The Evolution of Community Medicine: Part 3 – The Sanitary Era

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<Opening titles>

<Chave, seated, to camera>

We ended last time in the year 1858 with Chadwick in enforced and unwelcome retirement, and Simon busy as Head of the small medical department of the Privy Council and acting very much in the role of Chief Medical Officer. Now we're going to take a leap forward of about 12 years. And to mark the passage of time, we shall see Simon as he was when he had become the elder statesman of public health. But I used the expression leap forward and used it deliberately because in the life of nations, there are moments when the people are ready for the next great leap forward, when old institutions are reformed and new institutions created, and then in between there are periods of quieter consolidation.

The 5 years passing the following of the Great Reform Bill in 1872 was a period which saw massive reforms, some of which we have heard and there were others.

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The 5 years following the general election of 1945 was just such another period with the founding of the Welfare State and the creation of the National Health Service.

<Chave narrates over illustration>

And so it was, in the 5 years following the general election that came at the end of 1868, Gladstone's Liberal government took office and carried out a programme of massive reforms.

<Chave to camera>

There was reform of the civil service with the ending of the nepotism and the sinecures that had been part of the public service from its beginnings, and the opening of all posts in the public service to everyone by public examinations. There was reform of the army with the ending of the sale of commissions. There was reform of the universities with the ending of religious tests for admission to Oxford and Cambridge. There was reform of the system of administration of justice with the ending of a number of the old courts that had survived from the Middle Ages and the founding of the High Court of Justice. And the great leap forward came with Forster's Education Act of 1870 which established universal elementary education. And it was within the content of this ferment of reform that we get the next forward movement in public health.

Now, the 15 years that followed the fall of Chadwick have sometimes been called the period of the sanitary doldrums, a period in which nothing much seemed to happen, and certainly after the turmoil of the Chadwickian era, there was a certain amount of tranquillity. However, if we look at the statute book, we shall find that year by year Parliament was passing minor acts of sanitary relevance of limited and local application, but the administration of these acts was a complete muddle. It was said that by 1870, there were 160 Acts of Parliament in force making sanitary provisions of one kind or another, but so mixed up as to their administration that even the lawyers couldn't unravel them. The time was ripe for reform.

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<Chave narrates over image of Disraeli>

In 1867, Disraeli the Prime Minister, who had a very considerable interest in public health, announced his intention of setting up a Royal Commission to review the whole sanitary scene. However, he had wisely, or perhaps unwisely from his point of view, extended the franchise by the second Reform Act of 1867, which had extended the parliamentary vote to working men in the towns, and in the election at the end of 1868 they rewarded him by voting him out of office; or as he put it, he was dished by the Whigs.

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<Chave narrates over image of Gladstone and then over image of cover of Royal Sanitary Commission>

Gladstone took office and immediately implemented his predecessor's decision by setting up in 1869 the Royal Sanitary Commission which reported 2 years later. And the Royal Sanitary Commission made three important recommendations which were to determine the scope and pattern, the shape of English Public Health for the next 50 years.

<Chave to camera>

And they were first that there should be one central department of government with responsibility for the public health. Second that the country should be divided up into districts, each to be responsible for sanitary administration at the local level. And third that this mess of sanitary legislation should be consolidated into a single statute. So, there should be one central department of government, one authority in every district in the land responsible for sanitary administration and one public health law applying to the whole nation.

And so it was that the 1871 Local Government Board Act created the Central Department, the 1872 Public Health Act created the district authorities, and the 1875

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Public Health Act consolidated the law. And each one of these Acts of Parliament was to be important and I want to consider the implications of them for they were important and they spread over the next 50 years.

And first the Central Department. Now, Jon Simon in his evidence to the Royal Sanitary Commission, and as you can imagine he had a great deal to say to the Commission, he recommended that a strong Central Department of Public Health should be set up under a cabinet minister, that every local public health officer should stand in an official relationship to that minister who would thus head up what would, in effect, be a national public health service. However, Gladstone's administration decided to create the nineteenth century equivalent of our Department of Health and Social Security. But health and social security in those days meant public health and the Poor Law. And these two public services were brought together in a single department called the Local Government Board for these were local government functions. Now, this was the biggest setback that English public health ever suffered for it burdened the infant public health service with a millstone about its neck that it had to carry for the next 50 years; for the arrangement was such that public health was subordinated to the pinchpenny policies of the Destitution Authority with its avowed, its built-in philosophy of deterrence – the very last approach that you want in a health service.

For the years of its infancy, the public health service in this country was under the surveillance of a department which it was said was ever-ready to hinder and rarely, if ever, to help. Throughout its long life, the Local Government Board really didn't show very much interest in the health needs of the nation. It was so busy keeping the ledgers of the Poor Law, and those ledgers were most scrupulously kept, that it seemed never to have the will to lift its head and look out of the window to see what were the real health needs of the nation. Advances there were to be – substantial advances as we shall see, but rarely, if ever, did they come about as a result of leadership from the centre. Almost always they emerged as a result of initiatives shown by enterprising Medical Officers of Health, supported in almost every case by voluntary and charitable effort.

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And so it was right from the start: public health was subordinated to the Poor Law. The Head of the Poor Law side of the department – he had been secretary of the old Poor Law Board – had direct access to the minister; he was then called the President of the Board and was in daily conference with him on the programme, the policy of the department.

<Chave narrates over image of Simon>

But Simon, as head of the public health side, had no such access. He could only approach his political chief through memoranda submitted up through civil servants who were placed above him. You can imagine how humiliating he found this after the position he had held for so long. He protested about it. He wrote long memoranda to the President for which he received only formal acknowledgements. He sought interviews which were never granted. And so after four years, he could sustain the humiliation no longer and he threw in his hand. He retired – he retired to pursue his wide cultural interests of which he had many and to his writings.

<Chave to camera>

And his greatest written work was his book entitled English Sanitary Institutions in which he traces the development of hygiene and public health in this country from the time of the coming of the Romans until the end of the nineteenth century. And in a book of some 500 pages, he reaches the reign of Queen Victoria at page 178, and after that he is dealing with events that occurred in his own lifetime, many of which he was involved in himself and it is, in fact, autobiographical. So much then for Simon and the Central Department

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Now to the 1872 Public Health Act. This virtually created a national public health service. It divided the country up into districts which were to become known as urban and rural districts, each under a local elected authority. And each of these authorities was required to appoint a Medical Officer of Health. And this was Simon, who had

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seen, if the call of sanitary development was to be advanced across the country, it had to be spearheaded, it had to be lead at every level by a Medical Officer. Now you'll remember that under the Public Health Act of 1848, local authorities had been empowered to appoint Medical Officers of Health if they wished – but did they wish? Most of them didn't wish. Most of them looked on him as an expensive luxury they could afford to do without. So by 1870 only 92 authorities outside London had appointed a Medical Officer of Health. Now there were to be more than a thousand of them – more than a thousand of them! This literally put the MOH on the map and right across the country.

The Act required the appointment of a Medical Officer of Health, but it didn't require that he should have any special training or experience. However, the need to train doctors entering this new speciality of public health was quickly felt, and was first met in Ireland when, in 1871, Trinity College Dublin established a postgraduate course leading to a Diploma in State Medicine as it was called. And state medicine was a term which was used synonymously with public health at that time. Shortly after the title of the diploma was changed to the Diploma in Public Health, the DPH.

Cambridge followed with its DPH in 1875. And before long, just about every medical school and university in the country was running its postgraduate course in public health. In 1888 Parliament set the seal of statutory authority on the qualification by requiring the MOH of any district having a population of 50,000 to hold the DPH. This was an important first step, but the next step was many years away. For, because of the lethargy of the Local Government Board, it wasn't until 1926 that an order was made requiring every Medical Officer of Health appointed after that date to hold the DPH. And even here there was an escape clause exempting anyone who had held the office for 3 years, and it was only in 1936 that this last loophole was finally closed.

So, we see then that only slowly did the MOH become a specialist, win his spurs as a specialist, and the DPH became the criterion of proficiency in public health or state medicine. However, in those early days, the Medical Officer of Health had a great deal more to worry about apart from his training and qualifications. He was worried

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about his security, his salary and his status. At the outset he had precious little security. The Act forbad appointments being made for more than 5 years and the Board, whenever it could, limited appointments to only 3 years. In the matter of salary, local authorities were each a law unto itself. There were no annual increments and the amount could be altered at will. Woe betide any man who was too enthusiastic for sanitary reform. The Medical Officer of Health of Fulham who, shortly after his appointment, put forward a comprehensive scheme for sanitary development in the district had his salary cut from 600 to 300 pounds a year for his pains. How dare he propose to spend the ratepayers' money in so prodigal a fashion? That would teach him. And there were many other similar examples. And the Local Government Board did nothing to protect the MOH from these assaults. The only support he got was from his colleagues in the Society of Medical Officers of Health.

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And as most of the local authorities, and particularly the small ones, were only appointing MOH because they had to, to comply with the letter of the law, many a candidate for a post at his interview received the quiet intimation that his salary and his appointment would be safe so long as he made only minimal demands on the rate fund. This was the kind of situation of insecurity in which the MOH was to live and work through those early days. The Local Government Board gave him no security and it wasn't until 1921 that an order was issued by the Ministry of Health which laid down that a Medical Officer of Health should not be dismissed save only with the sanction of the Minister.

And then there was his status within the system of local government. For the most part, nearly all Medical Officers of Health held part-time appointments because the authorities expected them to earn their living out of general practice. Of course, the large cities and big towns had to make full-time appointments immediately by reason of the size and nature of the public health task. And always the trend was away from part-time to full-time appointments, but it wasn't until 1929 that Parliament laid down that every Medical Officer of Health should hold a full-time post. And where an

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authority was too small to employ the full-time services of one man, then they had to combine with their neighbours roundabout to share the services and salaries of a doctor holding a full-time post.

So, we see then that after the passing of the 1872 Act, there was a long uphill struggle of 60 years before the MOH emerged as a Medical Officer in the local government service holding a full-time post, having a statutory recognised qualification and secure from arbitrary dismissal by the protection of the Minister. And only then was the prescription written by Chadwick, long before, finally fulfilled.

And now we come to the 1875 Public Health Act.

<Chave narrates over image of page from Act>

Now this was a major, massive, magnificent statute incorporating the whole of public health law. And it remained a charter for action for the Medical Officer of Health for no less than 60 years. And rarely in our history has a major statute remained operative for so long, a testimony then to the man who had drafted it, and that was Simon. It was his swansong.

The conceptual basis of the Act was the sanitary idea; little was it touched by the more recent discoveries of the bacteriologists. Noxious effluvia from cesspools, sewer gas from drains, obvious dirt and filth rather than germs were the enemies to be tackled through sensible, practical sanitary action. Thus on the basis of a false hypothesis, much public good was to be achieved.

The great Public Health Act of 1875 marked the high-water mark of environmental sanitation as a notionally complete system of health for the nation. And it continued under its own momentum for many years, but towards the end of the century, the sanitary idea began to be overtaken by a new idea – a new concept, the concept of the individual and his or her personal health needs. The great feats of the sanitary engineers led by local Medical Officers of Health had brought about substantial improvements in the public health. Through the period with which we have been

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concerned, the annual death rate had fallen from 23 to 15 per 1000 persons. And the expectation of life of a male at birth had risen from 40 years, as it was in 1840, to 50 years, as it was in 1900. A marked, massive, measurable improvement in health adding years of life to the average person. But for the Medical Officer of Health and the Public Health Movement, there were no grounds for complacency for the infant mortality rate, perhaps our most sensitive index of social health, remained obstinately high at about 150 per 1000 births, indicating that about 1 in 7 of all babies born under Queen Victoria did not live to see their first birthdays. While every year some 4000 mothers were dying in childbirth, 4000 maternal deaths per annum.

It was becoming clear that environmental sanitation was not enough to secure an adequate standard of health for the great mass of the people of this country, and that what were needed were the services directed specifically towards the needs of vulnerable groups. And the first of these were mothers and children. And this swing of interest, the swing of the pendulum of primary concern in the Public Health Movement away from its traditional concern with the environment towards the health needs of the individual coincided very closely with the turn of the century. And it is to that that we shall turn next time.

<End credits>

<*In addition to those listed at beginning of transcription*>

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