Wellcome Film Project

The Evolution of Community Medicine: Parts 7 & 8

Presented by Dr Sidney Chave, London School of Hygiene and Tropical Medicine.

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Produced by John Winn and Paul Wilks.
Edited by David Crawford.

Colour
Duration: 00:33:38:24

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<Opening titles>

Part 7: Destruction and Reconstruction

<Chave, seated, to camera>

Last time, you may remember, we reached the year 1929 when, with the passing of the Chamberlain Local Government Act, the Medical Officer of Health reached the height of his powers, the peak of his career. 10 years later war came again and, within a short time, the Medical Officer of Health found himself stretched as never before because he had to continue to provide the ordinary public health services, which I listed last time, for a population living and working under difficult, dangerous and the abnormal conditions of war, but then in addition to that, he was responsible for the organisation of casualty services for his area and for co-ordinating them with the hospitals. Whenever the air raid warning sounded out, the MOH was on duty. A number of them lost their lives as a result of enemy action and others received awards for gallantry in civil defence.

The mass movement of population, the mass evacuation of people from the towns and cities to the greater safety of the countryside, and the massive bombing of the towns and cities that followed led to fears of epidemics. And these were met by a stepping up of the ordinary, ongoing public health precautions, especially in regard to the protection of water supplies from contamination with sewage which was always a danger under the bombing. And as a result of these precautions, there was no outbreak of waterborne disease attributable to enemy action through the whole of the war.

There was also an expansion of the ongoing immunisation programme, especially against diphtheria. Diphtheria, which in 1939 had taken 3000 lives, in 1946 took only 300. And there was also an expansion of the use of mass x-ray for the early diagnosis of tuberculosis, leading to early treatment. All this was good, sound public health carried out under the destructive conditions of war.

Now, war can bring out not only the worst but also the best in man, and so it was on this last occasion when, particularly in the early years, there was a new spirit of idealism abroad, a feeling that we were fighting to produce a better society, a more humane, a more caring society that we would bring in when the fighting was over. And so it was that in the dark days of 1941, Winston Churchill's coalition government set up a committee under […]

<Chave narrates over still photograph of William Beveridge>

[…] William Beveridge to plan a new system of social security. The committee immediately handed over their responsibilities to Beveridge himself, and a year later he produced his report, the famous Beveridge report, which was published in 1942 and it was published over his own hand. Just as 100 years before, Edwin Chadwick's report had also been produced in the same way. And just as the Chadwick Report had led to the founding of the English Public Health Movement, so the Beveridge Report was to lead to the founding of the Welfare State.

<Chave to camera>

The Beveridge Report embodied proposals for a universal, comprehensive system of social security to be based on a compulsory, contributory insurance scheme which should embrace all working people. And it was to provide benefits to meet all the crises of life: the crises of birth and death; of sickness and employment injury; and to supply, provide support in old age. It was a plan to cover us and our needs from the cradle to the grave. It was a plan to banish want from our society.

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It breathed the spirit of Beatrice Webb's Minority Report.

<Chave narrates over still photograph of Beatrice Webb>

And this is not to be wondered at because as a young man William Beveridge had been an assistant to the Webbs. What Chadwick had been to Bentham, so Beveridge had been to the Webbs.

<Chave to camera>

And it fell to him to realise the aspirations of his mentors. Now, Beveridge claimed that his proposals, his scheme, his system, must rest upon three assumptions, three premises that must be met by government. And the first of these was that there should be a system of family allowances to provide additional benefits, additional support to young families, which should be financed outside the social security system. The second premise was that governments would, through their policies, maintain full employment so that never again would the National Insurance Scheme be bankrupted as it had been by mass unemployment in the slump of 1930 to 31. And the third premise, and here I quote, was: that a comprehensive national health service will ensure that for every citizen there is available whatever medical treatment he requires, in whatever form he requires it, domiciliary or institutional, general, specialist or consultant, and will ensure also the provision of dental, ophthalmic and surgical appliances, nursing and midwifery and rehabilitation after

accidents, and that this be provided without payment at the time of need. And this was Beveridge's prescription for a national health service.

But why, you may ask, why a national health service to underpin a social security system? Because Beveridge, like Lloyd George, like the Webbs, like Edwin Chadwick before him, believed that sickness is a prime cause of poverty. Prevent the one, Chadwick had said, and you prevent the other. Lloyd George had seen this, the Webbs had seen it and Beveridge believed it. He believed, indeed, that a national health service might even pay for itself. How wrong he was. He did not foresee that adding years to life does not decrease but increases the demand for medical care because it is the elderly, the older age groups, who make the biggest demand on the health services. He didn't foresee the rising expectations people would have about the health services they wanted to have available to them. He didn't foresee the lowered threshold, the lowered tolerance of discomfort and disease that people would accept before they called on the help of the health services. And he didn't foresee, perhaps he couldn't have foreseen the Parkinson type effect that always operates in that whenever we provide a service, we thereby create a clientele to make use of it.

But then, how easy it is for us to say these things for we speak with the wisdom of hindsight, so let us not be too severe in our strictures. Beveridge had proposed a national health service. The idea was not his, indeed, it was not a new one; it had a long and respectable history. You may remember that Beatrice Webb in the Minority Report had recommended the setting up of a national medical service with the hospitals linked with the local public health services at the local level. Then in 1919, following the setting up of the Ministry of Health, Christopher Addison, the first minister, wanting to win his spurs had set up a committee under Lord Dawson of Penn to make recommendations about the future development of the medical services. And the Dawson committee had recommended a national medical service made up of a network of health centres. Health centres? What are health centres? That was a new concept. Well, to Dawson, a heath centre was to be a base where general practitioners would work in groups or teams with some perhaps practising in specific aspects of medicine. It was to provide a base for public health doctors and

public health staffs, and it was to be a place to which hospital consultants would come out to give specialist treatment and advice at a consultant basis, so to practice the whole of medicine in the community, for as Dawson so wisely said: preventive and curative medicine cannot be separated on any known principle. And it was going to take us a long time to learn that lesson.

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Then later still in 1926, a Royal Commission had reviewed the National Health Insurance Scheme. It had recommended the extension of the scheme to the dependants of the worker so far as the provision of care from a family doctor was concerned, but they could see no way of introducing treatment from hospitals in the scheme without transgressing the sacred principle of the voluntary nature of the hospitals. Then later on in 1929, the British Medical Association did a complete volte face. In 1912 it had bitterly opposed the introduction of the National Health Insurance Scheme. Now it turned round and came up with some very sensible proposals for what it called a national medical service for the nation. The scheme was a good one and so 10 years later, the BMA brushed it up and published it again. And then in 1938, PEP, Political and Economic Planning, an independent body which reports and recommends on matters political, economic and social in our society, also came up with its set of proposals for a national medical service.

Now, all these ideas, these plans, these proposals, these blueprints were on the table in 1944 when, following the breakup of the coalition government, the Conservatives came forward with their plan for a national health service which was embodied in their white paper of that year. However, the general election of 1945 swept all that and much else away. It swept the Labour government into office under Clement Attlee and […]

<Chave narrates over still photograph of Aneurin Bevan>

[…] it swept Aneurin Bevan into the Ministry of Health. And he quickly swept his predecessors proposals into the waste paper basket. And shortly after that he came up with his own plan for a national health service.

<Chave to camera>

And Bevan's plan for a national health service was based on a tripartite structure. The well-known tripartite structure with general practice organised through local executive councils of which there were to be about 150 across the country. And then quite separately, the personal health services to be provided by the major local authorities, that is the councils of the counties and the county boroughs, which were now designated local health authorities. And then quite separately again, a state takeover of all hospitals, municipal and voluntary, to be administered through 14 regional boards appointed by the Minister.

And this was the scheme that went onto the statute book in 1946 and then followed the discussions with the doctors. And they lasted a year and they were tough and they were nearly all about money. Does this remind you of 1912? The main issues were the sale of practices which at that time were bought and sold like bits of real estate; about pensions for doctors; about capitation fees and so on. There are threats of mass withdrawal from the service by the BMA, but, in the end, difficulties were resolved and all was sweetness and light.

On July 5th, 1948, when the National Health Service was brought to birth, it had been a long and difficult gestation, but the outcome was a healthy and vigorous infant. For the National Health Service provided comprehensive medical care for every man, woman and child in the country without payment at the time of need, and backed that up with a positive provision of the personal health services. That was its achievement. How it would have warmed the hearts of the pioneers of the Edwardian period who had set us out on that path.

The massive rush of patients to general practitioners to obtain free medical treatment, which had been expected, did not occur. What did occur and what was

completely unexpected was a massive rush to obtain dentures and spectacles. The people didn't want doctors – they wanted teeth to eat their food with, and spectacles to see what they were eating. And this indicated a hitherto massive unmet need.

But, what had happened to public health and the medical officers of health? The medical officers of health had strongly recommended that the National Health Service should be organised and administered at the local level by the local authorities. But, this was in no way acceptable to the rest of the medical profession, and so under the tripartite structure, preventive and curative medicine went their separate ways. And the MOH lost his hospitals and he was given the ambulances to look after instead. This caused something like dismay at first, frank dismay, but as the country moved into the post-war period, it brought for the medical officer of health new opportunities, new challenges and, let's face it, disappointment too; and all these, and what they were we shall see next time.

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Part 8: From Public Health to Community Medicine

<Opening shot of display of health promotion posters. Camera pans down to Chave, seated>

<Chave to camera>

We have reached the year 1948 when with the founding of the National Health Service, based as it was on the tripartite structure, preventive and curative medicine went their separate ways, and the MOH lost his hospitals and was given the ambulances to look after instead. This came as a serious blow at first. It seemed to take him back to before 1929, but as the country moved into the post-war period so it brought for the MOH new opportunities, new challenges, but, as we will see, disappointment too.

The opportunities came with the changing demographic structure of our society. We were becoming an older population and so there came the need to develop services to meet the needs of the increasing numbers of old people, who were surviving in the population; and also for the handicapped, the mentally and physically handicapped. The challenges came with the changing pattern of disease as the infectious diseases of the past gave way, through the use of immunisation procedures and antibiotics, to what we may call the behaviourally based diseases of the present – to the plagues of our contemporary society, by which we mean: lung cancer; coronary heart disease; death and disablement on the road; the large but largely hidden problem of alcoholism; the rising problem of drug addiction; the small but increasing incidence of venereal disease in young people; and the massive problem of unwanted pregnancy.

All this brought out the need for new methods of approach, new methods of detection and prevention. It saw the expansion of traditional prevention into what we now call primary, secondary and tertiary prevention. And it saw increasing importance being attached to health education as a weapon with which to attack these new problems. And if we put together these new opportunities and the way they were met, and the new challenges and the way they were met, and the expansion of prevention in the way that I've touched on, all that put together created what came to be called modern public health. This was modern public health as distinguished from traditional public health with its root down there in the drains.

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But, I spoke of disappointment. This came in the 1960s with what we may call the revolt of the social workers. By this time just about every department of local government was employing social workers. The Health Department had them, the Education Department had them, the Children's Department had them, Probation, the Housing Department had them and so on and so on. And in the 1960s, the social workers said, in effect, 'Look here, we are tired of acting as handmaids to other professionals. We are professional people in our own right with our own professional training, qualifications and expertise'. And they demanded the right to practise that expertise in independence from other professions. Their claim was examined by the

Seebohm Committee who came out in their favour. And so it was in 1969, all these social workers were withdrawn to the newly established Social Services Department. And so the MOH lost all his social workers and his welfare work and, incidentally, he lost half his budget.

However, this man was nothing if not resilient and, towards the end, we saw him building bridges across to general practice through the attachment of his remaining health visitors and nurses to GPs as they moved into group practice and into health centres. And so the National Health Service staggered along unsteadily on its three legs for 20 years. There were those who prophesised that it would fall flat on its face in complete collapse. In fact, it never did. It had an inherent sense of purpose, dare I say, a sense of dedication to its task that kept it going.

However, it was quite clear we hadn't got it right. The tripartite structure was not the best way of organising a health service for this country. And as we moved into the 1960s and particularly after the publication of the Porritt Report, people began to say the health service has got to be restructured; it has got to be integrated. And integration was the word that was used. You couldn't speak about our health service in the 1960s without mentioning integration. The health service has got to be integrated. Yes, said the medical profession. Yes, agreed the politicians. Yes, murmured the suffering public. But, how? That was to be a problem for the politicians.

Under Labour, Kenneth Robinson produced his green paper with his scheme, shortly to be replaced by a second green paper produced by Richard Crossman. A change of government put Keith Joseph into the hot seat and brought forth the Conservative's consultative document, better called a management document because that was what it was all about. What Keith Joseph was saying, in effect, was this: this health service we have created is a monster with an insatiable appetite. It is a bottomless pit into which we can go on pouring resources and it will never be filled. Times are getting hard. What the health service has got to do is something that it has never attempted to do yet and that is to make better use of the resources that it now has. And that is going to mean better management. And that was the keynote of the

scheme that went onto the statute book in 1973. And by one of the cruel ironies of our political system, it fell to his opponent, Barbara Castle, to have to implement it.

Now, when the integration of the health service began first to be mooted, it became clear to us, as indeed to others, that there will be no place in such a service for a medical officer of health. This specialist in public health and preventive medicine would become an anachronism. And so he must go. But, it was equally clear to us that there had to be someone, and that someone a doctor, into every one of the areas into which the country was to be divided for health service purposes, and at first there were 90 of these areas. They had to be a doctor in each one of these areas whose task it would be to have to make an assessment of the health status of the local population and to be responsible for advising the health authority on how best to use its available resources to meet those needs.

Now, who should this be? Not the medical officer of health. This has never been his job as we have seen. And he was not trained to do it. And so we created a new man, a new specialist and we called him the community physician. But who was he? And what were his antecedents?

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To understand these, we have got to hark back to the 1930s when, along the corridors of public health, a new word, a new term, a new subject began to be spoken about. It was social medicine. Now, by social medicine is meant the application of medicine not to the individual person or patient, which is clinical medicine, but to the population which is social medicine. Now, public health had always been population orientated in its programmes of prevention as we have seen. But, social medicine represented an extension of the public health idea for it was to be concerned with all the factors which influence health and disease in populations, including their use of health services. The subject attracted a lively interest.

It achieved its first measure of academic respectability in 1943 with the translation of John Ryle from Cambridge to Oxford.

<Chave narrates over still photograph of John Ryle>

John Ryle was a clinician who had had an eminent career in clinical medicine. And this was crowned by his appointment to the Regius Chair of Physics at Cambridge. But in 1943 he threw all this away to go to Oxford to take the first Chair of Social Medicine that had been funded by the Nuffield Trust.

<Chave to camera>

And he afterwards wrote his apologia in a little book that he called, Changing Disciplines.

<Chave narrates over series of still images and close-up shots of books, interspersed with talk to camera>

Now, this was an important first step. And thereafter, the subject expanded rapidly, it burgeoned. In 1944 came the second Chair of Social Medicine set up at Birmingham under Professor Tom McKeown, who is well-known for his writings. In 1947 the BMA founded the journal which was to become the British Journal of Preventive & Social Medicine for the publication of research in this field. And in 1948 the Medical Research Council founded the Social Medicine Research Unit under Dr – now Emeritus Professor – Morris. This not only undertook important research in the field of social medicine, and particularly with regard to the problem of coronary heart disease, Professor Morris's Unit also served as a training ground for academics and research workers entering the new field.

In 1956 there came the founding of the Society for Social Medicine for the presentation of research and the discussion of issues in this subject. And what was important here was that the membership was not confined to medical people but was open to the small band, the small but increasing band of social scientists and statisticians who were entering the new field. During the 1940s, 50s and 60s, social medicine was busy mapping out the field of its enquiry, developing epidemiology as

its basic science, learning to use the tools of the statisticians to express its findings and to test their validity.

The next important step came in 1968 with the publication of the report of the Royal Commission on Medical Education, the Todd Commission, when for the first time in any public document, this referred not to social medicine but to 'community' medicine, and defined it in terms which embraced social medicine of the past, but gave greater weight to the organisational and administrative aspects of the subject than had academic social medicine. And it was within the context of community medicine, as defined by the Royal Commission, that we began to speak of the community physician as the practitioner of community medicine.

In 1969 the training of the community physician began at the London School of Hygiene where Professor Morris and his colleagues established a course for a higher degree in community medicine, and in that year graduated their first postgraduate students. In 1970 the Hunter Committee, which had been set up by the Ministry of Health, issued its report setting out the role that the community physician would hold as medical administrator in the National Health Service. And then in 1972 came another and most important step when the Royal Colleges of Physicians of the United Kingdom combined to found the Faculty of Community Medicine, thus signifying the acceptance of the new speciality by the medical profession. And it is membership of the Faculty of Community Medicine, the MFCM, that is for the community physician today what the DPH was to the MOH of the past.

And so we come to that night of Sunday March 31st, 1974; on that night the MOH, the local health officer we had had in this country for a century and a quarter, passed into the pages of the history book – he was no more. But, on the following morning, there emerged out of his ashes, shining like the phoenix, the new man, the community physician, charged with the new tasks in the integrated health service that came into being that day. That day marked an end and a beginning. It marked the end of a system of public health that went back to the Royal Sanitary Commission and beyond that to the founding fathers, to John Simon and Edwin Chadwick. It marked

the beginning of a new system in which a community physician would occupy a key role in an integrated health service providing medical care for all the people.

The community physician came into being in a situation of change. And change continues: the National Health Service has been restructured, yet again, in 1982. But, through all the change the essential remit for the community physician is the same as it always was for the medical officer of health: it is so to order, the resources, the health resources of the community so as to promote the greater good of the greatest number. So, perhaps, we end where we began with an old philosopher who once persuaded a young lawyer to enter the public service and found the English Public Health Movement, from which there has evolved, in the way that we have seen, the new specialty concerned with the protection and promotion of the health of all the people that we call community medicine.

<End credits>

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

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