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Contexts

(i) Introduction

This booklet examines the development of medical services and arrangements for health care in Britain from the mid-nineteenth century until the eve of World War Two. It follows the survey in this series by Roy Porter and anticipates a third study by Virginia Berridge [8]. In the period reviewed a number of vital changes occurred. Mortality rates fell, with major variations according to age, social class and region, and the contribution of medical effort to this decline remains controversial. Recognised causes of mortality and morbidity also changed, with the concept of epidemiological transition, the broad replacement of infectious diseases by chronic and degenerative illnesses, a useful if not totally adequate guide [76]. Perceptions of sickness and health, as well as formal medicine and health care systems, were increasingly influenced by scientific and professional opinion. Bolstered by advances in knowledge and techniques, by its own organisational successes and with some assistance from state legislation, the medical profession expanded and enhanced its economic and social standing.

For most people basic standards of sanitation were improving over the last quarter of the nineteenth century and, it was now assumed, the development of personalised services could make an increasing contribution to health levels. The workings of the medical marketplace, the poor law, local authorities, voluntary institutions and the state each had a role to play, though respective weightings and patterns of combination varied over time. Hospital treatments, courtesy of medical research, specialisation and nursing reform took on new public esteem. If the teaching hospital

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represented the pinnacle of medical achievement, specialist and general facilities expanded throughout the voluntary hospitals sector, with a rural element in the shape of cottage hospitals. Poor law medical provision also improved and, given appropriate political support and local government reorganisation, became part of a prototype public sector offering one model for a future national health service.

Best practice examples in public and voluntary sectors confirmed rapid progress, yet hospital and health surveys in the 1860s and late 1930s indicated variable provisions [112,121,125]. For the sick loss of income, fear of the doctor's fee or poor law institution often still accompanied the pain and uncertainties of illness. Medical practitioners were not that popular among the less wealthy and the approved societies, which administered the state health insurance scheme after 1911, even less so [88]. In the twentieth century the limits of voluntary effort and the insurance principle in health care were frequently discussed but less often acted upon. Financial restraints, ideological and professional interests dogged attempts to provide public sector alternatives [125]. Near-miraculous cures in the shape of sulphonamide drugs and technological breakthroughs such as radium therapy occurred alongside basic deficiencies, neglect and even discrimination at the close of the 1930s. Well before the test of World War Two the need for thoroughgoing reform was the one agreed point on the agenda of all interested in health care provision.

(ii) **Medical history or social history of medicine?**

This brief introduction suggests that the traditional concerns of medical history are too narrowly focused, though interpretation of the subject as by, for and primarily about doctors seems unduly harsh [12]. Yet there has been a strong identification of medicine with the practice of doctors or scientific researchers, particularly those heroic figures associated with its advancement. Medical progress is largely equated with the build up of a scientific body of knowledge and new techniques, with associated claims of objectivity, precision and increased effectiveness [27]. Cultural influences upon medical personnel or features affecting the outcome of

medical practice, such as nutrition, are often ignored or assigned only peripheral roles. Similarly, the emergence of the medical profession and its exercise of power have been stressed in the context of decision making in hospital or asylum [20,25]. The medicalisation of aspects of social policy, such as the health of early twentieth-century schoolchildren, has also been a subject of controversy [102]. In turn, a distinctly anti-medical history has developed, focusing upon the inappropriate nature of medical intervention in, say, mental illness, the treatment of depression or overwork. Yet medical dominance in the past can itself be overstated, with portrayal of patients as victims, cases or even specimens.

A broader approach to the history of medicine and health care has many precedents. The practice of preventive medicine was not subject to professional claims before the division between public health and scientific medicine from the mid-nineteenth century [8]. Early twentieth-century studies of health and welfare or interwar investigations into poverty and malnutrition preceded the discipline of social medicine in the early 1940s [5]. Seminal works in the 1950s and 1960s cast doubt upon the impact of medical effort and nursing reform, encouraging critical and evaluative research [58,28]. The contribution of income or diet relative to medical measures or opinion resurfaced in this period, in new debate concerning the causes of late nineteenth-century mortality decline, infant mortality trends, the domestic impact of World War One and the ‘healthy or hungry’ 1930s.

Similarly with the delivery of medical services: not all sufferers became patients, nor were all healers doctors. Medical effort in its social context is a common theme in the social history of medicine, with the concerns of the sufferer and the role of lay care more fully acknowledged. Cultural influences which shaped medical knowledge and expertise may be traced via individual or communal experiences. Professionalism can be considered beyond possession of skills and specialist knowledge, with regard to questions of medical entrepreneurship, gender discrimination or the impact of interest groups on social policy formulation. The latter can be coupled with an assessment of life risks, or the meeting of social need vis-à-vis other objectives, such as social control.

With a more comprehensive approach some issues, such as

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professionalisation or treatment of mental illness, have received more attention than others, such as occupational health or twentieth-century rural health care. Such imbalances cannot be remedied in this short survey but medical services and the hospitals are examined in a series of contexts. The remainder of this chapter considers the background of social policy and social risk. Chapter 2 outlines developments in medicine along with trends in mortality and morbidity, to see the likely scope of medical effort in relation to other influences. Chapter 3 considers the growth and consequences of professionalisation and reform in medicine and nursing. Service provision and patient access before World War One are outlined in chapter 4. This approach is extended to the interwar period in chapter 5, which also contrasts plans for coordination of services with practice and surveys facilities and opinion as to the direction of future reform. Finally, chapter 6 considers change in the funding of services and its consequences, returning to issues of accountability and control in health care.

(iii) Social policy and health care arrangements

It is not surprising that historians and others in the era of the Welfare State and the mixed economy were tempted to see past provision of health care and related services in terms of the development of social policy. The role of the state and policy formulation were central concerns and implicit in this approach was a steady progression from individual to collective provision. Such developments need not be socialistic, for themes of modernisation or of national interest suited equally well, and health care offered a particularly good example. In consequence of industrialisation and urbanisation, individuals could not reasonably be expected to provide for all their health needs, yet failure to do so posed a general health risk. Hence the gradual assumption by the state of responsibility for sanitary and other preventive measures, even if implementation devolved to local levels. Medical developments and increased awareness meant the continuation of this approach into a range of formal health services involving the poor law, local authorities, and arrangements with doctors and insurance companies.

In this evolutionary process there might be accelerations, occasioned by war or medical innovation, and periods of retrenchment, usually for financial reasons. There were arguments concerning motives, purposes and extent of reform, but consensus in two areas. One was that public services were extended, increasingly replacing private or philanthropic provision over the twentieth century. The route to the National Health Service was marked by legislative signposts. In its categorisation of the sick, the 1834 Poor Law Amendment Act had demonstrated awareness of the need for minimal, if less eligible, provision, while the 1848 Public Health Act set a more durable precedent for sanitary reform than earlier localised or emergency measures. Between the Sanitary Act of 1866 and the 1888 Local Government Act, the responsibilities of local authorities for sanitation and a range of basic health services, from support for salaried medical officers of health to provision of isolation hospitals, were delineated [79]. With the Metropolitan Poor Act of 1867 and provincial emulation, the treatment of sick paupers primarily under medical supervision was considered, opening the way to a ‘hospitals branch of Poor Law administration’ and, later, treatment of the non-pauperised sick [40].

A combination of philanthropic and local authority effort provided health visiting services in the early twentieth century, usually focused upon midwifery and infant welfare, though more attention fell upon the adult male oriented provisions of the 1911 National Insurance Act. This produced a state primary health care service offering sickness benefits and access to medical practitioners for 12.7 million people in 1913 [16 and chapter 4]. The scheme’s critical flaws, lack of provision for the dependants of contributors or adequate hospital cover, were not remedied before World War Two and the introduction of an Emergency Medical Service. Neither the creation of a Ministry of Health in 1919 nor reforms associated with the 1929 Local Government Act offset these deficiencies. The ministry failed to coordinate existing arrangements and the 1929 legislation, facilitating local authority appropriation of poor law hospitals and the development of public hospital and health services, did little to guarantee improvements.

A second broad area of agreement concerns the impetus for reform. Workers or the poor, perhaps because of a lack of expertise or other priorities, allegedly displayed little interest in public health

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reform, so this was a matter for higher levels of policy making. There were tensions between the state and local authorities, or between civil servants and other bodies, notably the emergent medical profession. Aside from electing the occasional progressive councillor or passing conference resolutions, ordinary people figured to a very minor extent, though their interests were regularly evoked by social and medical reformers. With regard to health care, such views require considerable modification [chapter 6].

Features such as international economic and demographic – even racial – competitiveness loomed large in health and welfare reform [89]. British interest in national efficiency and fears of social deterioration by 1900 had continental parallels. French military and economic concern with lack of population growth stimulated infant and child welfare services, with municipal hospital and polyclinic provision geared also to TB and STD sufferers. Sickness and old age insurance provision, covering roughly eight million workers, followed by 1910. In Germany, compulsory sickness insurance from 1883 was part of 1880s legislation including industrial accident and old age provisions. One intention was to combat socialist ideas: the measures were aimed at urban workers in regular employment and involved graduated contributions and benefits. They applied to roughly one quarter of German workers, who paid for two thirds the cost of sickness insurance by 1914. The less organised, lowest paid or irregularly employed were mainly left to poor law style arrangements, again including TB treatments and dispensary facilities [89a].

In both countries levels of municipal hospital provision exceeded those in Britain until well into the twentieth century, but voluntary effort, works-based health care and insurance remained important. The USA provided a further contrast, for the late nineteenth-century expansion of health facilities was largely in hospital based personal treatment of acute illness, subject to maintenance charges and physician's fees. This represented a high cost form of treatment but patient pre-payment or insurance schemes were the popular response: charitable cases were a small minority and municipal, state or federal government efforts were limited to minimal services covering the poorest, particularly mothers and infants, and the mentally ill. Excepting a few social or medical reformers, self or family help with assistance from philanthropic

bodies or via workplace schemes in a market environment was emphasised [99a].

Few historians now subscribe to a simple transition from individualism to collectivism in British health arrangements, or to social policy parallels with the medical history model outlined earlier. Some recent contributions can briefly be examined. It is more generally recognised that the formulation of policy might not mean rapid or thorough implementation and there is greater emphasis upon delivery and effectiveness of services [79,9]. Thomson rejects both etatist models and nostalgia for individualistic or neighbourly provision. His attempts to identify and measure amounts delivered rather than policies discussed in his work on the elderly led to conclusions that the emphasis upon individual, family or community resources varied over time, with the 1860s marking a lurch towards familial responsibilities [93]. Even including a generous assessment of poor law provision, such conclusions challenge the concept of transition from poor law to public hospitals in these years [39]. When developments in poor law facilities for the sick in the last third of the nineteenth century are set beside the promotion of self-help arrangements via friendly societies, provident dispensaries, sick clubs, hospital collections and fees, public sector-centred interpretations are diminished.

A simple transition from philanthropic to state funding in the pre-welfare state era should also be rejected. Philanthropic effort was always more complex than private donations from rich to poor. In health care especially there are strong solidaristic and public aspects to voluntary provision. A pooling of resources was often required to obtain medical expertise when necessary and to offset the consequences of illness upon income. Policy makers could accept the principle of government subsidies to charitable provision on cost effective grounds in obtaining expertise or services. There were also ideological aspects to forms of assistance which avoided public admission that care was the right of the poor rather than the gift of the rich [95]. Social control features might be detected in any charitable focus on the deserving poor, particularly curable and accident victims in hospitals or sufferers from occupational diseases, and these dovetailed neatly with industrial requirements [106,86]. The charitable 'case' in hospital was also very much under medical control, compared with the fee-paying

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domiciliary patient. Yet if professional influence increased over the late nineteenth and early twentieth centuries, it might partly be countered by the growing numbers of patients who had quasi-contractual arrangements via clubs or contributory schemes, or who were fee-payers, or who had a limited voice in hospital administration and funding [97,99].

These last features suggest grassroots, self-help approaches. From the viewpoint of social risk rather than social policy, Johnson has argued that the most common responses in the period 1870–1939 were private rather than public, collective not individualistic and local instead of national [104]. It is unnecessary to follow his classification of risk to appreciate that individuals could make strictly contractual arrangements or solidaristic ones, as in friendly societies, using a collective method to achieve goals of self sufficiency which had little to do with a proto-public sector. By the early 1900s more than 40 per cent of males aged over twenty years were friendly society members, but Johnson overstates his case in implying that the pre-national insurance population was comparatively well provided for. The low paid figured much less prominently and some nineteenth-century ‘club’ benefits offered minimal cash payments or treatments and also neglected contributors’ dependants [87]. Allowing for other voluntary health care arrangements, the initial impact of state provision may have been exaggerated, however. Three quarters of those in the state insurance scheme were already sick club members and, though insured totals eventually rose over the interwar period, they represented 54 per cent of the adult population in 1936, compared with 47 per cent in 1914 [100,16].

For those at risk there was no guarantee of fundamentals to health such as adequate nutrition or housing. Contemporary investigation into interwar nutritional levels, for example, under the National Birthday Trust in south Wales or by MosH in north-east England, pinpointed the vulnerability of women and children, particularly in large families affected by unemployment [5]. Whatever the policy precedents inherent in poor law or sanitary institutions, the suggestion that an NHS for the poor was being created a century ahead of its time not only telescopes and oversimplifies the reform process, but understates social risks and their consequences [8]. If voluntary hospitals served the non-pauperised poor, they

tended by rule to exclude small children and the infectious or mentally ill. In practice, they also offloaded chronic or incurable patients. Their reluctance to change this approach in the twentieth century made local authority provision even more important, as NHI arrangements did not cover hospital treatments on any significant scale. For the unprotected in health and insurance terms, the doctor's standard fee might be prohibitive. Well into the twentieth century chance and uncertainty were dominant factors, unless their requirements fell within the remit of special local authority provision, such as the 1919 Schools Medical Service. Geography also played a part; twentieth-century arrangements for the chronic sick or infectious in rural areas might be little better than the standards of the nineteenth-century poor law. Even those considered to be comfortably off might have insufficient resources for family practitioner or nursing home fees and yet be disqualified from entry into the NHI scheme or treatment without charges in a voluntary or poor law hospital by the 1920s. Thus life cycle and other risks to the individual were compounded by problems of access, type of illness and social status.

Two other features can be noted in considering individual risk. State social provision and medical professionalism did not signal the end of grassroots or lay effort. Treatment facilities arose via workplaces, communities or friendly societies and people relied upon self or family diagnosis and nosology (the classification of disease) before seeking other forms of care. It is not possible to elaborate on Porter's discussion of belief systems or experience of pain, but, in the context of appeals to study the sufferers' agenda, it is essential to note that people took care before they 'took physik' [92]. Decisions to visit the dispensary, purchase patent medicines, go to hospital or seek some possessor of specialist knowledge, be it herbalist, bone setter or doctor, involved assessment and use of what today is considered pre-primary care [1]. Perceptions of appropriate forms of treatment were influenced by income, kinship or community networks, religious belief (Methodist sects, Coffin-ites), or moral stances (anti-vivisection). Alternative systems such as homeopathy and herbalism or home-doctoring proved durable throughout the period, others, such as mesmerism or hydropathy, suggested faddism [9].

Such alternative forms of practice are not fully recorded, let

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alone quantified. If the influence of herbalism declined in this period, that of patent medicines increased. Reputation, cost, advertising and availability all figured in choices made and the absence of ‘proper’ medical services might be insufficient explanation. We can agree with Porter’s general argument that all were affected by suffering. But not all were equally affected and some were better placed to complain, articulate or record their experiences, possibly producing distorted patterns of suffering. In the social history of medicine, as in the history of social policy, whilst noting ‘who said what to whom and why’, it is important also to utilise opportunities for ‘measuring and assessing who got what from whom, when, how often and at what cost to giver, receiver or society at large’ [93:357].