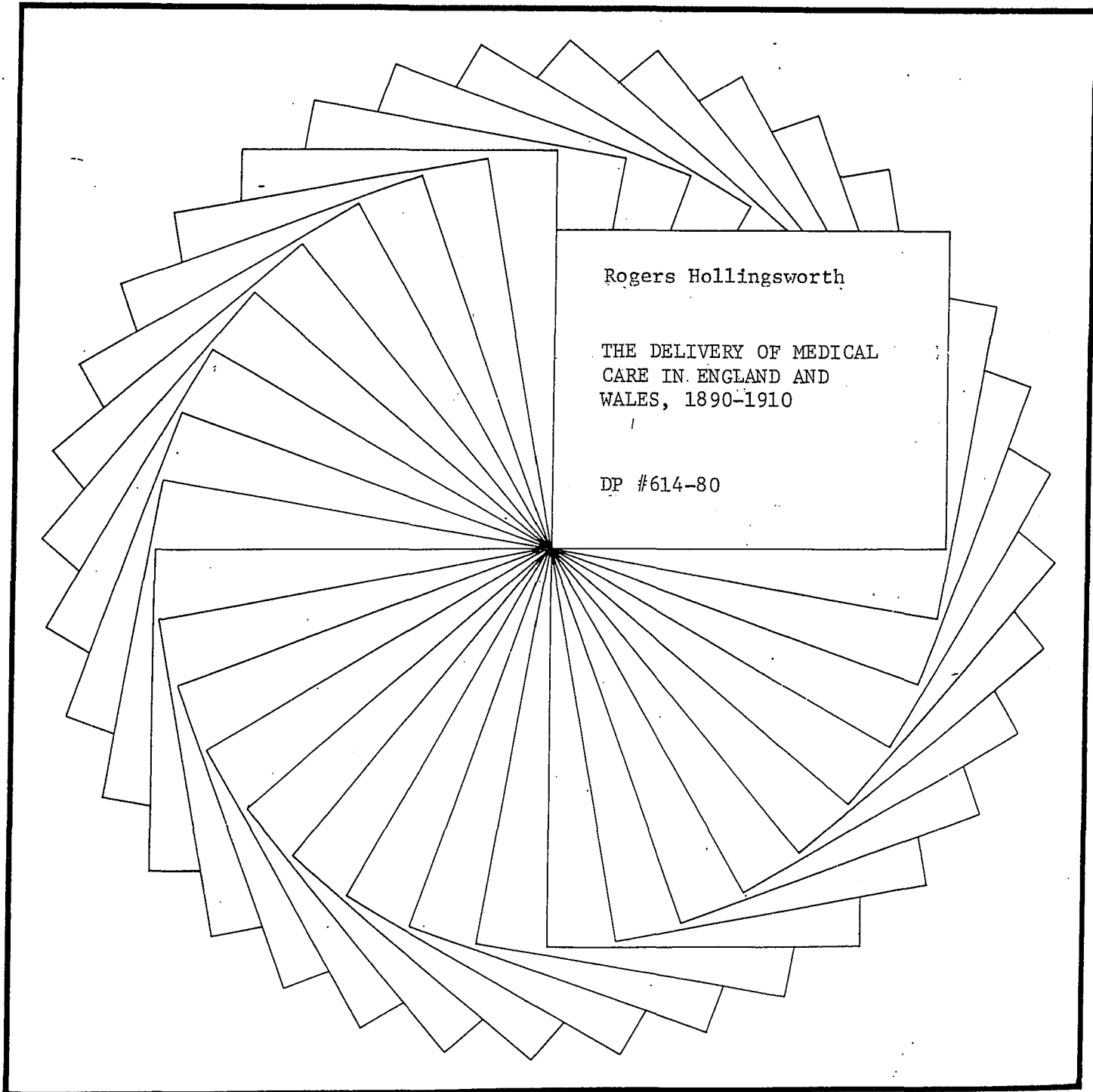


Institute for Research on Poverty

Discussion Papers



The Delivery of Medical Care
in England and Wales, 1890-1910

Rogers Hollingsworth

June 1980

This research was supported in part by funds granted to the Institute for Research on Poverty by the Department of Health and Human Services pursuant to the Economic Opportunity Act of 1964. The author also wishes to acknowledge assistance from the National Science Foundation under Grant Number SOC 76-17318, the German Marshall Fund of the United States, the Commonwealth Fund, and the Woodrow Wilson International Center for Scholars.

ABSTRACT

The medical delivery system of England and Wales in the early part of the twentieth century was structured in a manner consistent with Weisbrod's three sector economy: the for-profit, the nonprofit, and the public sector. The more heterogeneous the demands for private goods and the higher the income of individuals, the more the for-profit sector responded. The more heterogeneous the demand for collective goods, the more the voluntary sector responded. And the more homogeneous the demand for collective goods, the more the public sector responded.

The private for-profit sector tended to use private good substitutes for the government and voluntary sectors, substitutes which offered the consumer much more privacy and control. The voluntary sector was especially strong in parts of the country where there was considerable heterogeneity of demands for medical care--e.g., in London--and pioneered in the development of many collective goods which eventually would become common in the public sector. But the voluntary sector produced a qualitatively different set of outcomes from those in the public sector. The voluntary sector, although unresponsive to the demands of the very poor, provided relatively high quality services. In contrast, the public sector tended to provide a rather low quality of service for the very poor. It was the public sector which pioneered in the development of preventive health measures, but upper income and more specialized groups responded by developing substitutes in the area of curative medicine. As the curative medical model was responsive to the demands of upper income groups to have private control over medical care, it was the model which became dominant.

The Delivery of Medical Care in England and Wales, 1890-1910

Medical services in Britain at the beginning of the twentieth century were decentralized, inefficient, and inequalitarian, with considerable competition within and between the public and private sectors. Unlike in the American medical profession, in Britain there were serious cleavages and poor communication between physicians and surgeons on the one hand, and general practitioners on the other. Scientific discoveries with technological implications occurred with increasing frequency, but the level of medical technology was still quite crude. Moreover, medical technology was unevenly distributed from region to region, between urban and rural areas, among institutions within the same city, and most visible of all, among social classes.

There was great variation in the access of social classes to medical care. Considerable inequality in access to medical care and in levels of health existed in all western countries at the end of the nineteenth century, but Britain had a medical delivery system which was especially rigid and extreme in its class bias. One set of institutions was, in theory, for "the undeserving poor" or paupers, another for "the deserving poor," and yet another for the middle and upper classes.

Almost every group involved in the delivery of medical services was dissatisfied with the system of medical services. As a result, there was continual discussion and investigation about ways to prevent overlapping of services and waste, to make medical care more accessible to all members of the society, and to promote more efficient ways of financing medical care.

SCIENTIFIC ADVANCE AND TECHNOLOGICAL CHANGE

The demands for change in the delivery of medical services took place against a background of rapid transformation in medical science in the nineteenth century. A century of discovery, centered in France and Germany, was radically altering the practice of medicine.

The medical advances occurred in several large stages. The first stage involved advances in clinical medicine, with French clinicians in the first half of the century making impressive progress in differentiating disease entities by following cases from the hospital wards to the death house where they carried out careful autopsies (Ackerknecht, 1967). The second stage of advancement was the formulation of the cell doctrine. The work of Schleiden and Schwann (building on the work of Bichat) established that tissues were made of cells, a finding that was the basis for the subsequent advances in anatomy, physiology, and pathology. The great German scientist, Rudolf Virchow, reasoned that they must also form the basis for disease, and demonstrated changes which took place in the cell structure when different diseases occurred (Shryock, 1947, p. 205). Virchow's work prepared the way for the third stage of advance, in which scientists questioned why cells became abnormal in the first place, thus leading to discoveries about the cause of disease. The major contributions of bacteriologists--like Pasteur and Koch among others--lay in identifying particular microorganisms which caused specific diseases. The late nineteenth century was a period of many triumphs in the field of bacteriology, as first one and then another microorganism was isolated. From these discoveries by Koch, Pasteur, Obermeier, Neisser, Sternberg, Klebs, Loeffler, and Fehleisen came the fourth stage of medical advance--the treatment of patients and prevention of disease. In the treatment of

an illness, the most remarkable advances occurred in surgery. Once the work of Virchow demonstrated that many diseases were located in lesions, physicians increased their use of surgery. As a result of Lister's application of antiseptics and later asepsis, making surgical removals possible without infection, the profession of surgery began to dominate the clinical side of patient treatment.

Concurrently, reforms in nursing care led to improvements in the comfort and curative potential of hospitals; there was better hygiene and care (Abel-Smith, 1964, pp. 133, 152). As a result, whereas hospitals had previously been institutions for the treatment of the poor, by the turn of the century the middle classes began to seek hospital care. Increasingly, surgeons began to believe that hospitals were better places than the home for the treatment of patients and were unwilling to perform surgery in private homes. Moreover, the "X ray" or the Roentgen ray had been discovered by the end of the nineteenth century, giving rise to the field of radiology. This specialty, along with many others, reflected impressive advances which were occurring in medical technology during this period.

However, these advances had not diffused throughout the British medical delivery system by 1900. The citizenry were becoming more aware of advances in medical technology, and as a result the demands for access to recent technology increased substantially. There were various kinds of institutions which provided medical care during this period, but the medical technology diffused very unevenly and slowly across the entire

medical delivery system. Powerful social, economic, political, and legal constraints limited the speed with which medical technology could diffuse across the medical system, and the extent to which there was equal access to advancing technology across regions, and among social classes and groups.

Even in some of the best medical centers, the gaps between technological innovations and clinical practice were slow to close. By 1900, the study of anesthetics did not have a place in the curriculum of most medical schools, even though major changes in anesthesia had occurred more than a half-century earlier. Radiology was not considered a full specialty yet. At one of the better London hospitals of the day X-rays were under the direction of the honorary dentist, while at another the surgery theater's beadle did X-rays of fractured limbs (Stevens, 1966, p. 33). In most large hospitals, obstetrics was still an "outpatient affair." And physicians and surgeons prided themselves on being generalists, not specialists.

By focusing on the different types of social institutions which provided medical care during the late nineteenth and early twentieth centuries, one can better understand which groups benefited most from the advances in medical science and technology, how the technology was financed, and why the technology did not diffuse rapidly throughout the country and to all social classes and groups. The following discussion focuses first on the medical care of the most decentralized sector, that is the private sector, which in 1890 was far more important in terms of size than the public sector, though the latter was growing rapidly.

THE PRIVATE SECTOR: HOSPITAL CARE

General Hospitals

Before the last century, hospitals were not very important in treating the ill; in Britain, as in all of Europe, only a few thousand people were treated in hospitals by 1800. Indeed, most medical tools could be contained in a little black bag, and for most people it was better to receive what care there was at home rather than in a hospital where cross-infection was often rampant. It has only been during the past century that hospitals have become important institutions for treating the ill. But in Britain during the middle of the nineteenth century, hospitals were primarily for the sick poor--those who could not receive proper care at home. Essentially, there had been two types of institutions for treating the ill: the workhouses for paupers and the voluntary hospitals. It was the voluntary hospitals that became the elite institutions during the late nineteenth and early twentieth centuries for providing care for the ill.

The voluntary hospitals had historically provided care for the deserving poor, and had been dependent for their income on charitable contributions. Thus the speed with which they could adapt to medical innovations was dependent on the willingness of the wealthy to provide money. The wealthy supported the voluntary hospitals not only from religious and humanitarian considerations; donations often were provided on the condition that the donor could designate by letter specific individuals who would be eligible for care. In general, a patient who had a letter from an influential patron was likely to be admitted to a hospital. For a long period, patients had considerable difficulty in being admitted unless they had a

letter from a church warden or some influential person. As a result, the voluntary hospitals had long tended to exclude the destitute from care. Since the middle and upper classes received care at home, the beneficiaries of access to hospital care had been the deserving poor. By 1900, however, demands had increased, and the voluntary hospitals were providing services to all social classes. Because the large voluntary hospitals were heavily concentrated in the nation's largest cities, however, the deserving poor in most of the country did not have access to these hospitals. In addition, within these cities hospitals were inequitably distributed. Since most hospitals had been built to provide care for the poor, hospital facilities were concentrated in the poorer parts of cities. In 1890, for example, almost all hospitals were within an area of approximately two square miles; St. Thomas's and Guy's were the only general hospitals on the south side of the Thames (Poor Law Commission, 1909, vol. 37, pp. 254-255; Committee on Metropolitan Hospitals, 1892, vol. 14, pp. xlv-lv).

With the passage of time, the large voluntary hospitals provided enormous benefits to an important interest group: the elite physicians and surgeons. Historically, the physicians and surgeons had provided medical care in the large voluntary hospitals without payment. Instead, they received remuneration from the large fees which they charged their well-to-do patients whom they treated in their offices on Harley and Wimpole Streets, and who provided contributions to finance the voluntary hospitals. In short, the doctors who accepted positions in these hospitals were making charitable contributions to the poor but were also generating the good will of their wealthy clients or patrons.

Though the voluntary hospitals had been established to serve the needs of the deserving poor, they began to serve another important function during the nineteenth century: that of teaching institutions. While serving voluntarily on the staff of the general hospital, the doctors who taught also received compensation from medical students. The position of teacher of medical students increased their status and was a good investment, in that students in later years referred their wealthy patients to their former teachers (Abel-Smith, 1964, p. 18). Unlike the situation in Germany and the trend that was developing in America during the late nineteenth and early twentieth centuries, medical teaching was done by hospital staff, not by university professors.

Eventually, two archetypes of medical doctors emerged. Within the large voluntary hospitals were the physicians and surgeons, many of whom were graduates of Oxford or Cambridge and had upper class connections. But the few hospital positions were virtually monopolized by a small elite within the medical profession (*ibid.*, p. 19), and there was little incentive among those who held these positions to create new ones. Young men, of course, felt that their future was blocked by an older generation of physicians and surgeons who dominated the large general hospitals.

Because they treated patients in the hospitals without fees and were held in high esteem as great teachers, the hospital consultants generated widespread trust as brilliant medical practitioners. And yet, by 1910 the hospital consultant was beginning to be slightly anachronistic. In an age when medical technology was rapidly changing and new medical specialties were developing, the typical hospital consultant was a generalist who was not

engaged in scientific or medical research. In 1900, it was rare for specialty departments to exist in the great teaching hospitals. Each consultant, having considerable autonomy over his practice, simply had his own number of allocated beds and treated patients with a wide assortment of ailments. Indeed, this type of institutional constraint was an important reason that specialization did not develop more rapidly in some of Britain's best hospitals (Stevens, 1966, pp. 31-34).

The other archetype of the British medical system was the general practitioner, who was commonly excluded from the large voluntary hospitals and thus tended to treat poorer patients outside the hospital, who was lower in social status than the hospital-based consultant, and who was usually much more concerned than the consultant with his wealthy patients about the source of his income from practice. Serious cleavages developed between consultants and general practitioners. These divisions were to be permanent and were to have profound effects on the structure of the British health delivery systems.

Changes in technology slowly altered medical practice inside the large voluntary hospitals, affected who had access to the hospital, and changed the financing of hospital care. For example, surgery became more complex and sophisticated; thus the maintenance and equipment of the operating rooms of hospitals was a matter of major importance to surgeons. Whereas surgical procedures for the upper and middle classes had formerly been performed in their homes, the development of knowledge about asepsis and anesthetics meant that by 1900 a home had to be transformed if surgical procedures were to take place there.

To prepare a room for an operation, carpets, curtains and all hangings must be removed. The ledges over doors and windows must be cleansed and freed from the dirt which is apt to rest on them. Ceilings must be rubbed with a brush covered with a damp cloth and floors scrubbed until they are clean and sodden. (Quoted in Abel-Smith, 1964, p. 188)

Not only did high-income families and surgeons want to avoid all of this, but increasingly doctors believed that a private residence simply did not provide a desirable environment for the treatment of serious cases, whether surgery was involved or not. As surgery became more frequent within the hospitals, the number of patients treated in and discharged from hospitals increased (*ibid.*, pp. 32, 189). Consequently, there was a rise in the costs of managing the hospitals and a change in the clientele they admitted.

Certain types of cases were excluded from access to the voluntary hospitals, however. Doctors--especially in the teaching hospitals--wished to treat the unusual or the spectacular case, and preferred to concentrate their energies on curable cases which would demonstrate their skills, not their shortcomings. This meant that with increasing frequency, incurable cases were not admitted to the best hospitals in the country, and patients were generally discharged as soon as they were well enough to be moved--usually before they were fully cured (Committee on Metropolitan Hospitals, 1892, vol. 33).

Perhaps of equal significance, the general voluntary hospitals tended to exclude infectious diseases. This trend started before the end of the nineteenth century in order to protect the "health and morals" of the patients who were admitted--even though infectious diseases were among the

major killers in the population, especially among the poor. Indeed, two diseases which were widespread--tuberculosis and venereal disease--were virtually excluded from all of the general voluntary hospitals. Moreover, children were generally denied admission to these hospitals because they had a high susceptibility to infectious diseases. In sum, the large voluntary hospitals became institutions for the treatment of certain types of acute cases, and as soon as a case had passed the acute stage or it became apparent that a case was a chronic or incurable illness, there were arrangements for the patient to be transferred elsewhere (Abel-Smith, 1964, pp. 13-15, 24, 44-45, 185-186; Webb and Webb, 1910, pp. 151-152).

When the large voluntary hospitals had been viewed as exclusively for the deserving poor, most of the income had come from wealthy patrons who were willing to help the poor. But as hospitals developed higher standards for treatment and more expensive forms of care, the large voluntary hospitals encountered difficulty in raising the money necessary to meet the increased costs. When the wealthy failed to provide adequate funds in the late nineteenth century, two national organizations were established to raise funds from more varied sources: the Hospital Sunday Fund, which raised money through the churches, and the Hospital Saturday Fund, which collected small weekly contributions from the working classes. In return, the contributors expected assurance of hospital care when and if they needed it. Despite the fund-raising activities of these two organizations, the donations, endorsements, and special appeals still fell short of the necessary funds. As a result, the voluntary hospitals confronted the question of charging patients for care. However, the problem of whether voluntary hospitals should charge patients for care did not stem only

from the need to raise more revenue, but was also a recognition of a slow increase in the number of individuals other than the poor who needed and were receiving hospital care. This was a delicate matter, and the hospital elite feared that if they began to charge middle class patients who could afford to pay for services, the wealthy patrons of the hospital might think that the hospital was no longer dependent on them and charitable contributions might decline. Furthermore, there was some fear that payment from patients might cause the consultants to demand a fee for their services, thus creating a further strain on the hospitals.

Slowly, large voluntary hospitals began to set aside a separate set of beds for paying patients. Initially, the scheme for payments varied. Certain hospitals asked some patients to make contributions toward the total cost of their care. Other hospitals asked patients to pay a flat rate in addition to paying the doctor on the hospital staff who provided care. By the end of the century, however, some form of payment by patients had been introduced into the large voluntary hospitals. For example, by 1890 five of London's teaching hospitals and thirty-seven of its general hospitals were admitting paying patients (Abel-Smith, 1964, p. 149). At first the paying patients were from the middle class, as the wealthy patients had great difficulty overcoming their bias against entering any institution which treated charitable patients. But the efficaciousness of the changing medical technology meant that eventually the wealthy also would demand hospital services. By the turn of the century, the large voluntary hospitals of England and Wales were no longer serving only the deserving poor, although the overwhelming majority of

patients were still nonpaying (many of the patients were actually of the pauper classes, and the doctors still worked on an honorary basis).

Table 1 shows that by 1911 only ten percent of the income for voluntary hospitals in England and Wales came from patient payments. By admitting the well-to-do to its best hospitals and charging them fees for services, however, Britain was no longer singular among the richer countries of the world, as it had been operating its most elite hospitals entirely on a charitable basis (*ibid.*, pp. 134-137, 140-150, 189).

Specialized Hospitals

As the large general hospitals in the voluntary sector excluded many diseases from their concern, other types of institutions in both the public and private sector responded to the unmet needs. During the nineteenth century, both in London and in the rest of the country, a number of specialized private hospitals came into existence--largely in reaction to the structure of the general voluntary hospitals. Probably no factor was of greater importance in stimulating the development of the private specialized hospitals than the fact that many young doctors found their futures blocked in the general hospitals. It was not unusual for a physician in a London hospital to wait for twenty years before becoming a consultant. Meanwhile, the "junior staff" would carry out most of the routine work of the hospitals. Furthermore, a number of aspiring young doctors wished to move into specialized fields, but the senior doctors who controlled the general hospitals discouraged specialization. As a result, a number of younger doctors established specialized hospitals which concentrated on types of treatment usually neglected by the general hospitals.

Table One

Sources of Income for Voluntary Hospitals in England 1891-1938¹
(In Thousands of Pounds)

HOSPITALS	Voluntary Gifts	Investments	Total Patients Payments	Other Payments	Legacies for Special Purposes	TOTALS
1891 LONDON Hospitals	232	224	32	24	136	648
Percent of Total	35.8%	34.5%	5%	3.7%	21%	100%
1891 PROVINCIAL Hospitals	261	110	47	15	108	541
Percent of Total	48.2%	20.3%	8.7%	2.8%	20%	100%
1891 TOTAL Hospitals	493	334	79	39	244	1189
Percent of Total	41.5%	28.1%	6.6%	3.3%	20.5%	100%
1911 LONDON Hospitals	459	306	69	31	502	1367
Percent of Total	33.6%	22.4%	5%	2.3%	36.7%	100%
1911 PROVINCIAL Hospitals	321	176	179	21	347	1044
Percent of Total	30.7%	16.9%	17.1%	2%	33.3%	100%
1911 TOTAL Hospitals	780	482	248	52	849	2411
Percent of Total	32.4%	20%	10.3%	2.1%	35.2%	100%

Sources: Political and Economic Planning, Report on the British Health Services (London: Political and Economic Planning), p. 233. Robert Pinker, English Hospital Statistics, 1861-1938 (London: Heinemann, 1966), pp. 148-154.

¹These data do not contain incomes for all hospitals in England. These are data on all hospitals for which comparable information was available in the various sources which published data on hospitals. Data are current prices in British pounds.

Table One (continued)

Sources of Income for Voluntary Hospitals in England 1891-1938¹
(In Thousands of Pounds)

HOSPITALS	Voluntary Gifts	Investments	Total Patients Payments	Other Payments	Legacies for Special Purposes	TOTALS
1921 LONDON Hospitals	897	471	731	60	860	3019
Percent of Total	29.7%	15.6%	24.2%	2%	28.5%	100%
1921 PROVINCIAL Hospitals	768	266	811	44	475	2364
Percent of Total	32.5%	11.3%	34.3%	1.9%	20%	100%
1921 TOTAL Hospitals	1665	737	1542	104	1335	5383
Percent of Total	30.9%	13.7%	28.7%	1.9%	24.8%	100%
1938 LONDON Hospitals	1484	697	1678	397	639	4895
Percent of Total	30.5%	14.2%	34.3%	8%	13%	100%
1938 PROVINCIAL Hospitals	1724	889	4641	621	880	8755
Percent of Total	19.7%	10.2%	53%	7.1%	10%	100%
1938 TOTAL Hospitals	3208	1586	6319	1018	1519	13,650
Percent of Total	23.5%	11.6%	46.3%	7.5%	11.1%	100%

The private specialized hospitals focused on the needs of the rich and the middle class, meaning those diseases which were most common among the poor (tuberculosis and other types of infectious diseases) were generally not treated by the private specialized hospitals. Hospitals for children, midwifery, eye diseases, orthopedics, and diseases of the skin, became common. By the end of the nineteenth century, there were approximately 160 special hospitals in the private sector of England and Wales, located primarily in the largest cities (Committee on Metropolitan Hospitals, 1892, vol. 14, pp. lv-lvi).

Most of the private specialized hospitals charged fees for their services, though the poor tended to receive care without paying or by paying only a token fee. But there was great diversity in the extent to which specialized hospitals were dependent on patients for their financing. For example, specialized hospitals for diseases of the skin, ear, throat, and nose received at least sixty percent of their revenue from patients in 1909, but specialized hospitals for children were much more dependent on charity, receiving only four percent of their revenues from patients (Braun, 1909, pp. 22-25).

For some years, there was considerable institutional competition between the general and specialized hospitals in the private sector. Initially, the medical elite of the general hospitals tended to ridicule their junior colleagues who had moved to the specialized hospitals, for charging fees, for becoming specialists, and for treating diseases which were inappropriate for gentlemen (Committee on Metropolitan Hospitals, 1890, vol. 12, pp. 233-234, 251-253; 1890-1891, vol. 13, pp. 430-446, 504). Most of the medical elite of the general hospitals resented specialization as a matter of principle,

but they were even more upset when the special hospitals attracted some of their wealthy patients, especially when a few made generous contributions to the development of special hospitals.

The private special hospitals were important in the evolution of the British health delivery system in several respects. In an age when the medical elite of Britain frowned on specialization, the private special hospitals did much to advance specialization in pediatrics, obstetrics, and diseases of the eye, nose, throat, ear, rectum, and the skin. The field of obstetrics provides an interesting example. As a specialty, it had developed almost independently of the mainstream of British medicine. Indeed, one nineteenth-century president of the Royal College of Physicians reflected the prejudices of the social elite of British medicine by arguing that "midwifery was an act foreign to the habits of a gentleman of enlarged academic education" (Abel-Smith, 1964, p. 22). Because of this type of attitude, lectures dealing with obstetrics hardly existed in British medical schools until the latter part of the nineteenth century, and questions on the subject were rare on the examinations for membership in the Royal College of Surgeons and for the licentiate of the Royal College of Physicians. As a result, it is not surprising that obstetrics cases were rare in the large voluntary hospitals, that midwifery developed very differently in Britain from America, and that obstetrics as a specialty in the medical profession was accelerated in the special rather than in the prestigious general hospitals.

Because it was possible to demonstrate the efficaciousness of the specialized medical technology, the large voluntary hospitals

eventually had no alternative but to also develop specialized departments and to appoint specialists as consultants. In other words, the institutional competition between general and specialized hospitals in the private sector was important in diffusing the advances in medical technology to the voluntary general hospitals. Even so, for some years the medical elite in the best voluntary hospitals continued to look down on specialization and to treat specialists as being on the fringe of medical practice. As Rosemary Stevens (1966, p. 30) has indicated, the officer in charge of a specialty department was treated as a junior staff member, and those admitted as inpatients in the general hospitals continued to be under the primary care of a generalist some years after specialists became part of the general hospitals. For this reason, the special hospitals in England and Wales, especially in London, became the basic centers for specialist training and research, instead of the prestigious teaching hospitals, which were large general hospitals (ibid., pp. 27-30).

The specialized hospitals also influenced the general voluntary hospitals in another way. Once the specialists had acquired legitimacy among the social elite of Britain, and it was legitimate for those hospitals to admit patients on a paying basis, the governors of the large voluntary hospitals felt that they too could begin to admit paying patients on a limited basis (Committee on Metropolitan Hospitals, 1892, vol. 14, pp. lv-lix; 1890-1891, pp. 353-359, 413, 446, 704).

PRIVATE SECTOR: OUTPATIENT CARE

Outpatient Clinics of the Voluntary Hospitals

The outpatient clinics of the large general hospitals were originally quite modest in size, but over time they grew as the demand for medical care

increased. By the turn of the century, literally hundreds of thousands of patients received care in the outpatient departments of large general hospitals. Around 1890, more than one million outpatients were treated in all of London's hospitals, and in 1906, almost two million outpatients received more than five million attendances in London's hospitals (Steele, 1891, p. 267; Braun, 1909; p. 10).

No doubt, many patients benefited from the general hospital outpatient care. But at the time, a number of experts argued that the quality of care in the outpatient clinics was extremely low. Given the relatively small medical staffs of the voluntary hospitals and the overcrowded conditions in most outpatient departments, the quality could hardly be otherwise, as one experienced medical practitioner reported:

The outpatient department is so crowded that the work has to be done in a slipshod fashion, and unless the case happens to be an interesting one, the patient is put off with the stereotyped "How are you today? Put out your tongue. Go on with your medicine." (Poor Law Commission, 1909, vol. 37, p. 869)

Another doctor voiced the opinion that "at present, the outpatient department of the voluntary hospital is to a great extent a shop for giving people large quantities of medicine" (*Ibid.*). In other words, the outpatient departments may have helped the voluntary hospitals to raise money and to select interesting cases for treatment inside the hospitals, but the superficiality of treatment provided at these centers had very little curative effect on the vast majority of the patients who presented themselves. (See the extensive testimony in Great Britain's

Report of the Committee on Metropolitan Hospitals, 1890, vol. 12, pp. 6, 12-16, 57-67, 232; 1890-1891, vol. 13, p. 305.)

General Practitioner Private Practice

The increasing urbanization and expansion of the middle class were accompanied by rising demands for medical care outside the hospitals. As the general practitioner was for all practical purposes excluded from practicing in the prestigious general hospitals, the need for his services was bolstered as medical practice outside the hospital expanded. Outside the metropolitan areas, the large charity hospitals had failed to develop, meaning that in parts of the country, the only type of institution for providing hospital care was the Poor Law workhouse. In response to this gap in services, the cottage hospital emerged in small towns and villages, financed by a variety of sources: primarily small legacies and donations, local subscribers, and investments by general practitioners. In most instances, a group of general practitioners controlled the local hospital, and therefore each was able to admit and treat patients in the hospital. This, of course, did much to increase the status of general practitioners. On the other hand, the cottage hospitals did not have access to the sizeable charitable donations available to the large metropolitan hospitals. Therefore, by the end of the nineteenth century the cottage hospitals and general practitioners charged patients for services, generally on the basis of what they could afford to pay.

The world of the general practitioner had become very competitive. Not only did general practitioners compete among themselves for patients

on a fee-for-service basis, but the most intense competition--resulting in serious cleavages--was with the physicians who practiced in the large voluntary hospitals. As the size of the outpatient clinics expanded in the voluntary general hospitals, general practitioners argued that many patients who could afford to pay for care were receiving free treatment, and therefore these outpatient clinics were wrongfully luring patients from the general practitioners. They felt that a person able to pay a fee for service had no right to receive free treatment in a hospital outpatient clinic and that when hospitals permitted patients to receive free care, the fees of private practitioners were driven down. Because the majority of general hospitals provided free care around 1900, general practitioners of London argued that they were being pauperized by the outpatient activities of the large voluntary hospitals (Committee on Metropolitan Hospitals, 1892, vol. 14, pp. xxxviii-xxxix). Although it is difficult to determine the extent to which the voluntary hospitals served various social classes, the Poor Law Commission of 1905-1909 did investigate the subject, and reported that approximately fifteen percent of those who received outpatient care in the voluntary hospitals were capable of paying for their own treatment, and that almost forty percent of the patients were probably eligible to receive treatment from the Poor Law authorities. Moreover, almost forty percent of the inpatients of London voluntary hospitals were of the "pauper class" (Poor Law Commission, 1909; vol. 37, pp. 255-257).

Because the large voluntary hospitals had a reputation for being major centers for learning, many patients preferred to seek care in their outpatient clinics rather than from a general practitioner. The general

practitioners also alleged that consultants and specialists in the large voluntary hospitals stole patients who were referred for consultation purposes, and as a result, many general practitioners became increasingly reluctant to refer patients to consultants for fear that they would never get them back.

These antagonisms had become especially bitter by the end of the nineteenth century, reflecting the basic cleavage between the doctors in the metropolitan areas who had hospital-based appointments and those who did not. As a result, the pages of the medical journals were filled with proposals for defining and stabilizing the relations between the hospital-based consultant and the general practitioner. But the cleavages between the hospital-based doctors and those outside the hospital have remained, and do much to differentiate the British medical profession from that in the United States (Abel-Smith, 1964, pp. 102-118).

Contract Practice in Friendly Societies and Medical Clubs

The provision of outpatient medical care by friendly societies was one of the most important means of organizing medical care and was also one of the features which gave rise to the difference in historical development between medical delivery in Britain and in America. For a small sum of money, members of friendly societies were assured of receiving the care of a general practitioner during times of illness. The doctors who provided services to the friendly societies worked on a contract basis and were paid a set fee for each person on their list.

Friendly societies were workingmens' organizations that had been in existence since the eighteenth century, but their numbers reached

unprecedented heights in the early twentieth century. At that time, the Registrar of Friendly Societies reported that there were approximately 24,000 registered societies with about five and three-quarters million members (Gilbert, 1966, p. 165; Poor Law Commission, 1909, vol. 37, p. 258). Primarily for skilled workers, the friendly societies made very little appeal "to the grey, faceless, lower third of the working class" (Gilbert, 1966, p. 166). They provided no services for the families of friendly society members, and they attempted to screen those who might be eligible for care so that those who suffered from physical defects were excluded from coverage. Doctors vigorously objected to providing any type of care to women via the organization of a friendly society, and some local medical societies had rules prohibiting such service (Poor Law Commission, 1909, vol. 37, p. 870). Approximately one-half of the adult males in Great Britain were members of the societies, some of which were very large, with two having over 700,000 members, and several with over 50,000. As their size increased, the organizations became somewhat more oligarchical and less fraternal in nature.

Being organizations that were exclusively for the working class elite, the friendly societies were reluctant to use their power to provide better medical care for all groups in the society. Indeed, by the end of the nineteenth century the friendly societies tended to view as competitors all forms of government programs that might overlap with any activity that they carried out. With the passage of time, however, the financial condition of the friendly societies caused them to turn to the central government for assistance in maintaining their medical benefits. The basic financial problem which confronted the friendly societies during the late nineteenth century resulted

from the fact that their actuarial tables were based on the assumption that a sizeable portion of their membership would die before middle age, and therefore would never make any claim on sickness benefits. Mortality rates for middle-aged adult males improved in the late nineteenth century, but increased longevity was not accompanied by less sickness. As more members survived and lived longer, the demand for medical and sickness benefits increased, thus placing considerable strains on the friendly societies' resources. In March 1891, there were more than 4,500 paupers in workhouses who had been members of friendly societies which had become bankrupt. (*ibid.*, vol. 14, Appendix, p. 158). It was the recognition of these financial problems that eventually caused the friendly societies to support a national health insurance scheme--something to which they were opposed as long as they believed their organizations to be solvent.

It was not cleavages with the government that caused serious problems for the friendly societies in the late nineteenth century, however, but with the general practitioners. In addition, increasing financial difficulties of the friendly societies, brought about by demographic changes among their members, intensified friction with the general practitioner. In 1905, the British Medical Association published a report on contract practice which blasted the low fees which friendly societies paid the general practitioner. In general, doctors received three shillings annually per friendly society member; resentment over the low fees did much to solidify medical opinion against friendly societies. Medical opposition to friendly societies can easily be exaggerated, however, for large numbers of doctors were very anxious to be employed by them. Even so, there was considerable resentment among many doctors who had contracts with friendly societies over the fact that they could be dismissed by a society secretary, that they had little

bargaining power with the society, that some doctors' appointments were obtained as a result of bribery and corruption, and that doctors had little opportunity to set their own fees. Moreover, many doctors were upset over the fact that patients had no choice over the selection of a doctor, and that a doctor could not refuse to treat someone on a contract list; indeed, they had to treat however many people there were on a list or risk losing the contract to someone who would. Many doctors believed that some people joined friendly societies merely as a means of qualifying for low cost medical care, thus forcing general practitioners to charge lower fees to compete. It was concern over these issues and the resulting cleavages between the general practitioners and the friendly societies which the National Health Insurance Act would later attempt to resolve (*ibid.*, vol. 4, Appendix, p. 83).

In a service as large as that provided by the friendly societies, there was obviously a great deal of variation in the quality of care. However, there is considerable evidence that the quality of care was generally low. Many members of the friendly societies complained that they received only perfunctory treatment unless the doctor also was able to charge the friendly society member fees for treating other members of the family. There were numerous accusations that the friendly society doctor supplied only the most inexpensive medicine and treatment. In fact, it was not uncommon for a friendly society member, when ill, to pay additional expenses to receive care from another general practitioner rather than to rely on the society's contract practitioner. For these reasons, the friendly society doctor was generally held in low esteem both in and outside the medical profession (*ibid.*, vol. 37, pp. 868-872; Gilbert, 1966, pp. 288-318).

There were also medical clubs which individual doctors organized. In these, unlike the friendly societies, there was no intermediary between the doctor and patient. Medical clubs generally provided care for poorer patients and tended to cover entire families. With this type of service, there were numerous complaints about the careless and inattentive manner of the doctor. There was also widespread dissatisfaction that the contract often did not provide for the type of care that a patient needed when ill (Brand, 1965, pp. 195-199). Most contract doctors refused to treat patients in their homes--a major inconvenience in the age before the automobile--and most contracts did not provide for treatment of chronic diseases. As the fees were generally three shillings per annum per member and the doctor was to provide for medicine from this fee, the remuneration was generally inadequate to provide care that was really needed. When patients needed serious treatment (e.g., surgery) or most anything other than routine care, the contract doctor referred the patient to a voluntary hospital for what was often free medical care (Poor Law Commission, 1909, vol. 37, p. 872).

Provident Medical Associations and Provident Dispensaries

In many towns, the local general practitioners joined together to form provident medical associations, a type of prepaid medical insurance that eventually received the endorsement of the British Medical Association. These associations differed from the medical clubs organized by individual doctors in that all of the medical men of a particular locality participated in the activity and shared in the practice and remuneration in proportion to

the number of subscribers who selected each of them as a doctor. From the viewpoint of the B.M.A., this provided doctor and patient a certain freedom of choice in the selection of provider and client. However, this type of organization was never very widespread because of the intense competitiveness among practitioners and the difficulty of convincing doctors that there were incentives for them to join together. In some of the large cities where doctors frequently attempted to organize provident associations, they suffered from the competition of the free care offered by the outpatient departments of the large voluntary hospitals, as well as from the free dispensaries and medical missions. Provident associations located near large voluntary hospitals fared very poorly. Though the outpatient department of London's Metropolitan Hospital was a provident (e.g., insurance) plan, it was attacked by many general practitioners for admitting subscribers whose incomes were alleged to be too high. Generally, provident associations specified a maximum income for membership eligibility so that the upper classes would have to pay much more for medical services (Poor Law Commission, 1909, vol. 13, pp. 313, 458-459, 514-516; vol. 37, pp. 257-259; Committee on Metropolitan Hospitals, 1890, vol. 12, pp. 83, 105, 108, 113, 251-282; vol. 13, pp. 304-306; Brand, 1965, pp. 194-195).

Free Dispensaries and Medical Missions

These were organizations which were located in the slums of large cities: A few had existed for more than a century, but most emerged as a result of the religious charitable activity that produced the Salvation Army and the

settlement house movements of the nineteenth century (Gilbert, 1966, p. 306). Many of them were financed by local parishes and charitable subscribers, but in general they lacked the necessary funds to provide responsible medical supervision. These organizations received strong condemnation from medical practitioners and other observers for "mixing up medicine with religion and seeking to attract persons to religious services by the bait of cheap doctoring" (Poor Law Commission, 1909, vol. 37, p. 869). Although they did not provide care for large numbers of people, their very existence helped to convince many middle and upper income people who never visited the slums or a medical mission that there were adequate facilities to care for the sick poor. On the other hand, free, and even partial-paying dispensaries were looked upon with disfavor by advocates of provident plans, as well as by most general practitioners, on the grounds that they freely dispensed medical care to many individuals who could afford to pay fees to a private practitioner (ibid., pp. 260-261; Committee on Metropolitan Hospitals, 1892, vol. 14, pp. lxviii-ixx).

MEDICAL CARE IN THE PUBLIC SECTOR

The private sector had not been able to meet all of the medical needs of the country, and its limitations influenced the public sector provision of medical care. These two sectors were interdependent, however, for the inadequacies of each generated responses from the other.

The public sector was organized largely around a set of Poor Laws, which severely constrained the expectations and size of the public sector. Nineteenth century Poor Laws reflected the view that poverty demonstrated a personal failing and that alms were likely to contribute to the shortcomings of the poor. Because the taxpayer was compelled to contribute to the poor via the state's tax mechanisms and was therefore deprived of the opportunity of experiencing his own generosity, the recipient of Poor Law relief should in turn be stigmatized by temporarily losing his rights as a citizen (Gilbert, 1966, pp. 13-14). Following the Poor Law Amendment Act of 1834, the poor were to be treated as though they were a race apart from the rest of the society, a group to be tolerated, perhaps pitied, but despised. They were "assumed to be guilty of sin, of laziness and improvidence" (ibid., p. 21). An assumption of the Poor Law was that people should be deterred from applying for state aid, and therefore a condition of receiving state aid was that the recipient would live in the workhouse, where one would clearly be branded a pauper and impelled to reform. The rules were not intended to apply to the aged and the sick, however, and they were to be eligible to receive outdoor relief--that is, relief outside the workhouse. If they could not manage at home, the sick might also receive relief in the workhouse; but in theory, it was anticipated that they would be accommodated separately so that they would be immune from the punitive aspects of the workhouse which the "able-bodied" poor were to experience (Abel-Smith, 1964, pp. 46-47). As a disincentive, the stamp of pauperism was to be clearly marked upon all who received Poor Law medical relief. And in an effort to minimize the number of those receiving

outdoor care, a means test for qualifying for Poor Law Relief was expected to be rigorously enforced.

Because paupers had limited voting privileges, they had little political power with which they might influence the type of care available to them. The upper, middle, and skilled working classes had medical care which was responsive to their demands. These were the groups who financed the Poor Law medical facilities but consumed none of their services. Thus, the only groups in society who exerted pressure to improve the quality of the Poor Law facilities were the doctors involved in the Poor Law service and social workers, and these pressures were not sufficient to be of great consequence by the turn of the century.

Poor Law Outdoor Relief

At the level of the central government, the Local Government Board-- established in 1871--administered grants to local government authorities and established the guidelines for administering Poor Law medical relief to the poor. At the local level, domiciliary treatment of the sick poor was under the control of a Board of Guardians in each of the 646 unions into which England and Wales were divided. The Local Government Board mandated that each of the Boards of Guardians appoint a District Medical Officer, who was to be a qualified medical practitioner residing in the district, to provide medical care to the sick poor. By 1910, there were approximately 3,700 District Medical Officers, or about one-sixth of the doctors practicing in the entire country. Although in theory the central government established the standards for Poor Law medical relief, in fact each local Board of Guardians controlled the administration of medical relief within its

district. For all practical purposes, the District Medical Officers were subject to no inspection or supervision by the Local Government Board, for between 1870 and 1910 there was no official inspection of the Poor Law medical service by the Local Government Board (Poor Law Commission, 1909, vol. 37, p. 850). With a public system which was so decentralized, there was considerable variation in the administration of medical relief from district to district. The districts varied greatly in size and in population, in the salary paid to the District Medical Officers, in the work-load of the District Medical Officers, and in the quality of care provided to the sick poor. Even so, the salaries for most of the medical officers were very low, the usual figure being approximately £100 per annum. From this figure, most medical officers had to provide their own drugs and medicines, as well as dressings and bandages. As a result, much of the care provided by District Medical Officers was rather perfunctory in nature; medical officers generally provided the indigent with the most inexpensive medication, so they would not have to spend all of their salary on expensive medical treatment (*ibid.*, pp, 249, 268-269, 859).

The morale of most medical officers was quite low for several reasons. First, the medical officer was under the direct administration of a relieving officer, who rarely had any medical qualifications, but who had the power to decide who was eligible to receive Poor Law medical relief. The relieving officer was expected to visit the home of the applicant for aid in order to determine, not the medical condition of the applicant, but whether the applicant was indeed destitute. Because the criteria for defining destitution were very vague, the relieving officer had considerable discretion

in passing on applications. Indeed, there was no statutory definition of destitution for purposes of medical relief, and it was not at all unusual for a relieving officer to overrule the recommendations of District Medical Officers (*ibid.*, pp. 852-857; Webb and Webb, 1910, pp. 26, 40-41).

Because the Local Government Board and the Boards of Guardians believed that the District Medical Officers were likely to be too generous in determining the eligibility of applicants for aid, the real function of the relieving officer was to keep the number of people receiving medical relief to a minimum to prevent costs from soaring. As the concern of most relieving officers was to economize and the concern of the medical officers was to provide medical treatment, the two goals usually conflicted, thus generating a great deal of tension between the two officials (Poor Law Commission, 1909, vol. 37, pp. 282-283).

Second, there was considerable disagreement, for similar reasons, between the Boards of Guardians and their medical officers. Unlike the social elite who served on the Boards of Governors of the elite voluntary hospitals, the background of the Guardians was more similar to many of those who were applying for medical relief. They may have attempted to upgrade their own status by expressing contempt for paupers, by emphasizing the necessity for economizing, and by arguing that better medical services would be extravagant. As the medical officers had been trained in the voluntary hospitals where they were socialized to believe that there should be a high quality of care for the ill, perhaps it was inevitable that they would clash with the lay administrators of medical relief who believed that it was their responsibility to operate the Poor Law program parsimoniously (Abel-Smith, 1964, p. 64).

Third, the morale of the medical officers was low because there was little relationship between their salaries and the amount of work that they did, which had less to do with the amount of sickness in a district than with the policies and character of the Board of Guardians and the relieving officer. If the Guardians and the relieving officer were generous in providing funds for the sick poor, there was likely to be too much work for the medical officer; but his salary tended to be no higher than the medical officer who was in a district with Guardians and a relieving officer who were very parsimonious with funds. Moreover, the more work there was, the greater the likelihood the medical officer had to pay for more medications from his own salary (Webb and Webb, 1910, p. 19; McVail, 1909, pp. 119-121).

The quality of outdoor Poor Law medical relief varied greatly between those districts which had a dispensary (a place for consultations between doctor and patient, where the expense for medicine was paid by the Guardians and not by the doctor) and those which did not (Webb and Webb, 1910, p. 27). Where there were dispensaries, the work conditions for medical officers and the quality of medical care were somewhat better, but as a rule, the dispensaries existed only in the metropolitan areas. By 1890, there were 44 dispensaries operating in London, and by 1910, 138 in all of England and Wales. But even in the metropolitan areas, the medical officer saw almost as many patients at their homes as at the dispensary (ibid., pp. 28, 31; Abel-Smith, 1964, p. 90; McVail, 1909, pp. 126-139).

Whether outdoor care was provided at home or at a dispensary, most of the sick poor required medical extras--that is, food and other nourishment.

A large majority of the cases treated by District Medical Officers were those of the aged, many of whom suffered from chronic diseases. Not only were many of the elderly poorly educated but they also suffered from bad housing, inadequate nutrition, and grinding poverty, and all too often lived in a state of squalor and filth (Poor Law Commission, 1909, vol. 37, p. 849). The Guardians, however, often regarded nourishment as being other than medical care, and thus placed serious constraints on the ability of the doctor to provide adequate care for his patients. Another problem was the lack of proper nursing. Technically, the Guardians had the authority to appoint nurses for the outdoor sick, but in fact they almost always refused to do so. Even the dispensaries were generally without a nurse (Webb and Webb, 1910, pp. 38-39). As one District Medical Officer pointed out before the Poor Law Commission (1906-1909), "many cases die simply from want of proper nursing. . . . It is one of the Medical Officer's greatest drawbacks that he cannot get efficient nursing for his outdoor cases" (Poor Law Commission, 1909, vol. 37, pp. 250-252). A common type of outdoor care was the attending of women during childbirth. Medical officers were very receptive to this type of case, for they usually received an extra fee ranging from ten to twenty shillings. As midwives under the Midwives Act of 1902 were required to summon a qualified medical practitioner when they encountered difficult cases, District Medical Officers were frequently summoned. In many emergencies, however, there was not adequate time to obtain a medical order from the relieving officer, with the result that all too frequently the time had passed when a medical officer could provide any assistance. Several practitioners testifying before the Poor Law Commission of 1909 estimated that between a fourth and a third

of those blinded from childhood (a sizeable percentage being born in a state of poverty) were blinded shortly after birth by ophthalmia neonatorum, many cases of which could have been prevented by better care. Indeed, one witness, Dr. N.D. Harman, estimated that one child in every 100 births suffered from the disease (ibid., pp. 774-775).

There were considerable variations among districts in regard to the domiciliary treatment of expectant mothers. In some districts, they could not receive Poor Law relief if they had able-bodied husbands, or if the mother were unmarried, if she were able-bodied. In other areas, an expectant mother with a husband could receive assistance, but only if the husband qualified for Poor Law relief. Many districts refused all assistance to unmarried mothers, while others granted it frequently. And many districts refused all types of relief unless the mother encountered some type of exceptional or emergency problem (ibid., pp. 772-775).

In most districts, very few poor children received outdoor medical treatment from a District Medical Officer. Doctors complained that because of the stigma attached to pauperism, parents refused to seek medical attention until a child was gravely ill. Infectious diseases--whooping cough, scarlet fever, etc.--were frequently unrecognized by parents, and no doubt this helped to explain the high level of serious complications which resulted from children's illnesses.

In many areas, destitute families were unaware of their rights to obtain Poor Law medical care. But where people were aware of their eligibility for Poor Law relief, they were reluctant to apply because of the dread of being stigmatized as a pauper and losing certain rights as a citizen. Although the stigma of pauperism was felt less strongly in large

urban areas where there were shifting populations than in small towns and villages where most everyone knew everyone else and local feelings and traditions were strong, throughout the country, many individuals preferred to suffer until they were in great agony or near death rather than to seek Poor Law relief and be classed as a pauper. The deterrents to Poor Law relief were very effective, and were very harsh in some areas. A relieving officer might require individuals who were receiving relief to send some of their children to the Poor Law workhouse during the illness. In some instances, a relative of a recipient of Poor Law medical relief was required to pay for the medical care, and in some areas the relieving officer was permitted to receive twenty percent of the costs which were recovered. Another deterrent was to apply Poor Law medical relief in the form of a loan. Although the amount of the loan which the relieving officers were able to recover varied from individual to individual and from area to area, one of the real purposes of the loan was to deter the poor from applying for medical relief the second time if they still had a debt with the Poor Law authorities (*ibid.*, pp. 252-254, 936-937). In some districts, individuals had to appear before the Board of Guardians in person to make an appeal for relief. Where Guardians thought that there was not a sufficient deterrent, the ill were provided a relief order for only two weeks or a month, so that the case would necessarily emerge for periodic review. At the very minimum, the relieving officer was expected to make periodic calls on the patient in order to verify that the individual had not obtained some undisclosed resources which would permit the medical relief.

to be withdrawn. (ibid., pp. 252-254; McVail, 1909, p. 147; Webb and Webb, 1910, pp. 46-51).

A major problem of the Poor Law medical service resulted from the fact that people were not encouraged to seek medical care in the early stage of disease when they might be cured. At that stage of a disease, one might still be employed, however, and thus not be eligible for Poor Law medical relief. Because one would be eligible for care from a District Medical Officer only when one was destitute, most patients were in a pitiful condition by the time they sought assistance. One Local Government Board official testifying before the Poor Law Commission noted that "one hears of men and women who have struggled with this disease (tuberculosis) as long as possible before applying for relief, often sleeping in small rooms with children. . . . Out-relief is generally given till finally the sufferer enters the workhouse infirmary to die, in the meantime possibly having infected other members of the family" (Webb and Webb, 1910, p. 76). A medical officer reflecting the views of many of his peers about tuberculosis testified, "The whole of my experience up to now is that it is very unusual for what is called a curable case to come to the Poor Law."

As indicated above, the question of whether a medical officer would provide treatment to a patient had little to do with the severity of an illness, but with whether the individual suffering from an ailment had convinced the relieving officer that he was in a state of destitution. Some districts were very rigid in their designation of eligibility, while others were more lax and would permit an individual to receive medical care, even though he might not be destitute, if he could demonstrate that it would be impossible to obtain the necessary medical attendance and

nursing at his own expense (*ibid.*, p. 42). The medical officer had virtually no connection with patients who might be transferred to a workhouse of a Poor Law infirmary. His charge from the public authorities was to assist in relieving specific individuals by providing outpatient care. Overworked, underpaid, and confronted with numerous patients who were to be treated under the most adverse of circumstances, the District Medical Officer providing outdoor medical relief could do little to diagnose and treat illnesses according to the standards by which medicine was being practiced in the prestigious voluntary hospitals.

Institutional Care Under the Poor Law

The number of paupers receiving outdoor medical relief under the Poor Law did not change during the last two decades of the nineteenth century. This resulted from the Poor Law authorities continuing to restrict outdoor relief in preference to indoor treatment as a means of deterring people from seeking Poor Law relief. Each of the 646 unions had a workhouse, and it was there that most of the sick poor sought relief. Most every workhouse had a sick ward, thus separating the ill from those who were not. Of course, there was great variability in the quality of the workhouses, especially between urban and rural districts. Usually, the sick poor preferred to receive outdoor treatment, but those who had no one to care for them and who thought that there was no institution in the voluntary sector accessible to them would seek aid in the workhouse. However, the conditions of workhouses were often so awful that many people refused to enter them until they were almost in a "moribund state" (Webb and Webb, 1910, p. 89).

The rural workhouse. By 1910, there were approximately 300 rural workhouses with fewer than 50 beds in them. Without doubt, these were the worst places for institutionalized medical care in Great Britain. In the workhouses, there were elderly men and women suffering from chronic diseases, senile imbecility, and paralysis, children afflicted with an array of childhood diseases, the feebleminded of all ages and sexes, and a few women on the verge of childbirth. There were others suffering from infectious diseases, some of which were highly contagious; almost all workhouses had at least one person suffering from tuberculosis--one authority estimated that at least one-half of the deaths from tuberculosis occurred in Poor Law institutions (Webb and Webb, 1910, p. 76).

Many of the rural workhouses were originally constructed as factories, and were poorly adapted to deal with the ill. The rooms were often small and poorly ventilated, with very primitive sanitation, bad lighting, and poor water supply. The British Medical Journal (1895) reported after a careful survey and many reports that many workhouses were without hot and cold water or children's wards, and had inadequate or nonexistent privacy for lying-in women, no surgical supplies, no means of isolating patients, and were greatly overcrowded. The journal summarized its findings by noting that there was "an absence of all intelligent appreciation of the needs of the sick" (p. 1231). None of the 300 rural workhouses had a medical officer in full time residence. Rather, the Guardians usually appointed a part-time doctor who was able to visit patients only irregularly and infrequently. Because the workhouse medical officer was required to pay for medicine from his meager salary, the patients tended to receive the most simple type of remedies. Moreover, many of the rural

workhouses for reasons of economy had no trained nurse, and many had no nurse, trained or untrained, available for night duty. Where workhouses had no salaried nurse, pauper nurses cared for the patients. In 1910, there were approximately 2,500 paupers serving as the nursing staff in workhouses throughout England and Wales. In sum, most rural workhouses were no better able to care for the sick poor by 1900 than a half century earlier (Webb and Webb, 1910, p. 96-97; McVail, 1909; Poor Law Commission, 1909, vol. 37, pp. 273, 859-862).

Urban workhouses and Poor Law infirmaries. Some of the workhouses in urban areas were just as deficient in quality as the rural workhouse, though there was much more variability among the urban workhouses. In general, the urban workhouses tended to improve during the late nineteenth century; Many of the urban workhouses by 1900 had a resident medical officer, trained salaried nurses, medicine financed by the Boards of Guardians, and new wings built to accommodate the ill. Nevertheless, most urban workhouses were overcrowded, lacked modern medical facilities, and had an inadequate supply of nurses and doctors.

Some of the worst care in workhouses was that for childbearing women and young children. Although few expectant mothers were confined in rural workhouses, there were numerous confinements in urban workhouses. In the early twentieth century, approximately 11,000 children were born annually in the workhouses of England and Wales. Although there are no exact data on the extent of infant mortality in the workhouses, available evidence indicates that it was very high. One study for the Local Government Board demonstrated that almost one-third of the infant population in workhouses died. Alarmed by these data, the Poor Law Commission conducted its own studies; whereas the rates in their studies were somewhat lower, the infant

mortality rate in workhouses was almost three times higher than the infant population at large. Moreover, there were a number of workhouses in which forty percent of the infants died (Poor Law Commission, 1909, vol. 37, pp. 777-784).

In workhouses throughout the United Kingdom, there resided approximately 15,000 infants, most of whom were orphans left by destitute parents. By almost any standard, the facilities for the care of infants was most inadequate. Much of the infant nursing was done by pauper inmates. Numerous witnesses before the Poor Law Commission testified that the sanitation for infants was invariably primitive and that the nurseries were usually characterized by intolerable stench. Officials at some workhouses testified that because of inadequate staff, many babies were never taken into the open air or into a well-lighted or properly ventilated area (*ibid.*, pp. 784-787).

In a few districts where the local workhouse was seriously overcrowded, the Guardians responded to criticisms about the conditions of the local workhouses by constructing a new and independent Poor Law infirmary. Compared with the best hospitals of the day, these infirmaries provided care of a medium quality. They had their own staff of doctors and nurses and had no pauper nurses or attendants. Unlike the Poor Law workhouses, most of the cases were not directed exclusively to chronic and incurable cases, and over time the infirmaries became institutions which increasingly provided treatment for those with acute illness. Some of the infirmaries were very large hospitals: for example, the Poor Law infirmary of Liverpool had 900 beds, and that in Birmingham had approximately 1400. Aside from performing many surgical operations and treating infectious

diseases, the infirmaries also became logical institutions for receiving accident cases and emergency illnesses. By 1910, the type of hospital treatment provided in these institutions did not differ greatly from that provided in the best voluntary hospitals. Rather, the difference between the two types of institutions resulted from the fact that the infirmaries had a lower proportion of doctors, specialists, and nurses, and that although the newer infirmaries were housed in modern buildings containing up-to-date medical and surgical facilities, their staffs were generally inferior to those found in the best voluntary hospitals, and their salaries were somewhat lower (*ibid.*, pp. 246-247). Most of the staff were greatly overworked, and in contrast to the doctors in the voluntary hospitals, had much less control over the patients who were admitted, as the infirmary admitting office was required to admit every case recommended by a relieving officer. In 1909, the London teaching hospital averaged one nurse for every 2.86 patients, voluntary, nonteaching and general hospitals throughout England and Wales averaged one nurse for every 3.83 beds, but the large metropolitan Poor Law infirmaries averaged only one nurse for every 10.67 beds (*ibid.*, pp. 863-864; McVail, 1909, pp. 48-50).

Even though the infirmaries were operated under the Poor Law statutes, their clientele slowly changed as people who were not paupers sought medical care there. In some areas, where there was no voluntary hospital, the local population looked to the infirmary as their general hospital. As the Poor Law Commission (1909) reported, "The skilled artisans and the smaller shop-keepers are coming to regard the Poor Law infirmary. . . as a municipal institution, paid for by their rates, and maintained for

their convenience and welfare" (vol. 37, p. 865). Those above the pauper class who sought medical care from the infirmaries were expected to provide some modest or token payment for the services which they received, however (ibid., p. 244).

By 1910, there were approximately 40,000 patients in Poor Law infirmaries, compared to approximately 60,000 in the sick wards of the workhouses. In Liverpool, where the development of Poor Law infirmaries was more extensive than in any other city, there were three times as many beds as in all the general hospitals combined. It is indicative of the rising status and broadening function of the Poor Law infirmaries that some of the better ones established training schools for nurses, turning out approximately 400 a year, from which workhouses throughout the country received their nurses (Webb and Webb, 1910, p. 106).

Owing to a variety of cultural, legal, and political constraints, workhouses were slow to adapt to the newer medical technology available for treating the sick poor. In the large urban centers where there was more demand for medical care, more professionals to pass judgment on the quality of care which was being practiced in their areas, and more resources-- financial, intellectual, and technological--available for the sick poor, the institutions under the Poor Law statutes adapted more quickly to the available medical technology, and there was increasingly a convergence in the quality of care provided between the best voluntary hospitals and the large Poor Law infirmaries. But it was the prestigious hospitals in the private sector that served as the pacesetters of what constituted high quality medical care. Subject to many more constituencies and constrained by more diverse legal and political factors, the Poor Law

infirmaries were unable to provide the same quality of care as that in the best private hospitals. But the fact that many Poor Law infirmaries were providing very adequate medical care in the midst of considerable demand for medical care forced them to open their doors to those who were not in the pauper class. This decision was, in the long run, to be of considerable importance in removing a social stigma among those who received care in hospitals maintained by Poor Law rates.

Despite the progress which the infirmaries represented, Poor Law medical services were poorly distributed over the country. As suggested above, the decentralized character of the services meant that the quality of medical facilities accessible to the sick poor varied enormously from district to district. Ranging from the hospitals with the best physical equipment which money could buy to workhouses which were filled with filth and vermin and totally unsuited for humans, Poor Law medical care was greatly in need of reform--a problem which would last for many years.

Another problem, one which would persist in the delivery of medical services in Britain to the present, resulted from the poor communication between the medical officers who provided domiciliary care and the doctors who provided institutional treatment for the sick poor. Both were under the control of the local Government Board and the various Boards of Guardians, but they were for all practical purposes two distinct types of services. As such, the District Medical Officer treated no patients inside workhouses or infirmaries. Once a patient entered a medical institution, his doctor on the outside had no communication with the one inside about the patient's care, and when the patient was discharged, there again was no communication about the type of care received while under confinement. As the Webbs (1910) remarked, "This complete separation between the domiciliary and the institutional treatment of the sick poor, so

irrelevant from a medical standpoint, results . . . from nothing more rational than their medical attendance being, in both cases, regarded solely as relief, and subject, as such, to the fundamental Poor Law classification of indoor and outdoor, which it seems a cardinal point of policy to keep entirely separate" (pp. 125-126).

Public infectious hospitals. The development of public infectious hospitals reveals a great deal about the institutional innovation in the area of medical care. Even though the prestigious voluntary hospitals tended to exclude patients with infectious diseases, these diseases represented a major problem for the entire society. When the voluntary hospital sector was unresponsive to the problem, the public sector responded to the widespread demand for facilities for isolating and caring for patients with infectious diseases. As the Poor Law machinery with the Local Government Board and local Boards of Guardians was already in existence, the government responded by placing infectious hospitals under the Poor Law statutes.

When the existing public institutions of London were inappropriate for isolating patients, the Metropolitan Asylums Board was created and given the responsibility for providing facilities under the authority of the Poor Law, which meant that they should be used only by paupers. With the passage of time, however, the technicalities of the Poor Laws and the needs of society came into conflict; with the law giving way to society's needs, the public health authorities were permitted to administer the asylums. As infectious epidemics broke out, the asylum hospitals responded by admitting patients who were not paupers, though patients who had the financial ability were expected to make some payment for their care. By

the end of the nineteenth century, however, the asylum hospitals were permitted to admit all patients suffering from infectious diseases in London and were denied the authority to charge a fee for the care provided patients suffering from infectious diseases. This, of course, represented an important precedent for the future of the delivery of medical services in Britain. Even though the asylum hospitals were financed by Poor Law rates, their services became free and universal to all citizens of London (Abel-Smith, 1964, pp. 122-130). By the early twentieth century, patients from the middle and lower strata of the society were using the hospitals of the Metropolitan Asylums Board without any financial obligation (Poor Law Commission, 1909, vol. 37, p. 945).

Outside London, the local sanitary authorities provided most of the hospitals for infectious diseases. In the early twentieth century, approximately 400 of the different 1,600 sanitary authorities provided some form of hospital for infectious disease, though with such a decentralized system, the facilities and politics varied considerably from district to district. There were approximately 700 municipal hospitals with approximately 25,000 beds--almost as many beds as contained in the voluntary sector. Although the municipal hospitals had originally been established to treat infectious diseases, the Public Health Acts under which they were established were vague concerning the types of diseases which they could treat. As a result, there was a tendency over time for the municipal hospitals to treat many diseases other than infectious ones. In the early part of the twentieth century, a few towns established municipal hospitals exclusively for acute illness,

whereas others established public outpatient departments and dispensaries. However, the distribution of the public health medical facilities was uneven, as some towns had no hospitals, even for infectious diseases (ibid., pp. 876-878, 885).

AN UNCOORDINATED AND ILLOGICAL SYSTEM

By 1910, England and Wales had a very decentralized, uncoordinated, and inequitable medical delivery system. In the private voluntary sector, there were hospitals and dispensaries, and in the public sector, there were two highly institutionalized medical services--the public service maintained by the Poor Laws, and the public health authorities Asylum and municipal hospitals maintained by local governments.

Although the local public health authorities had originally been concerned primarily with preventing the spread of diseases, local health authorities began to assume that the treatment and curing of existing diseases among individual patients was necessary to prevent further disease. Thus, preventive and curative medicine were integrated in the eyes of local sanitary authorities, leading the medical services of the local public health authorities to become the most extensive in scope in England and Wales. The local health authorities attempted to search out disease, to provide early diagnosis and treatment, specialized treatment if necessary, and a more sanitary environment in an effort to prevent disease. However, the scope of the local public health activities varied greatly from area to area. In some cities, the public health authorities maintained hospitals for all types of diseases, in others

there were only infectious disease hospitals, and in many areas, there were no public hospitals (Poor Law Commission, 1909, vol. 37, p. 890).

In theory, the Poor Law services were not available to patients until they were destitute. For this reason, Poor Law authorities did nothing to prevent disease and very little to treat disease in its incipient stage. The purpose of the Poor Law medical service was to provide relief. Whereas the Poor Law service generally attempted to deter individuals from applying for medical services, the local public health officials exhorted all citizens to seek diagnosis and medical treatment as soon as illness began. Most Poor Law relief was given reluctantly, and patients in effect had to slip slowly into a state of poverty before they were eligible to apply for Poor Law medical services. Indeed, there were numerous studies which demonstrated that many people eventually became paupers as a result of being ill (ibid., p. 289).

The poor were eligible to receive medical care from a multiplicity of institutions, but care was based on a set of contradictory principles. For example, a lower income individual who was employed might gain admission to a voluntary hospital and receive treatment for free. Here, it was rare for a patient or his family to be placed under a firm obligation to pay for more than a fraction of his treatment. On the other hand, an individual with the same malady and similar socioeconomic background who lived in a different area, and thus was unable to gain admission to a voluntary hospital, might enter a workhouse infirmary. As a result of receiving treatment in a Poor Law institution, this individual technically became a pauper, and the patient or relatives

could be required to repay the entire cost of treatment. Yet a third individual might gain admission to a municipal hospital provided by the local sanitary authority and receive free medical care with no stigma attached and no obligation to repay the hospital for the cost of treatment. In some instances, a person of the pauper class received treatment in a voluntary hospital, while another with somewhat higher social standing, but with a chronic disease, could only receive treatment in a Poor Law infirmary. It was especially common for the sanitary authorities to provide isolation hospitals for infectious diseases, but in many parts of England and Wales, the Poor Law authorities provided the only institutions available for treatment of infectious diseases (*ibid.*, pp. 930-931). Because of the decentralized character of the Poor Law, public health, and voluntary services, institutions were unevenly distributed over the country. As a result, the type of service people received was, in part, a function of where they lived.

REFERENCES

- Abel-Smith, Brian. The Hospitals 1800-1948. London: Heinemann, 1964.
- Ackerknecht, Ervin H. Medicine at the Paris Hospitals, 1798-1848.
Baltimore: Johns Hopkins Press, 1967.
- Brand, Jeanne L. Doctors and the State. Baltimore: Johns Hopkins Press,
1965.
- Braun, Percy. "The Cost, Condition and Results of Hospital Relief in
London," Journal of the Royal Statistical Society, 72 (March, 1909),
1-30.
- "British Medical Journal Reports re: Provincial Infirmaries," British
Medical Journal (June 1, 1895), 1231, 1232.
- Committee on Metropolitan Hospitals. See Great Britain, "Report of the
Committee on Metropolitan Hospitals."
- Gilbert, Bentley B. British Social Policy. Ithaca, New York: Cornell
University Press, 1970.
- . The Evolution of National Insurance in Great Britain. London:
Joseph, 1966.
- Great Britain, Parliamentary Papers (Commons), "Report of the Royal
Commission on the Poor Laws." London: H.M.S.O., 1909.
- Great Britain, Parliamentary Papers (Lords), "Report of the Committee
on Metropolitan Hospitals." 1890-1892. Reprint. Shannon, Ireland:
Irish University Press, 1970.
- McVail, John C. Report to the Royal Commission on the Poor Laws and
Relief of Distress on Poor Law Medical Relief, Cmd. 4573, vol. 42.
London: H.M.S.O., 1909.
- Pinker, Robert. English Hospital Statistics 1861-1938. London:
Heinemann, 1966.

Political and Economic Planning. Report on the British Health Services.

London: Political and Economic Planning, 1937.

Poor Law Commission. See Great Britain, "Report of the Royal Commission on Poor Laws."

Shryock, Richard H. American Medical Research Past and Present. New York: The Commonwealth Fund, 1947.

Steele, Dr. "The Charitable Aspects of Medical Relief," Journal of the Royal Statistical Society, 55 (1891), 263-299.

Stevens, Rosemary. Medical Practice in Modern England: The Impact of Specialization and State Medicine. New Haven: Yale University Press, 1966.

Webb, Sidney, and Beatrice Webb. The State and the Doctor. London: Longmans, Green and Co., 1910.