homes.* (Chapter 8, p149)

18) *The functions of home helps should be extended to permit a lot more work on*

behalf of disabled people; short courses of training, specialisation of functions and the availability of mini-bus transport, especially to day centres, should be encouraged. (Chapter 8, p152)

Prevention: the role of government

23) Effective prevention requires not only individual initiative but a real commitment by the DHSS and other government departments. Our analysis has shown the many ways in which people's behaviour is constrained by structural and environmental factors over which they have no control. Physical recreation, for example, is hardly possible in inner city areas unless steps are taken to ensure that facilities are provided. Similarly, government initiatives are required in relation to diet and to the consumption of alcohol. Legislation and fiscal and other financial measures may be required and a wide range of social and economic policies involved. We see the time as now opportune for a major step forwards in the field of health and prevention.

19) *National health goals should be established and stated by government after wide consultation and debate. Measures that might encourage the desirable changes in people's diet, exercise and smoking and drinking behaviour should be agreed among relevant agencies.* (Chapter 8, p154)

20) *An enlarged programme of health education should be sponsored by the government, and necessary arrangements made for optimal use of the mass media, especially television. Health education in schools should become the joint responsibility of LEAs and health authorities.* (Chapter 8, p153)

24) The following recommendation should be seen not only as a priority in itself but as illustrative of the determined action by government necessary in relation to many elements of a strategy for prevention:

21) *Stronger measures should be adopted to reduce cigarette smoking. These would include:*

a) Legislation should be rapidly implemented to phase out all advertising and sales promotion of tobacco products (except at place of purchase);
b) Sponsorship of sporting and artistic activities by tobacco companies should be banned over a period of a few years, and meanwhile there should be stricter control of advertisement through sponsorship;
c) Regular annual increases in duty on cigarettes in line with rises in income

should be imposed, to ensure lower consumption;

d) *Tobacco companies should be required, in consultation with trade unions, to submit plans for the diversification oftheir products over a period often years with a view to the eventual phasing out of sales of harmful tobacco products at home and abroad;*

e) *The provision of non-smoking areas in public places should steadily be extended;*

f) *A counselling service should be made available in all health districts, and experiment encouraged in methods to help people reduce cigarette smoking;*

g) *A stronger well-presented health warning should appear on all cigarette packets and such advertisements as remain, together with information on the harmful constituents of cigarettes.* (Chapter 8, p154)

We have already recommended that steps be taken to increase utilisation of ante-natal clinics, particularly in the early months of pregnancy (Recommendation 11). Given early attendance there are practical programmes for screening for Down's Syndrome and for neural tube defects in the foetus. In relation to adult disease, screening for severe hypertension is practicable, and effective treatment is available.

22) *In the light of the present stage of knowledge we recommend that screening for neural tube defects (especially in high risk areas) and Down's Syndrome on the one hand, and for severe hypertension in adults on the other, should be made generally available.* (Chapter 8, p156)

Additional funding for ten special areas

23) *We recommend that the government should finance a special health and social development programme in a small number of selected areas, costing about £30m in 1981-2.* (Chapter 8, p157)

25) At least £2m of this sum should be reserved for evaluation research and statistical and information units. The object would be both to provide special help to redress the undeniable disadvantages of people living in those areas, but also to permit special experiments to reduce ill health and mortality, and provide better support for disabled people. Some elements of such a programme are illustrated, particularly in connection with the development of more effective ante-natal services. (Chapter 8, pp157-9)

Measures to be taken outside the health services

26) In discussing actions outside the Health Care system which need to be taken to diminish inequalities of health we have been necessarily selective. We have attempted to pay heed to those factors which are correlated with the *degree* of inequalities. Secondly, we have tried to confine ourselves to matters which are practicable now, in political, economic and administrative terms, and which will none the less, properly maintained, exert a long-term structural effect. Thirdly, we have continued to feel it right to give priority to young children and mothers, disabled people, and measures concerned with prevention.

27 Above all, we consider that the *abolition of child poverty* should be adopted as a national goal for the 1980s. We recognise that this requires a redistribution of financial resources far beyond anything achieved by past programmes, and is likely to be very cosdy. Recommendations 24-27 are presented as a modest first step which might be taken towards this objective.

24) *As an immediate goal the level of child benefit should be increased to 5.5 per cent of average gross male industrial earnings, or £5.70 at November 1919 prices.* (Chapter 9, p171)

25) *Larger child benefits should be progressively introduced for older children, after further examination of the needs of children and consideration of the practice in some other countries.* (Chapter 9, pp170-71)

26) *The maternity grant should be increased to £100.* (Chapter 9, p171)

27) *An infant care allowance should be introduced over a five-year period, beginning with all babies born in the year following a date to be chosen by the government.* (Chapter 9, p172)

28) Beyond these initial elements of an anti-poverty strategy, a number of other steps need to be taken. These include steps to reduce accidents to children, to which we have referred above (Recommendation 3). Further:

28) *Provision of meals at school should be regarded as a right. Representatives of local authorities and community dietitians should be invited to meet representatives of parents and teachers of particular schools at regular intervals during the year to seek agreement to the provision and quality of meals. Meals in schools should be provided without charge.* (Chapter 9, p180)

29) *A comprehensive disablement allowance for people of all ages should be introduced by stages at the earliest possible date, beginning with people with 100 per cent disablement.* (Chapter 9, p183)

30) *Representatives of the DHSS and DE, HSE, together with representatives of trade unions and CBI, should draw up minimally acceptable and desirable conditions of work.* (Chapter 9, p. 187)

31) *Government departments, employers and unions should devote more attention to preventive health through work organisation, conditions and amenities, and in other ways. There should be a similar shift of emphasis in the work and function of the Health and Safety Commission and Executive, and the Employment Medical Advisory Service.* (Chapter 9, pp187-8)

32) *Local authority spending on housing improvements under the 1974 Housing Act should be substantially increased.* (Chapter 9, p189)

33) *Local authorities should increasingly be encouraged to widen their responsibilities to provide for all types of housing need which arise in their localities.* (Chapter 9, p190)

34) *Policies directed towards the public and private housing sectors need to be better co-ordinated.* (Chapter 9, p189)

35) *Special funding, on the lines of joint funding, for health and local authorities should be developed by the government to encourage better planning and management of housing, including adaptations and provision of necessary facilities and services for disabled people of all ages by social services and housing departments.* (Chapter 9, p. 191)

29) Our recommendations reflect the fact that reduction in health inequaUties depends upon contributions from within many policy areas, and necessarily involves a number of government departments. Our objectives will be achieved *only* if each department makes its appropriate contribution. This in turn requires a greater degree of co-ordination than exists at present.

36) *Greater co-ordination between government departments in the administration of health-related policies is required, by establishing inter-departmental machinery in the Cabinet Office under a Cabinet sub-committee along the lines of that established under the Joint Approach to Social Policy QASP), with the Central Policy Review Staff also involved. Local counterparts of national co-ordinating bodies also need to be established.* (Chapter 9, p193)

37) *A Health Development Council should be established with an independent membership to play a key advisory and planning role in relation to a collaborative national policy to reduce inequalities in health.* (Chapter 9, p194)

30) Within such co-ordinating machinery major initiatory responsibility will be vested in the Department of Health and Social Security, and we recommend that the Cabinet Committees we have proposed be chaired by a Minister, and by a senior DHSS official respectively, having major responsibility for health and prevention. Similarly it will be an important obligation upon the DHSS to ensure the effective operation of the Health Development Council.

Index

A

Abortion, legalisation 1966, 174
Accountability 199
Accum, F 19
Acheson, *Sir* Donald CMO 141, 163
  on housing 167
  public health definition 192
Acheson Committee 192
Acheson Report 1988, 141-3 156, 157, 158, 181
Addison, Dr Christopher, MOH 30, 37, 40, 57, 62
Administrative responsibility unification 79
Adulteration of Food, Drink and Drugs Act 8, 1872
Adulteration of Food Act *8,* 1860
Advisory Council for Probation and After-Care 110
AIDs 174
Air pollution 172
Air raid injury, hospital care 71
Ambulance provision 109
Anderson, Sir John 69
Antibiotic treatment 183
Arthritis 173
Artisans and Labourers Dwelling Act 1868, *8*
Artisans and Labourers Dwellings Improvement Act 1875, *8*
Ashley, *Lord 31*
Asthma and air pollution 172

B

Bains Report 1972, 179
Bassetlaw Health Authority 1990 annual report 181
Bazalgette, Joseph 12
BCG vaccine 171
Behavioural problems 202
Benefit adequacy in amount and time 79
Bentham, Jeremy 6
Bevan, Aneurin, Minister of Health 87, 88-9, 91
  message to the medical profession 92
  resignation over NHS charges 106
Beveridge, Sir William 73-4, 82
Beveridge Plan for social security 80, *81-3*
Beveridge Report on Social Insurance and Allied Services 1942, 62, 73, 75, *83,86*
Bicycle helmets 207
Bills of Mortality 6, 21
Birth registration act 1836, 21
Black, *Sir* Douglas 159
Black Report: Inequalities in Health 1980, 143 159

Black Report: Inequalities in Health 1992 ed 159
Black Report: Inequalities in Health, summary and recommendations 224-36
Block grants 209
BMA 57-8
  Committee on minimum diet 55, 1933
  funding views 150
  opposition to National Health Service 87, 89-91
  Proposals for a General Medical Service for the Nation 1929, 1938, *86*
Board of Education, school medical service 37
Board of Health, 1854-58, 11 *31*
Boards of Governors 96
Bradford Hill *see* Hill
Breast cancer screening 188
Bristol, William Budd Centre 104
British Association of Social Workers 110
British Hospitals Association 71
British Medical Association *see* BMA
British Restaurants 67
Brockington, CF 99-101
Brotherston, Sir John 13, *120, 123,* 134
Brown, Ernest, Minister of Health 85
BSE 174
Budgets, responsibility for 196
Building maintenance 209

C

Cadbury 15
Cancer 173
  mortality increase 171
Cardiff, poor 19th century pubhc health 7
Caring for People 1989, 150
Census 6,21,1801
Central Board of Health 9
Central Training Council in Child Care 110
Cervical cancer screening 188
Chadwick, Edwin 4, 5-7, 9-11, 14, 24, *31*
Chalmers, Dr AK, Glasgow MOH 42-43
Chamberlain, Neville, Minister of Health 168
Chief Executives in Health Authorities, accountability 201
Chief Medical Officer
  Annual reports 44-9
  powers 209,215-16
  roles 208-9
Child abuse 175
Child Accident Prevention Committee 227
Child allowances 76, *81*

Child health services, administration in 1914, 32
Child mortality
  Glasgow decline 1900-38, *44*
  reduction 171
Cholera 11,21
Chronic bronchitis 172
Chronic diseases 183-4
  multiple factors in development 205
Circulatory disease, mortality increase 171
CJD 174
Clean Air Act 1956,172
Clinical consultants, prescription freedom 180
Clinical Standards Advisory Group 151
Co-ordinating mechanisms 209
Cochrane, *Professor* Archie 121, *123,* 184
Commission of Public Health, modification 215
Committee on Social Insurance and Allied Services 73
Communicable disease control 197
Communicable Disease Surveillance Centre, Public Health Laboratory Service 158
Communication skills importance 189
Community Care: Agenda for Action 1988, 149
Community health index numbers 204
Community medicine
  falling recruitment 114-15, 133
  term usage 182
Community medicine concept 93
Community Medicine and Faculty of Community Medicine 1974, 194
Community NHS Trusts 197, 198
Community physicians 117
  role 117
Computers 174
Consultative Council on Medical and Allied Services 40
Contraceptive pill 174
Contraceptive provision 154
Contribution flat rate 79
Cooking facilities 19
Coronary heart disease 173
  preventive programme 199
Council for Training in Social Work 110
Crew, FAE, *Professor of Public Health and Social Medicine* 102-3, 114, 139
Crossman resource formula 136

D
DavyJS 29
Dawson, *Lord,* of Penn 40

Dawson Committee 70
Dawson Report 1920, 40-2, 57, *86*
Death grants *84*
Death Registration Act 21, 1836
Deaths, official returns 6
Demographic, social and environmental data 203
Department of Health
  disease containment 154
  Research and Development Directorate 156
Department of Health and Social Security *120*
  division in 1988, 147
Depressive illness 175
Deprivation effects 50
Diabetes 173
Diet
  calorific deficits 55
  post-1945 War 64-8
  primary school children 1933, 52
  'working class' 19
Diphtheria
  Glasgow cases and deaths *43,* 1905-54
  immunisation 196
  immunisation campaign 68
Diploma in Public Health 45, 116, 183, 184
Diploma of Social Medicine or Community Health 116
Directors of Public Health 180, 198
  annual report 181, 200
  as Executive Directors 200
  relationship with Chief Executive of Health Authority 201
  role 199-200
Disability benefits 82
District Action Programme 230-6
District General Hospital 108
District Management Team 196-7
District Medical Officers 196
Doll, *Professor Sir* R *120,* 173
Driving test introduction 1935, 48
Drug safety testing 176
Drummond, *Professor* JC 65-6
Duncan, William H 7, 28

E

E.coli food poisoning 174, 193, 197
Economic decline 63
Economic depression effects 48-9
Economics 203

Education (Administrative Provisions) Act 1907, 34, *35*
Education of the people in hygiene *39*
Education (Provision of Meals) Act 1906, 34, *35*
Elderly, care quality 112
Elementary Education Act 1880, *8*
Emergency Medical Service 71
Employment maintenance 76, *81*
Environment in 20th century 172
Environmental advice 200
Environmental factors and ill-health 205
Environmental health 112-13
Environmental health inspectors 179
Environmental problems 202
Epidemiology 183, 202-3
Eugenics and the principles of sound breeding *39*
Evacuation of mothers and children 69-70
Exercise
  advice 200
  lack 173

F

Factories and Workshops Act 1878, *8*
Factory Act 1867, *8, 35,* 1933
Faculty of Community Medicine 118
  first Board members *123*
  foundation 1972,119-24
  qualifying conditions for membership *122*
  training and development programme 184
Faculty of Community Medicine of the Royal Colleges of London, Edinburgh and Glasgow 179
Faculty of Public Health Medicine 155, 214
  guidelines 181
  Working Party 189
False teeth, charges 106
Family Allowances Act 1945, 83, *86*
Family planning 195
Family Practitioner Committees 131
Farr, William, Compiler of Abstracts to the Registrar General 5, 22
Fertility 174
Fluoridation 105
Food adulteration 19
Food Advice Division 66
Food control, organisation in 1939, 65-8
Food (Defence Plans) Department 65
Food hygiene directorate 179
Frazer, Dr, Liverpool MOH, annual report 1933, 48
Future Provision of Medical and Allied Services 1920, 40

G

Garden Cities of Tomorrow, 1902, 16
Garden Cities and Town Planning Association 16-17
Garden City movement 168
General Board of Health 1848, *8, 31*
General Household Survey 228
General Medical Council 45
General practice(s)
  contract 148, 151
  duties 148
  prescription freedom 180
  and public health 109
  purchase of services 147
George, Lloyd 33, 37, 57
Glasgow
  cases and deaths from infectious diseases 1905-54, *43*
  Chadwick's findings 9
  child mortality decline 1900-38, *44*
Gloucester, 1923 annual report 181
Godber, *Sir* George, CMOH 97-98, 105
Goodenough Report 1944, 93, 183
Graunt.John 21
Greenwood, *Major* 183, 187
Griffith, Gwilym Wynne 105
Griffiths, Sir Roy 149
Griffiths Report 1983, 135, 149
Growth rate deficits 50
Guardians benefit *84*
Guidelines to medical practice 180-1
Guillebaud Committee of Enquiry 1953, 107

H

Hall, Sir Benjamin 11,31
Handicapped, care quality 112
Harding, DrWG 120-121, *123*
Health agencies linking and co-ordination 46
Health and Welfare: the Development of Community Care, Ministry of Health 1963,109
Health Authorities 198-9
  responsibilities 206
  role 153
Health Boards 198-9
Health Care Commissioning Development Project 1996, 198
Health Centres 41
  concept 104-5
Health Department, inauguration 11

Health Divide: Health Education Council, 143, 161
Health Education Council 143
Health inequalities 158-63
Health Ministers 1919-1997, 222-3
Health of the Nation 1992, 152 154-6
Health of the Nation, health authority performance 201
Health of the Nation Working Group Report 1995, 161-2
Health needs, monitoring 203
Health and physique of the school child and adolescent *39*
Health and rehabilitation services *81*
Health risks 205-6
Health service
  comprehensive 76
  issues 202
Health Services Supervisory Board 135
Health and Social Security Act 1984, 131
Hill,A Bradford 173, 184, 187
Holland, *ProfessorWW 123*
Hospital insurance schemes 70
Hospital Management Committees 96
Hospital Plan, Ministry of Health 1962, 108-9
Hospital services 56-8
  development 70-3
Hospital use in wartime 72
Hospitals, competition between 147
House of Lords Select Committee on Science and Technology 1987, 156
Housing
  19th century 14-19
  in 20th century 167-9
  and drainage system 11
  and health 168
Housing standards directorate 179
Howard, Ebenezer 16-17, 168
  garden city diagrams 18
Hunter Report 1972, 118
Hygiene, term usage 182

I

Ill-health determinants 205
Immunisation 68-9
Immunising agents
  assessment 187
  and reduced mortality 171
Industrial accident or disease, provision for 82
Industrial communities 15
Industrial hygiene, the health of the worker in the workshop *39*

Inequalities in Health 1980, 143, 158-63
Infant and child welfare clinics 194
Infant mortality 22-23
 20th century decline 47
Infant welfare and the reduction of infant mortality *39*
Infection, *See* Infectious diseases
Infectious diseases
 19th century 21
 20th century 170-1
 and immunisation 68-9
 outbreaks 202
Infectious Diseases (Notification) Acts 1889/99, *8,* 21
Infectious Diseases (Prevention) Act 1890, *8*
Infertility treatment 174
Influenza pandemic 34
Information, collection, analysis and dissemination 203
Institutes of Public Health, restoration 215
Insulin 42

J

Johnstone, Jervis, *Professor of Public Health at Leeds* 115
Joseph, Keith, Minister for Social Services 112, 130

L

Largactil 175
Lead as environmental issue 172
Leeds, poor 19th century public health 7
Legal powers 197
Legionnaires Disease 174, 197
Letchworth 17, 169
Lever, William 15
Liddle, John 10
Life expectancy 1841, 22
Life expectancy, increased 175, 181-2
Lifestyle and early death 153
Liverpool, 19th century public health 7
Local authority hospitals 195
 staff responsibility to MOH 177
Local Authority Social Services Act 1970, 111
Local government, 19th century 2-3
Local Government Act 1858, *31*
Local Government Act 1871, 13
Local Government Act 1929, *35, 86*
 implications 46-7

Local Government Act Office 11
Local Government Board 1871, 23, 25, 30, *31,* 34, 37
London
  Lord Rosebery's description 17
  sewerage system 12
London Hospital, Social Medicine Research Unit 184
London School of Hygiene and Tropical Medicine 183-4
  postgraduate courses 185
Long-term care issues 175
Lung cancer 173

M

Macgregor, Sir Alexander, Glasgow MOH **42-43**
McKeown, *Professor* Tom 184
Maclean Report 1917, 57
MacNalty, Sir Arthur, CMO 44, 99
Manchester, poor 19th century public health 7
Marriage Registration Act 1836, 21
Mass radiography campaigns 104
Mass X-ray assessment 187
Massie, Arthur, MOH, and Coventry air raid 91
Maternal health services, administration in 1914, **32**
Maternal mortality reductions 171
Maternity benefit *84*
Maternity and the care, protection and encouragement of the function of motherhood *39*
Maternity and Child Welfare Act 1918, *35*
Measles
  controlled trials 187
  Glasgow cases and deaths 1905-54, *43*
Meat inspection 46
Media, medical profession relationship 189
Medical Act 1858, *8,* 33
Medical education 113-117
Medical examinations, routine 149
Medical officer, permanent, first appointment 11
Medical Officer of Health, definition by Local Government Act 1929, 46
Medical Officers of Health 24, 180, 195-6
  20th century 28
  annual reports 50
  as community physicians 118
  memorandum on duties 1925, 50
  part-time teaching 183
  restoration 211-12
  role 1948-74, 176-8
Medical Research Council 184

foundation 33
Medical statisticians 217
Medical statistics 202
Medical students' curriculum 45
Medical technology improvements 183
Mental Deficiency Act 1913, *35*
Mental illnesses 175
Mental Treatment Act 1930, *35*
Mentally ill, care quality 112
Merrison Royal Commission 1976-9, 129-30
main recommendations *131*
M'Gonigle, Dr GCM, Stockton-on-Tees MOH 50, 51-6, 169
MIDSPAN study 218
Midwives Act 1902, amended 1918, 1936, *35*
Milk supply control 46
Minister of Public Health 163, 220
Ministry of Food 65
Ministry of Health 1919, 30-3 J 32-40, 58
Ministry of Health
health responsibilities in government departments *38*
hospital bed planning 1939, *71*
priorities 40
Ministry of Health Act 1918, *35*
Ministry of Social Security 82
Moran Report 1944, 93, 183
Morant, Sir Robert 34, 36-7, 41
Morbidity and mortality in the 20th century 170-1
Morris
Professor JN 117, *120-121,* 159, 184
William 15
Mortality
in the 20th century 170
increased, and dietary deficiencies 56
Mortality rate, 19th century fall 22-23
Multidisciplinary teams 127
Municipal hospitals 70
Murray, *Sir* Keith, Chairman of University Grants Committee 113

N

National Assistance Act 1948, 83
National Assistance Act 1948, provisions 110-11
National assistance with means test 82
National Association of Health Authorities and Trusts 150
National Association of Maternity and Child Welfare Centres 91
National Commission of Public Health 212-13
National Food Survey 227

National Health Insurance Act 1911, 33-4, *35*
National Health Service 82, 85-91
  1989-91 reforms 197
  effect on public health 97
  estimated and actual costs 106, J07-9
  executive councils 96
  funding 145-6
  hospital administration bodies 96
  introduction 1948, 196
  local authorities 96
  organisation 96
  public health service structure 208
  re-reorganisation 130-3
  Regional Offices 158
  reorganised 126-9
  sector integration 112
  structure
    1948-74, 95
    after 1990, **152**
    in England 1974-82, **128**
    in England 1982-90, **132**
    in Scotland, Wales and Northern Ireland 1974-82, 129
National Health Service Act 1948, *86-1* 89, 91
National Health Service Act 1974, 127
National Health Service and Community Care Act 1990, 151-2 156
National Health Service Management Board 135
National Health Service Management Executive, Research and Development Directorate, funding 184
National Health Service (Scotland) Act 1974, 129
National Health Service Trusts 197
National Health Services, main documents and legislation *86*
National Institute for Economic and Social Research (NIESR) 107
National Insurance Act 1911, 63 *86*
National Insurance Act 1946, 83
National Insurance Act 1946, benefits *84*
National Insurance Act 1948, *86*
National Study of Health and Growth 170
Nation's Health 158
Nephritis 171
New Lanark 15
New Zealand, public health organisation 214
Newman, *Sir* George, MOH **36-7,** 39, 40, 44-8, 50, 58
Newman's ten principal elements for a national policy in preventive medicine *39*
Newsholme, Dr Arthur MOH 24, 36-7
Nuffield Provincial Hospitals Trust 11.6, 184
Nutrition 19
  in 20th century 169-70

in ill-health 50
post-1945 64-8

O

Obesity and health 170
O'Brien, M 198
Office of the Chief Scientist, research programme funding 184
Otitis media 171
Our healthier nation 1998, 220
Overweight, advice 200
Owen, Robert 15

P

Parkes, Louis 10
Parry, RH, Bristol MOH and Professor of Public Health 101-2, 104
Penicillin 42
Pensions, old age 30
Pesticides as environmental issue 172
PET scans evaluation 187
Plan for Social Security 75-6
Planning Committee Report on Medical Education 1944, RCPL 183
Points rationing scheme 67
Polio vaccine controlled trials 187
Political and Economic Planning, 1937 survey of health services and proposals *85-86*
Poor Law
20th century reform attempts 30
integration with public health services 46
Poor Law Act 1597, 1
Poor Law Act 1934,29
Poor Law Amendment Act 1834, 3, 4, 6
Poor Law Board *4, 31*
Poor Law Commission 4, 6
Poor Law Commissioners 195
Poor Law hospitals 57, 70
Poor Law system 2
Population growth in 19th century *3*
Porritt Report 1962, 115 126
Port Sunlight 15
Poverty
and health 176
and public health 49-56
Poverty and Public Health 50
Prescribing, 1927 economy 46

Prevention and treatment of infectious disease *39*
Prevention and treatment of non-infectious disease *39*
Preventive Medicine, term usage 182
Preventive services importance 194-5
Primary care, requirements 148
Primary Health Centres 41
Prime Ministerial review of NHS funding 1987, 146-50
Prime Ministers 1919-1997, 222-3
Priorities for Community Care BMA 1992, 155
Privy Council 11, 23, 33
Promoting Better Health 1990, 148
Protein shortage 55
Public Assistance Committees 70
Public health
- 19th century issues 9-25
- 20th century 28
  - changes 42-4
- 1839 inquiry 6-7, 9
- 1974 service integration, 179
- administration 1848-1919, *31*
- community services 177
- general practice co-operation 178
- historical background 1-26
- ill-health control studies 204
- independent organisation 210-11
- individual role clarification 217
- in the NHS 91-3
  - after 1991, 152-6
- possible solutions 208-10
- preventive services 174
- recruitment 185
- reforms and legislation 2-4
- relationship to clinical practice 176-82
- research and education development 184
- research and practice relationship 188
- research and training 156-8
- resource needs 209
- responsibilities today 202-5
- service co-ordination 178
- specialisation 186-7
- specialist training funding 184-5
- as specialty 183
- status in NHS 97-103
- teaching 183
- tensions 193-7
- term usage 182
- terminology 193
- working patterns and tensions 180

working in teams 186
Public Health Act 1848, 1872, 1875, *8* 9, 11, 13
Public Health Act 1875, 1936, 13 34, *35*
Public health consultants, role 194
Public Health Laboratory Service 158, 198
Public Health Medicine, training and development programme 184
Public health practitioners 157
independence 214
obligations 210
skills required 203
Public Health (Scotland) Act 1897, 13

Q

Quack treatments 207

R

Rationing 64, 66, 169
Record linkage 203-4
Reform Act 1832, 1867,1884, 3, *8*
Regional Directors of Public Health 158
NHS 179-180
Regional Hospital Boards 96
Rehabilitation service 76
Reid, *Professor* Donald 184, 187
Sir John, MOH 116
Report on the British Health Services 1937, 56
Report of the Interdepartmental Committee on Medical Schools 1944, 183
Report of the Interdepartmental Committee on Physical Deterioration 1904, 33
Report of the Royal Commission on the Housing of the Working Classes 14
Report of the Royal Commission on National Health Insurance 1926, *86*
Report of the Royal Commission on Physical Training (Scotland) 1903, 33
Report of the Royal Commission on the Poor Laws
majority report 29-30
minority report 29-30
Report of the Royal Commission on the Sanitary State of Large Towns and Populous Districts 14
Report of the Voluntary Hospitals Commission - Sankey Report 1937, *86*
Reproductive medicine 174
Research, inquiry and investigation; and the extension of the boundaries of knowledge *39*
Research Assessment Exercise 218
Resource allocation 136-9
Resource Allocation Working Party 1975, 136-9

Resource Consequences of Capital Schemes 136
Respiratory disease, mortality reduction 171
Responsibilities, ambiguity 197
Retirement pensions 82, *84*
Rheumatic fever 171
Rhonnda, *Lord,* President of the Local Government Board 56-7
Rickets 50, 169, 196
Risk communication 207-8
Risk estimates 207
Risk-taking behaviour and ill-health 205
Road accidents, fatalities and injuries 1931, *41*
Robbins Committee 113-14
Rosenheim, *Lord X22-123*
Royal College of Nursing 149-50
Royal College of Pathologists 214
Royal College of Physicians, Planning Committee Report on Medical Education 93
Royal College of Physicians of London. Planning Committee Report 1944, 183
Royal Commission on Medical Education 1968, 179
Royal Commission on the Poor Laws 6
Royal Sanitary Commission 1868, *31*
Ryle.John, *Professor of Social Medicine* 139-40

S

Salary scale 201
Salmonella 174
Salt, Sir Titus 15
Saltaire 15
Sanitary Act 1866, *8,* 13
Sanitary Conditions of the Labouring Classes, Chadwick Report 7
Sanitary Officers' Regulations 1935, 102
Sanitation 10-14
  and an improved personal and domestic environment *39*
Sanitation Act 1875,22
Sanitation directorate 179
Sankey Report 1937, *86*
Scarlet fever 171
  Glasgow cases and deaths 1905-54, *43*
School children
  medical inspection 34
  primary, physical condition 1933, 51-2
School Medical Service establishment 34
School milk scheme 66, 169-70
Scottish Association of Medical Administrators *120*
Scottish Home and Health Department *120*

Screening assessment 187
Screening services 204-5
Scurvy 50
Seat belts 207
Secondary Health Centres 41
Secretary of State for Health, appointment of health authorities 208
Seebohm Committee on Local Authority and Allied Personal Social Services 1965, 110-11,117
Seebohm Report 1968, 110-11, 179
Semple, Andrew, Livepool MOH, mass radiography campaign 104
Sewerage 10-11, 13, 24, 68, 172
Sex education for primary schoolchildren 207
Shaftesbury, *Lord 9*
Sickness, state insurance schemes 30
Sickness benefit *84*
Simon, Sir John 5, 11, 21, 24, 30, *31,* 46
  on housing 14
Slum demolition, Stockton-on-Tees 52-3
Smallpox vaccination abolition 174
Smith
  Alwyn 140
  Dr Cyril 159
  Dr Southwood *9,31*
'Smog' 172
Smoking
  advice 200
  and ill health 154-5, 172-3
Snow, Dr John 5,11
Social factors and ill-health 205
Social insurance 78
  classification 79-80
  principles *81*
Social Medicine, term usage 182
Social problems 202
Social sciences 202-3
Social security 78, 79, *81*
Social service departments, organisation 111
Social Services Research Working Group 1977, 159
Social work 110-12
Social workers 110-11,179
Society of Medical Officers of Health 93, 119-20
  Scottish Branch *120*
Society for Social Medicine 119-20
Special Health Authorities 131
Spectacles, charges 106
Staff canteens 66
Standardized mortality ratios 229
State insurance schemes 30

Statistics, vital and health 21-5
Stevenson, J 62-3
Stewart, Alice 184
Stockton-on-Tees
  birth rate and infant mortality rate before and after demolition *54*
  crude and age/sex standardised death rates before and after demohtion *53*
  incidence of conditions in children *52*
  quantities of food purchased as percentages of BMA scale *55*
  rent and rates per family per week *54*
Streptococcus, reduced pathogenicity 171
Streptomycin 171
  controlled trials 187
Stroke 173
Subsistence benefit rate 78
Suicide increase 48
Sulphonamides 42
Surgery, minimally invasive, evaluation 187-8

T

Taylor, Dr Stephen, MP 89
Teaching hospitals 41
Technology, assessment and application 187-8
Thalidomide 175
Thames, poor condition 12
The Times 11, 1854
Todd Commission on Medical Education 117
Todd Report 1968, 119, 179, 182
Towns, growth in 19th century *4*
Townsend, *Professor* Peter 159
Traffic calming 209-10
Tuberculin testing in cattle 46
Tuberculosis 21-2
  in the 20th century 170-1
  mass prevention and cure campaigns 42
Typhoid 21
Typhus 21

u

Under-nutrition 196
Unemployment
  avoidance 76
  state insurance schemes 30
Unemployment benefits 82, *84*
Urban and Rural Sanitary Authorities 1872, *31*

V

Vaccination Act 1853, *8*
Vaccines assessment 187
Venereal disease decline 69
Venereal Diseases Act 1917, *35*
Violence 175
Vitamin deficiencies 169
Voluntary hospitals 41, 57, 70, 195
  independent consultants 177

W

Walton, Stanley, MOH, and West Bromwich air raid 91
Warin,JF, Oxford immunisation programme 104
Warren, *Professor* Michael 121, *123*
Warrington, children's weight increase 1932, 49
Wash house, Liverpool 7
Waste dumps as environmental issue 172
Waste incinerators 207
Water fluoridation 105, 207
Water supplies 10-11
Webb, Beatrice 29
  and hospital reform 57
  and Sidney 36-7
Welfare State 73-85
Welwyn Garden City 17, 169
White Paper on a National Health Service 85, *86-1*
Whooping cough, Glasgow cases and deaths 1905-54, *43*
Widows pension *84*
Willink, HU, Minister of Health 85-7
Windsor, poor 19th century public health 7
Wofinden, *Professor* RC 104, *120*
Workhouse abolition 29
Working for Patients 1989, 147
Working Together for a Healthier Scotland 1998, 163
World Health Organisation, public health definition 187
World War
  First
    army recruits examination 50-1
    costs 27-30
  Second
    hospital planning 71
    impact 61-4