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THE FUTURE OF LOCAL AUTHORITY HEALTH SERVICES*

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It does not require a very vivid imagination to foresee that during the next few years the British health services are likely to be the subject of searching investigation. No country can afford to go on spending indefinitely one-third of its government's revenue on social services, and the economists have pointed out the dangers. For example, Hagenbuch, in a recent review of the social services, gave the alternatives as "an inflation that at any time may get out of hand and leave us freedom but no security" or "a hurried return to the regime of rationing and controls, with security but no freedom," and, thirdly, "a supreme effort to cut consumption and investment and social services with the minimum of controls. The last is the hardest way and may not be possible. But if it were, it might bring us both freedom and security, not brimming over, but in fairly good measure."¹ When the day of reckoning comes all branches of medicine will be concerned, and indeed from the financial point of view doctors are peculiarly vulnerable.

Some signs of public discontent are already visible. The announcement of the Danckwerts award to general practitioners was swallowed by the public in glum silence. The methods of payment of merit awards to consultants are also open to attack, for these mark a departure from the constitutional principle that the expenditure of public funds must be public. In the words of an annotation in the *British Medical Journal* of February 4, 1950 (p. 295): "As this is public money used to provide pensionable increments to income, has not the public a right to know the names of the recipients? We know of no other public award of money that is kept secret—except the presumed payments to members of the Secret Service." The increases in salaries of medical officers of health have forced the local authorities, much against their will, to raise the salaries of the other chief officers; and, lastly, the disparity between the stipends of clinical professors and the other teachers in the universities has resulted in controversy and dissatisfaction.

The position is a disturbing one, with few precedents on which to rely for guidance. Hasty action by political leaders who feel that they are voicing public demands for full value for money might well result in a rigidly controlled or a full-time salaried service. The only experience on which we can draw is that of the local authority health services. It is difficult to realize how short a time those services have been in existence.

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Urban and rural sanitary districts date effectively only from 1875 (the Public Health Act of 1848 was an "adoptive" Act). County councils and county borough councils were created by the Local Government Act of 1888 and urban and rural district councils were established as health authorities by the Local Government Act of 1894. Thus our oldest administrative health machine dates back less than 80 years. In those few years it has had to shoulder an extraordinary variety of burdens. At the beginning the pattern of disease with which it was confronted was an appalling one, and the mass of the people were ignorant, illiterate, and indifferent.

In 1852, for example, precisely one hundred years ago, the Registrar-General was gratified to find that "the proportional numbers of men and women who write their names [in the marriage register] is increasing; still, however, 30.5% of men and 44.6% of women sign with marks. And in several counties more than half the women are unable to write their names."² In that year, which was a prosperous one, with the "price of provisions low until after harvest, when the price of wheat rose, and potatoes, which are consumed so largely by people of all classes and ages, became dear,"² scarlatina caused 18,887 deaths, diarrhoea 17,617 deaths, and typhus, smallpox, and cholera numbered their victims in thousands, as did measles and whooping-cough. Above all there was consumption—"the greatest, the most constant, and the most dreadful of the diseases that affect mankind. It is the cause of nearly half the deaths that happen between the ages of 15 and 35 years."³ The fact that one mother died in childbirth for every 192 children born alive passed almost unnoticed. Disease and early death were part of the expected order, and curative medicine was almost powerless. On February 13, 1863, the *Medical Times and Gazette* published a letter by Dr. Farr in which he castigated the general hospitals as "ways of death to their inmates" which did not "benefit mankind directly" but merely served as pathological observatories and medical schools.⁴

The field of prevention was wide open to all comers, and voluntary organizations and local authorities buckled to with such good will that by the year 1900 definite improvements had begun to appear, and by 1950 the pattern of disease which the local sanitary authorities had been set up to meet no longer existed. In case this should seem an exaggeration it should be noted that in 1950 scarlet fever caused four deaths in London, diphtheria four, typhoid three, smallpox nil, measles and whooping-cough together 34, and enteritis 64.⁵ Typhus and cholera had of course disappeared many years before. In that year (1950) the whole-time staff of the Public Health Department of the London County

Council numbered 7,243, with a gross annual cost of £4,167,204.⁶ The London health organization includes also the health services of the 28 metropolitan boroughs, the four metropolitan regional hospital boards, the 26 teaching hospitals, and the general medical services administered by the executive council—a truly formidable machine.

The Swing to Full-time Services

With the turn of this century came a swing from environmental to personal health services actuated partly by fear. In this instance the spur was not cholera or social unrest but the trouncing administered by the Boers in the South African War. The potential soldiers of the Queen were rejected in the proportion of 40-60%.⁷ The Interdepartmental Committee on Physical Deterioration reported in 1904 and the school medical service followed in 1907. Here it seems to me that the medical profession made a fundamental mistake in not recognizing the importance of this new service. It is true that the first treatment centre for minor ailments, opened in Hampstead in 1910, had an advisory committee of general practitioners, but it was left to the local authorities to build up a salaried service in which the general practitioner and the hospital consultant played only a subsidiary part. The same comment may be made of the tuberculosis service.

In 1911 the State came openly into this field of clinical medicine because it was recognized that tuberculosis, if neglected, could play havoc with the National Health Insurance scheme. Once again a golden opportunity was lost and the tuberculosis service became a full-time one. So the story continued. Maternal and child welfare, midwifery, mental disease and mental deficiency, the care of the physically handicapped and the chronic sick all became in effect full-time services administered by the local authorities. Meanwhile these authorities were themselves undergoing a remarkable metamorphosis. Local sanitary districts became merged in combined sanitary districts, county councils and county borough councils came increasingly to dominate the local health scene, and under the Local Government Act of 1929 became hospital authorities in open competition with the long-established voluntary hospitals.

It is interesting to speculate on the outcome if that struggle had been allowed to continue, but the comment was soon heard that "regional areas are obviously more suitable for hospital administration than the areas of existing local authorities."⁸ The outbreak of war in 1939 saw the introduction of both regionalization and a national (emergency) hospital service. Subsequent developments are so well known that they do not need repetition. To-day we have superimposed on the pattern of local authorities hospital management committees, regional hospital boards, boards of governors of teaching hospitals, local executive councils, and a regional civil service in which each central government department is represented, often with its own medical staff, and, most important, dealing directly with the general public.

Multiplicity of Organizations

We have therefore the extraordinary position that many of our medical services are now administered by bodies on which the locally elected representatives of the people either do not serve at all or are in such a minority that their contributions are not decisive in influencing policy. Indeed, at this stage one may well ask whether local authorities should retain any health services at all. Why not make an all-purpose health and hospital region? It could be said that they have done the work they were set to do and that we cannot afford the luxury of our present multiplicity of organizations. The school-teacher, the bank clerk, and the small trader, hard pressed to live on a few hundred pounds a year, may justifiably inquire why they must continue to support, for example, a medical officer of health, a senior administrative medical officer to the regional hospital board, secretaries to the local hospital management committees and the teaching hospital, all at salaries several times

more than their own. There is also a vague and as yet almost unspoken belief that costly hospital and general-practitioner services might well be asked to show more interest in the personal health services which are now the responsibility of the local authority.

On the other side of the medal is the instinctive distrust of powerful monopolies. A regional authority administering health and hospital services, including perhaps industrial medical services, could soon become the object of attack from two opposite sources. The central government departments might regard such an authority with great distrust and do all in their power to curb its growth. The people in the area served would (unless their present apathy continues, which God forbid!) soon protest against remote control and "dictatorship." It seems probable that the pendulum, which has swung violently away from the local authority, would recoil equally quickly from regional control. The alternative of full State control is not one which is likely to be tolerated unless imposed by force or dire necessity. The tradition of local representation is deeply rooted, and it is all the more disturbing to note the trend towards party politics on the national pattern within the local authorities over the past few years. If that continues and expands and the business of the local authority is conducted on the basis of the "party line" instead of local needs it will mean the end of local government as we have come to understand it.

Needs of the Future

When considering the future of local authority health services the best indication is perhaps to ask where the needs lie. But one fundamental question must be answered before this. Do we still believe that the prevention and cure of disease are distinct entities to be retained in separate administrative and technical compartments? If we do then not only must the distinction between local authority and hospital and general-practitioner services be maintained but other new services, such as an industrial medical service, must be established and two kinds of worker, preventive and curative, must be trained. I suggest that the distinction is no longer tenable, and that prevention, diagnosis, treatment, and after-care now form one continuous process, and that we should revise our undergraduate and postgraduate teaching accordingly. If we continue on our present narrow lines of specialization then inevitably gaps will appear in our framework of medical services which will be filled by the layman, and especially the lay administrator and the lay ancillary worker.

That process is already evident in the local authority health services. Environmental sanitation, still a most important part of our health services, is already in the hands of specialists. Purity of water supplies is the responsibility of the water undertaker. Sewage disposal has become an engineering matter. The quality and quantity of food supplies, including milk, are increasingly the concern of the Ministry of Agriculture and Fisheries and the Ministry of Food. The local interests in this matter of purity of food supplies are well served by the sanitary inspector and the public analyst. The control of infectious diseases has ceased to be a matter of concern only to the local sanitary authority. Epidemics are now of national and international importance and require an organization for their prevention and control which oversteps all administrative boundaries. The responsibility for the diagnosis of infectious disease rests increasingly with the laboratory worker, although he is unfortunately not responsible for notification. It is therefore possible for the medical officer of health to remain unaware of the existence of infectious disease in the hospitals in his area for days and even weeks after the laboratory diagnosis has been made—a ridiculous state of affairs.

To question the need for maternity and child welfare services and the school medical service in their present form is to invite a storm of protest and the confident assertion that the facts speak for themselves. Indeed they do. An

infant mortality rate of 26 and a maternal mortality rate of 0.7 show that the years of endeavour have at last borne fruit. They also show that, having defeated the enemy, the great army of workers could now be demobilized, retaining only a highly skilled skeleton staff. These sentiments may be unpopular, but I do suggest quite seriously that the time has come to merge the maternal and infant welfare services with the hospital obstetric and paediatric services.

A similar case could be made for the aftercare of tuberculous and mental patients to be conducted from the hospital rather than by the local health authority.

One other point must be made here. We are no longer dealing only with a population at risk from disease in youth or early adult life, but with a rapidly ageing community. Miss Hornsby-Smith, Parliamentary Secretary to the Ministry of Health, in her address to the Institute of Almoners this year said: "I would remind you that 100 years ago there were nearly 13 people of the working population to every one over 65. At the present time there are only six people of the working population to one old-age pensioner, and by 1977 it is estimated that the figure will be down to four. If I may put it another way: there were a million people over 65 in 1861, and there are expected to be 8,000,000 by 1977." The burden of the chronic sick already presses heavily on the hospitals.

Co-ordination of Local Medical Services

It was not a mere whim by the parliamentary draftsman to place local health authority services in Part III of the National Health Service Act of 1946, between the hospital services in Part II and general medical services in Part IV. That was done deliberately, for it was felt that the local health authority could provide the essential link between hospital and domiciliary care. It was also believed that the provision of health centres by those authorities would encourage the development of preventive and curative services under one roof. Restrictions on building have prevented the general provision of health centres, but there is no doubt that much of the distrust of health centres on the part of the general practitioner stems from the ease with which they could lead to a full-time salaried service; for private practice in the health centre might, like the private wards in hospital, be subject to restrictions to be tightened at will, and few men could afford to run private consulting-rooms as well. In the meantime the hospital has become established as the focal point of our medical services, a position that it is likely to retain for many years to come. That the Americans have already realized this is clear from their proposals to make health and hospital regions continuous. Much of the present suspicion of health centres would be allayed if these could be associated with the hospital, and preferably built within the hospital curtilage, so that the practitioners could call readily on the full range of diagnostic facilities and keep in close touch with the consultants.

The Central Health Services Council has recently submitted to the Minister of Health a report on co-operation in the National Health Service¹⁰ and has recommended that local joint consultative committees should be established for convenient groups of local health authorities, executive councils, and hospital management committees. The area to be covered by a joint health consultative committee is to be called a local health service area. While this recognition of the need for co-operation is valuable it is clear that the committees will be advisory and without power. They can only recommend to the existing bodies. It is to be hoped that these consultative committees may lead to a statutory health and medical care committee administratively responsible for local health services, hospital services, and general medical services. The formation of such an all-purpose health and medical care committee would simplify many matters. It would effect a great saving in secretarial, finance, and records staffs, for at present the health departments, hospital management committees, and executive councils run quite independently. The district nursing service would

be more closely associated with the hospital and the general practitioner, and the medico-social workers, health visitor, almoner, and psychiatric social worker would come under one administration. Most important, the position of the medical officer of health would become clear.

The first medical officers of health were clinicians, and if they had been allowed to remain "walking gentlemen with a nose"—that is, physicians interested in the detection and reporting of all matters detrimental to the health of the people—many of our present difficulties would never have arisen. It is most unfortunate that the medical officer of health and the salaried medical officer in central and local government employment were left by their colleagues to play a lone hand for so long, for it has resulted in a dearth of competent medical administrators when they are most needed. Never were Macaulay's words more apt than in this connexion when he said, "It is indeed most important that legislators and administrators should be versed in the philosophy of government."¹¹ How can we expect others to be versed in the philosophy of government of medicine if we do not ourselves display any interest in it?

The work of the deans of the great medical schools has shown that it is possible for a medical man to be a good administrator. The medical officer of health could play a similar part in the co-ordination of the local medical services if he had the full and active support of his clinical colleagues. An effective first step would be to give him an honorary contract on the staff of the local group of hospitals as home-care physician. It would then be his duty to ensure that all existing resources, and they are many, were used to prevent disease from arising in the individual, to encourage the medical care of patients in their own homes, and, above all, to ensure that the chronic sick do not block valuable hospital beds. He would also be responsible for the co-ordination of aftercare on discharge from hospital. Such an appointment would not trespass on the work of the general practitioner or the consultant, but would be of value to both.

There is no doubt that in the long run any service gets the type of administration it deserves. In the past the medical profession has actively discouraged the medical man who had a flair for co-ordination, and thereby allowed, by default, the lay administrator to take his place. That mattered little when the administrator was in daily personal contact with the medical staff, and indeed the medical profession owes a great debt of gratitude for the help it has had from the house governors of hospitals and the clerks of local authorities. But the fact remains that curative medicine has now followed in the wake of preventive medicine and become a major interest of the State.

Conclusion

The changes in the health functions of the local authorities over the past eighty years have been many. It is not too fanciful to foresee the same process occurring in our medical services in the future. We certainly do not want to see curative medicine develop into the rigidly administered state of the German insurance medical service just before the last war, when even the number of aspirin tablets was dictated. The results of that regimentation are painfully well known to you. Equally we do not want to find ourselves confronted with investigators bent on discovering whether much of the work of the costly clinician could be done by someone with a shorter training and a smaller salary. If the practice of medicine is to be kept at an economic level and at the same time incorporate all the benefits of recent progress, the medical profession must pay more than mere lip service to the adage that prevention is better than cure, for it applies to the health of the medical profession as well as to the health of the nation.

As to method, that was laid down with the greatest clarity by a writer in Dublin more than 200 years ago. Many of you will recall that Gulliver in the course of his travels found, in the Academy of Lagado, a most ingenious doctor, who seemed to be perfectly versed in the whole nature and

system of government and who had somewhat unusual views on the preservation of the health of the body politic. This same doctor, having noted that those in power are often troubled with short and weak memories, proposed that "whoever attended a first minister, after having told his business with the utmost brevity, and in the plainest words, should, at his departure, give the said minister a tweak by the nose, or a kick in the belly, or tread on his corns, or lug him thrice by both ears, or run a pin into his body, or pinch his arms black and blue, to prevent forgetfulness."

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RECENT ADVANCES IN ACTIVE IMMUNIZATION

(DIPHTHERIA, WHOOPING-COUGH, TUBERCULOSIS)*

BY

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A discussion on active immunization enables us to review advances made in the laboratories of many countries since the war, and also to indicate current trends likely to prove useful to the medical practitioner—surely a main function of the Annual Meetings of the British and Irish Medical Associations. It must be remembered, however, that there is a long incubation period between the conclusion of any new work and the writing of a paper on the subject. Following this there is a long latent period before the article appears in print. Any summary of advances in active immunization cannot ever be up to date, and any statement made to-day may be contradicted to-morrow.

Since chemotherapy and antibiotics are being employed with varying success in the treatment of many diseases, inquiries are naturally made about the future of specific means of control (toxoids and vaccines). In spite of the progress of chemotherapy, immunology has still a very important part to play in prevention and treatment, and there is a need for further research on antigens and methods of using them effectively.

Diphtheria

Since the launching of the national immunization campaign by the Ministry of Health, London, in 1940, the reduction in the toll of this disease in England and Wales has been dramatic. In 1951 diphtheria deaths numbered only 34 (provisional figure) and corrected notifications 699, compared with approximately 3,000 deaths and 55,000 to 60,000 notifications per annum just before the second world

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war. Fifty years ago there were nearly 10,000 deaths per annum. Moreover, in the past, about 10% of infants might have been expected to suffer an attack of diphtheria and 1% (10% of cases) to die from it (*Medical Officer*, 1951). Where inoculation has been fully practised the toll has been reduced to about 1% of what it was. More convincing evidence of the value of immunization is that the diphtheria notification rate was three times higher and the fatality rate seven times higher over the three years 1945, 1946, and 1947 among non-immunized than among immunized children aged under 15 (Logan, 1952). The chance of a non-immunized child under 15 dying of diphtheria was 22 times as great as that of an immunized child in the same community. These magnificent achievements have not received the attention they merit, because preventive medicine is largely impersonal. The benefit conferred is not appreciated consciously by the person whose life is saved, nor indeed by anyone else. Yet the cost is relatively insignificant both in money and in the trouble involved.

I think we should be careful not to ascribe the improvements in the diphtheria position solely to immunization. As is well recognized, scarlet fever and other acute infections have shown a decline in mortality during the last 50 years, although there has been no comparable immunization campaign for their control. Other factors are at work, including, in diphtheria, a possible change in the invasiveness of the causal bacillus. There must be no slackening in our propaganda, but rather an intensification, for there are already in different countries too many susceptible persons, presumably prone to attack by the "enterprising" virulent bacillus we used to know. In a recent review by McGuinness (1952) 30 to 50% of American adults are mentioned as being susceptible. Barr, Glenny, and Parish (1951) examined the diphtheria antitoxin content of 100 samples of cord blood from each of 15 districts of the British Isles; in 10 of the groups, 30 to 59% of the samples contained no detectable antitoxin (under 0.001 unit per ml.). It is obvious that the decline of attendance last year at British clinics must not be accepted with complacency, but be countered by really forceful official propaganda. Mothers who have lost their fear of diphtheria as a deadly illness must not be allowed to remain apathetic.

Not only are there very few cases of diphtheria to-day, but also apparently very few carriers in the general population. Immunization has not increased the number of carriers, as was once thought possible. Thus a paper from Leeds (Bradshaw *et al.*, 1952) stated that no carriers were found in the examination of 6,675 swabs from a highly immunized child community. Other evidence, too, suggests that carrier rates fall along with diphtheria morbidity as a result of immunization. This means that, to-day, immunity to diphtheria is less likely to be maintained at a safe level as a result of subinfecting doses of toxigenic diphtheria bacilli. These are so infrequent that we can no longer expect any "boosting" of circulating antitoxic titres from natural immunization. Artificial immunization has therefore taken on an important function, and it must be continued vigorously, endeavouring to conform to good immunological procedures. I have presented the essential principles in convenient form elsewhere (Parish, 1951).

Logan (1952) has stated that the eradication of diphtheria as an indigenous disease in England and Wales can be foreseen as a very real possibility within the next few years. Nevertheless, let us not be overconfident, since the immunity state of the population is disconcertingly low in many areas.

The Prophylactics

All the preparations in use in the world to-day have toxoid or formol-toxoid (French=anatoxine) as their basis; the original highly dangerous toxin has been modified and rendered harmless with formaldehyde, while its capacity to stimulate the production of antitoxin is retained. The fact that unmodified toxin is never used is important, since it precludes any possibility of accident of the type encountered when toxin-antitoxin mixtures were favoured in the U.S.A.