How the minority report deals with the sick, the infirm, and the infants / The National Committee to Promote the Break-up of the Poor Law.

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How the Minority Report deals with the Sick, the Infirm, and the Infants.

(*a*) *The Existing Muddle.*

When the present Poor Law was established it comprised within itself the whole of what little public provision was then made for the sick or infirm poor, or for maternity and infancy. To-day we are spending in the United Kingdom out of the rates and taxes not less than six or seven millions sterling annually on these services, by different public authorities, with an amount of overlapping, duplication, waste, and muddle that is almost incredible. The Minority Report describes, in vivid detail, how there are throughout the United Kingdom, at the present time, two separate and distinct public authorities dealing with the sick poor: the Poor Law Authority, providing medical attendance, nursing and medicine, and often institutional treatment, for destitute sick persons whatever their diseases; and the Local Health Authority, providing, in the same area, medical attendance, nursing and medicine, together with institutional treatment where required, for persons, whatever their affluence, suffering from certain specific diseases. Alongside of these two ubiquitous rate-supported Medical Services, we find a whole array of medical charities of one sort or another, dealing with essentially the same classes of persons and many of the same diseases.

(*b*) *The Medical Service of the Poor Law.*

Of the million of simultaneous paupers, probably 250,000 are definitely ill, requiring, primarily, not maintenance, but appropriate medical treatment. These are attended to in England and Wales by nearly 3,800 Poor Law doctors, and in Scotland by over 1,000—nearly always local practitioners who are paid a quite inadequate stipend to look after the

paupers. Only in London, Glasgow, and a score of large towns have separate Poor Law institutions for the sick been provided. These, which have sometimes become virtually general hospitals, are a vast improvement on the workhouses, but they still suffer from (1) insufficiency of medical staff, (2) having far too few nurses, and (3) the "deterrent" influence of the Poor Law. *Everywhere else the sick are still in the General Mixed Workhouse*—the maternity cases, the senile, the cancerous, the venereal, the chronically infirm, and even the infectious all together in one building, often in the same ward—where they cannot be properly treated. For the phthisical, for instance, there is (except in a few places) no proper provision at all.

The Outdoor Medical Service of the Poor Law for treatment of the sick poor at home is equally behind the times. The underpaid parish doctor is nearly always made to find medicines, dressings, etc., at his own expense. Practically nowhere do the Poor Law Authorities supply a trained nurse, even where no "district nurse" is available. With regard to the sick the failure of the rural districts is even greater than that of the larger urban centres, with their separate infirmaries.

But the fundamental failure of the Poor Law with regard to the sick lies not in any of these shortcomings, serious as they are, but in its very nature. It is inherent in any Poor Law that it is confined to the relief of the destitute; until the man stricken with disease has become so ill as to be unable to go to work he is not destitute. But when the disease has gone as far as that, it is usually too late to prevent its ravages. One-third of all the deaths from phthisis take place in Poor Law institutions. Yet the Poor Law doctors testified that they never saw a phthisical case in the stage in which the disease could be arrested and cured. *The Poor Law fails with regard to the sick, in town and country alike, because it has to wait until destitution has set in.*

(c) *The Provision under the Poor Law for Childbirth and Infancy.*

The Poor Law, like everything else, starts from childbirth. The ordinary citizen is unaware that to the Poor Law Authorities are confided our public Maternity Hospital and our State Nursery. Yet *every day of the year sees at least forty children actually born in the Workhouse.* What does

the Poor Law do with these hapless "Children of the State"?

Two facts only need be stated in this connection.

Firstly, it does not even occur to many Poor Law Authorities to go to the expense of paid nurses for the actual handling of the babies, even when they leave the mother's care. We learn that "In *all* the small Workhouses and in many of the larger ones, the infants are wholly attended to by, and are actually in charge of, aged and often *mentally defective* paupers." The "Children of the State" in the hands of imbeciles! One case is mentioned of such a pauper attendant being told to wash a baby. *She did so in boiling water*, and the child died.

Secondly, comparing the infantile mortality statistics for the general population with those for 450 Poor Law Unions, it appears that out of every 1,000 non-pauper babies born in England and Wales amidst the unregulated conditions of the average home, twenty-five die within a week, whilst out of every 1,000 babies born in Poor Law institutions no less than *40 to 45* die within a week. In Scotland the contrast is at least as great. Lest it be supposed that this excessive mortality arises from the class of mothers dealt with, it may be added that some Workhouses surmount all the difficulties and lose only one or two infants by death in a whole year. Others, actually in the same towns, and dealing with populations of no worse class, have an infantile mortality percentage throughout the infant's first year six or *even ten times as great*. Again, in many Workhouse Nurseries the mortality among children up to four or five years of age is apparently also excessive. Though infants are constantly being admitted, the Workhouse Nurseries have no probation wards or quarantine arrangements for newcomers, so that epidemics of measles and whooping-cough are frequently introduced, with deadly results. Even the very elements of health are ignored. The Royal Commissioners actually visited some Workhouse nurseries on the fourth storeys of gigantic buildings *where the babies never go out into the open air!* All this means not only an excessive mortality in most of the Workhouse Nurseries but also *the bringing up with enfeebled constitutions and disordered digestions of those infants who survive*. The Poor Law, in fact, here as elsewhere, creates its own future paupers!

(*d*) *The Provision for the Sick by the Public Health Authorities.*

The voluntary agencies treating the sick poor are not the only rivals whose work overlaps or surrounds that of the Poor Law Medical Service. It was formally brought to the notice of the Royal Commission by the Medical Officer of the Local Government Board for England and Wales, by the Medical Member of the Local Government Board for Scotland, and by the Medical Commissioner of the Local Government Board for Ireland, as well as by the Medical Officer of the Board of Education for England and Wales, that every part of the United Kingdom is now provided with an equally ubiquitous, quite as highly qualified, and nearly as costly a service of public medical officers, maintained by the Local Sanitary Authorities.

Starting from the provision of temporary isolation hospitals for cholera patients and then for those attacked by small-pox, the Public Health Authorities in England and Wales alone now maintain over 700 permanent municipal hospitals, having, in the aggregate, nearly 25,000 beds, or nearly as many as all the endowed and voluntary hospitals put together. These vary in size and elaboration, from the cottage or shed with two or three beds set aside for an occasional small-pox patient, up to such an institution as the Liverpool City Hospital, divided into seven distinct sections in as many different parts of the city, and having altogether 938 beds, served by six resident and seven visiting doctors, and treating nearly 5,000 patients a year, for an average period of seven or eight weeks.

The Manchester Town Council maintains the Monsall Fever Hospital, with 415 beds, which makes no charge whatever to the patients; another at Baguley, with 100 beds; and a third at Clayton Hill for small-pox cases. The Birmingham Town Council has a couple of hospitals, having together 610 beds. The Leeds Town Council provides a series of hospitals and isolation dwellings, principally for scarlet fever, diphtheria and small-pox, accommodating over 600 persons, where patients are admitted "without any charge whether they belong to the families of ratepayers or of paupers." These towns are typical of many others. Mention must here be made of the hospitals of the Metropolitan Asylums Board, because, though administered by a

body largely made up of representatives of Boards of Guardians, and actually maintained out of the poor rates, they have become, both by statute and by Local Government Board decisions, practically public health institutions. The dozen great hospitals thus maintained for small-pox, scarlet fever, enteric fever and diphtheria, now admit all cases recommended by any medical practitioner, irrespective of the patient's affluence. The maintenance and treatment, once made matter of charge, is now by virtue of the Public Health (London) Act, 1891, universally free. The inmates, originally exclusively paupers, are now explicitly declared to be not pauperised, the treatment, and even the maintenance, being (by the Diseases Prevention Act of 1883) expressly stated not to be parochial relief and to involve no stigma of disqualification whatsoever. The municipal hospitals of the provincial towns, provided in the first instance usually for small-pox, have had their spheres extended to scarlet fever, enteric fever, and usually diphtheria; in addition to any stray cases of plague, cholera or typhus that may turn up. But they do not stop there. The Public Health Acts do not prescribe the kind of disease to be treated in the hospital which they authorise, and whatever may have been the primary object for which it was established, there is nothing to prevent the Local Authority from admitting any sick patients whatsoever. Hence, although it is generally assumed that these so-called "Isolation Hospitals" are for infectious cases only, the list of diseases dealt with is steadily growing. At Barry and Widnes there are even municipal hospitals which exclude all infectious diseases.

But the greatest recent development has been in the provision for tuberculosis. The Brighton Municipal Hospital in 1906 actually dealt with more cases of phthisis than of any other disease, they forming a third of its whole number of patients, and amounting to nearly two per 1,000 of the entire population of the town. The object of their admission is not so much immediate cure as treatment with a view to instruction in good hygienic habits. They are therefore admitted preferably at an early stage, before being invalided, and they are retained only a few weeks, passing then to their homes, where they are periodically visited. At Manchester, the Town Council not only pays for beds at the Delamere and Bowden Sanatoria, but has for several years opened special phthisis wards at its Clayton Vale Hospital.

At Leicester, the Town Council has set aside a special hospital block for curable cases, no charge being made for maintenance and treatment during the first month. In Scotland the Local Government Board has definitely made the Local Health Authorities as responsible for all phthisis cases as for small-pox.

(*e*) *The Health Visitor and the Municipal Milk Dispensary.*

An equally striking development of the Local Health Authorities' work is the organisation, in a hundred towns, of a staff of Health Visitors. The Local Health Authority found the bulk of the poor mothers—those in receipt of Outdoor Relief no less than the others—totally unaware how to rear their babies in health. They were both unable and unwilling to pay for the private practitioner's advice, at any rate so long as the babies were not actually ill, and the Destitution Authority provided no instruction even for the mothers whom it was relieving. The result has been the creation of a remarkable organisation, partly paid and partly voluntary, by which the Medical Officer of Health attempts to keep under observation during the whole of the first year of life, all the babies born in the poorer families, including those who are on the Outdoor pauper roll of the Destitution Authority, and those among them who are actually under the attendance of the District Medical Officer. This organisation has already gone very far. At the present time, in the poorer districts of many towns of Great Britain, every house at which a birth occurs, or at which a child under two years has died (even those at which the District Medical Officer is in attendance) is visited by an officer from the Medical Officer of Health's Department—in some places by a lady volunteer, in others by a semi-philanthropic paid agent, in others again by a trained professional Health Visitor, qualified by a sanitary certificate or a nurse's experience. Including the organised volunteers, there are already more Health Visitors than there are Relieving Officers in England and Wales. At Huddersfield and elsewhere some of these Health Visitors are even qualified medical practitioners. They interview the mother and inspect the baby; they advise how it should be fed, washed, clothed, and generally treated; they criticise what is being done wrong or unskilfully; they keep a sharp eye for the presence of disease

to be reported to the Medical Officer of Health; they suggest hygienic improvements in the household; if the baby is ailing they are often able to suggest the cause and remedy; and, finally, if the case looks serious, they urge the obtaining of further professional advice either by the calling in of a doctor for payment, or by application to the Relieving Officer for the attendance of the District Medical Officer.

In a dozen towns (St. Helens since 1899; also Liverpool, Battersea, Finsbury, Lambeth, Woolwich, Glasgow, Leicester) the Health Authority has gone a step further. It provides a municipal milk depôt, or rather a "milk dispensary," at which babies requiring artificial feeding are supplied with pure milk (and hygienic feeding teats) on payment of a small sum. At Liverpool this has developed into an elaborate organisation with branch depôts in various parts of the city, supplying "humanised sterilised milk" of seven different grades, for infants of various ages (in addition to the babies brought to the depôts) to many hundred families by direct delivery. But the special interest of the "milk dispensary" to the sanitarian is the personal supervision which it enables the Medical Officer of Health to exercise over these ailing babies. At Finsbury the supply of the milk was made conditional on the babies being brought regularly for inspection, accurate weighing, and hygienic advice. Those who cannot be brought are visited in their homes. At Glasgow a qualified medical practitioner (lady) visits every home as a matter of course. Practically, though not avowedly, the Medical Officer of Health becomes the Medical attendant of each of these infants; to whom, indeed, he not infrequently supplies the milk gratuitously rather than let them die or compel the destitute parents to "go through the rigmarole" of obtaining Poor Law relief for them. "During the hotter portion of the year," reports the Medical Officer of Health for Norwich, "and to a lesser extent since, with the sanction of the Health Committee, I have distributed (through the lady health visitor) a considerable quantity of dried milk powder to necessitous mothers and, on the whole, have been well satisfied with the results."

The Health Visitors are not confined to infant visiting. They often go at once to every house at which either an infantile death or a death from phthisis or any infectious disease is notified, with a view of inquiring into the sanitary condition of the premises, ensuring the execution of any

necessary disinfection, and (with regard to deaths of infants under two years old) also obtaining elaborate particulars as to the method of feeding, source of milk supply, etc. The Health Visitor goes also to any house in which sanitary defects are complained of. She follows up "contacts." She visits all the cases reported from the public elementary schools of children staying away or excluded on account of measles, whooping-cough, ringworm, etc. She investigates cases of erysipelas for the Medical Officer of Health. She visits the patients discharged from the municipal hospital, and exercises a certain amount of supervision over them. She may even, so far as time permits, visit from house to house in blocks or districts in which special sanitary care is for any reason required. Wherever she goes, she makes such inspection of the inmates as she can; she is able to report to the Medical Officer of Health where and what diseases exist, and which cases are without medical attendance; she gives hygienic advice; she makes known the facilities with regard to phthisis; and she advises the calling in of a medical practitioner where necessary. Her advice is found specially useful in those children's ailments which are so often treated lightly without medical aid. The Medical Officer of Health for Warwickshire points out in one of his reports (1903) that "the work of the Health Visitor does not trench on the work of the Sanitary Inspector; that she is not an inspector in any sense of the word, and that her functions are those of friend of the household to which she gains access. He also states that although at first there may have been some opposition to her entering a house, it rapidly died away, and in numerous instances she has been asked to return and aid the family by her help and counsel. He also believes that in this new departure of carrying sanitation into the home, we have not only an important, but almost the only, means of further improving the health of the people, and that in the future, although sanitary authorities, by providing water supply, drainage and decent houses, have done much in the past, the most important advance will come from an appreciation by the people themselves of the value of good health."

In addition to the work of the health visitors and school nurses, some Public Health Authorities have begun a system of domiciliary treatment of the adult sick by municipal home nurses. At Brighton, for instance, under a Local Act, the Town Council employs a trained nurse, who is employed in

attending at home on cases, such as puerperal fever or erysipelas, in which removal to hospital is not considered desirable. Nurses are also provided, "in special cases of infectious diseases," by the Barry Urban District Council. Even more interesting is the action of the Health Committee of the Worcestershire County Council, which maintains a staff of nurses for the domiciliary treatment of the sick poor in certain of the sanitary districts within the county, in which the Local Authorities do not, either in their capacity of Guardians of the Poor or in that of Rural District Councillors, make adequate provision for home nursing.

Conclusions.

Many other instances of divided responsibility and overlapping of work are given in the Minority Report. *It is significant that the Chief Medical Officers of all the departments concerned urged upon the Commission the necessity of putting a stop to all this duplication and overlapping by establishing one Unified Medical Service, unconnected with the Poor Law, to deal with all the sickness, infirmity, childbirth, and infancy for which any public provision was made.* The Minority Report adopts this authoritative recommendation, against which no rebutting evidence was presented. In this brief outline, only the summary can be given.

(i) *Birth and Infancy.*

"We have, therefore, to report:—

1. That the Boards of Guardians of England, Wales, and Ireland, and the Parish Councils of Scotland, have proved themselves to be, by their very nature as Destitution Authorities, wholly unsuited to cope with the grave threefold problem as to Birth and Infancy with which the nation is confronted. Alike in the prevention of the continued procreation of the feeble-minded, in the rescue of girl-mothers from a life of sexual immorality, and in the reduction of infantile mortality in respectable but necessitous families, the Destitution Authorities, in spite of their great expenditure, are to-day effecting no useful results. With regard to the first two of these problems, at any rate, the activities of the Boards of Guardians and Parish Councils are, in our judgment, actually intensifying the evil. If the State had desired to maximise both feeble-minded procreation and birth

out of wedlock, there could not have been suggested a more apt device than the provision, throughout the country, of General Mixed Workhouses, organised as they now are to serve as unconditional Maternity Hospitals. Whilst thus encouraging irregular sexual unions and the procreation of the feeble-minded, the Destitution Authorities are doing little to arrest the appalling preventable mortality that prevails among the infants of the poor. The respectable married woman, however necessitous she may be, can, with difficulty, take advantage of the free food, shelter, and medical attendance provided at great expense by the Destitution Authority for maternity cases. In Scotland she is—if living with her own husband, he being in good health—absolutely debarred from relief by law. In England and Wales she is, as far as possible, deterred.

2. That in view of the fact that the Destitution Authorities of the United Kingdom have constantly on their hands more than 65,000 infants under five years of age, and that there is grave reason for believing the mortality among them to be excessive, alike among the 50,000 who are maintained on Outdoor Relief and among the 15,000 in Poor Law Institutions, careful statistical inquiry ought immediately to be made, in order to discover where the mortality is greatest, and how this loss of life can be prevented.

3. That, in accordance with the recommendations of the Royal Commission on the Care and Control of the Feeble-minded, those unmarried mothers who come on the rates for their confinements, and are definitely proved to be mentally defective, should be dealt with exclusively by the Local Authority for the Mentally Defective.

4. That, whatever provision is made from public funds for maternity, whether in the way of supervision, or in domiciliary midwifery, or by means of Maternity Hospitals, should be exclusively in the hands of the Local Health Authority.

5. That, in accordance with the recommendations of the Vice-Regal Commission on Poor Law Reform in Ireland, the fullest possible use should be made, under the inspection and supervision of the Local Health Authorities, of such Voluntary Agencies as Rescue and Maternity Homes, Midwifery Charities, and Day Nurseries.

6. That the system, which has already proved so successful, of combining the efforts of both salaried and voluntary

Health Visitors with the work of the Medical Officer of Health and his staff, should be everywhere adopted and developed so as to extend to all infants under school age.

7. That the Local Health Authority should, in all its provision for birth and infancy, continue to proceed on its accustomed principles of :—

(*a*) The provision, free of charge, of hygienic information and advice to all who will accept it;

(*b*) The strict enforcement of the obligation imposed upon individuals to maintain in health those who are legally dependent on them; and

(*c*) Where individual default has taken place in this respect, the immediate provision of the necessaries for health, and the systematic recovery from those responsible, if they are able to pay, of repayment according to their means.

(ii) *The Sick and Infirm.*

"We have, therefore, to report :—

1. That the continued existence of two separate rate-supported Medical Services in all parts of the Kingdom, costing, in the aggregate, six or seven millions sterling annually—overlapping, uncoordinated with each other, and sometimes actually conflicting with each other's work—cannot be justified.

2. That the very principle of the Poor Law Medical Service—its restriction to persons who prove themselves to be destitute—involves delay and reluctance in the application of the sick person for treatment; hesitation and delay in beginning the treatment; and, in strictly administered districts, actual refusal of all treatment to persons who are in need of it, but who can manage to pay for some cheap substitute. These defects, which we regard as inherent in any medical service administered by a Destitution Authority, stand in the way of the discovery and early treatment of incipient disease, and accordingly deprive the medical treatment of most of its value.

3. That it has been demonstrated to us beyond all dispute that the deterrent aspect which the medical branch of the Poor Law acquires through its association with the Destitution Authority causes, merely by preventing prompt and early application by the sick poor for medical treatment, an

untold amount of aggravation of disease, personal suffering and reduction in the wealth-producing power of the manual working class.

4. That the operations of the Poor Law Medical Service, being controlled by Destitution Authorities and administered by Destitution Officers, inevitably take on the character of unconditional " medical relief "—that is, relief of the real or fancied painful symptoms—as distinguished from remedial changes of regimen and removal of injurious conditions, upon which any really curative treatment, or any effective prevention of the spread or recurrence of disease, is nowadays recognised to depend.

5. That whilst domiciliary treatment of the sick poor is appropriate in many cases, it ought to be withheld :—

(i) Where proper treatment in the home is impracticable;

(ii) Where the patient persistently malingers or refuses to conform to the prescribed regimen; or,

(iii) Where the patient is a source of danger to others.

It has become imperative in the public interest that there should be, for extreme cases, powers of compulsory removal to a proper place of treatment. Such powers cannot, and in our opinion should not, be granted to a Destitution Authority.

6. That where Destitution Authorities cease to abide by the limitation of their work to persons really destitute, or pass beyond the dole of " Medical Relief," their attempt to extend the range or improve the quality of the Poor Law Medical Service brings new perils. We cannot regard with favour any action which, in order to promote treatment, openly or tacitly invites people voluntarily to range themselves among the destitute; or which tempts them, by the prospect of getting costly and specialised forms of treatment, to simulate destitution. Nor do we think that an Authority charged with the relief of destitution, whatever its method of appointment, or whatever the area over which it acts, or any authority acting through officers concerned with such relief, whatever their official designation, can ever administer a Medical Service with efficiency and economy.

7. That, with regard to the suggestion that the medical treatment of the sick poor should be left either to provident medical insurance or to voluntary charity, it has been

demonstrated to us that these offer no possible alternative to the provision for the sick made by the Public Authority. With regard to domiciliary treatment, the evidence as to medical clubs, "contract practice," Provident Dispensaries, and the out-patients' departments of hospitals, is such as to make it impossible to recommend, in their favour, any restriction of the services at present afforded by the District Medical Officers and Poor Law Dispensaries. Nor do we feel warranted in giving any support to the proposal made to us that the whole of this Outdoor Medical Service of the Poor Law should be superseded by a publicly subsidised system of letting the poor choose their own doctors. Any such system would, in our judgment, lead to an extravagant expenditure of public funds on popular remedies and "medical extras," without obtaining, in return for this enlarged "Medical Relief," greater regularity of life or more hygienic habits in the patient. With regard to institutional treatment, we gladly recognise the inestimable services rendered to the sick poor by the hospitals, sanatoria and convalescent homes supported by endowments or voluntary contributions. We approve of the use now made of these institutions by Public Authorities, and we think that many more suitable cases than at present might, on proper arrangements as to payment, be transferred from rate-maintained to voluntary institutions. But it is clear that such institutions provide only for a small fraction of the need, and that they leave untouched whole districts for some cases, and whole classes of cases everywhere, which there is no prospect of their being able or willing to undertake.

8. That the Medical Service of the Public Health Authorities, which now extensively treats disease, and actually maintains out of the rates a steadily increasing number of the sick poor, is based on principles more suited to a State Medical Service than that of the Poor Law. These principles, which lead, in practice as well as in theory, to searching out disease, securing the earliest possible diagnosis, taking hold of the incipient case, removing injurious conditions, applying specialised treatment, enforcing healthy surroundings and personal hygiene, and aiming always at preventing either recurrence or spread of disease—in contrast to the mere 'relief' of the individual—furnish in fact the only proper basis for the expenditure of public money on a Medical Service.

9. That such compulsory powers of removal in extreme cases, as have been asked for, are analogous to those already exercised, with full public approval, by the Public Health Authorities; and that the proposed extension of such powers can properly be granted only to an authority proceeding on Public Health lines.

10. That we therefore agree with the responsible heads of all the four Medical Departments concerned—the Chief Medical Officer of the Local Government Board for England and Wales, the Medical Member of the Local Government Board for Scotland, the Medical Commissioner of the Local Government Board for Ireland, and the Medical Officer of the Board of Education—in ascribing the defects of the existing arrangements fundamentally to the lack of a unified Medical Service based on Public Health principles.

11. That in such a unified Medical Service, organised in districts of suitable extent, the existing Medical Officers of Health, Hospital Superintendents, School Doctors, District Medical Officers, Workhouse and Dispensary Doctors and Medical Superintendents of Poor Law Infirmaries—the clinicians as well as the sanitarians—would all find appropriate spheres; that one among them being placed in administrative control who had developed most administrative capacity.

12. That we do not agree with the suggestion that the establishment of a unified Medical Service on Public Health lines necessarily involves the gratuitous provision of medical treatment to all applicants. It is clear that, in the public interest, neither the promptitude nor the efficiency of the medical treatment must be in any way limited by considerations of whether the patient can or should repay its cost. But we see no reason why Parliament should not embody, in a clear and consistent code, definite rules of Chargeability, either relating to the treatment of all diseases, or of all but those specifically named; and of Recovery of the charge thus made from all patients who are able to pay. In our chapter on 'The Scheme of Reform,'* we propose new machinery for automatically making and recovering all such charges that Parliament may from time to time impose."

* To be had separately as "The Scheme of Reform, Part I: The Poor Law," 80 pp., price 3d., post free.

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