Public Health Adminstration in England*

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THE broad pattern of public health evolution is probably similar in most civilized countries. First comes the improvement of environmental conditions —the removal of nuisances, the introduction of refuse removal, and of drainage and sewerage, and the control of water supplies. These gradually merge into the statutory maintenance of reasonable housing conditions (and the destruction of slums), the registration of sickness and death, and food inspection. Evolving in parallel are two other services, the medical treatment of the indigent sick and the prevention (by isolation) and treatment of the dangerous infectious diseases.

Then, finally, marking the emergence from the sanitary idea to the health idea, come the personal health services which are essentially preventive in scope and method; maternity and child welfare; and school health. My "finally" in the last sentence is perhaps already out-of-date and should read "penultimately." New Zealand and England already have a national health service and discussion on the same subject tends to become acrimonious in Australia, Canada, and America. However that may be, I would personally readily accept as a gauge of the public health maturity of any country, the level reached by the maternity and child welfare and school health services.

Yet, however common these basic aims may be, the administrative methods by which they are achieved vary from country to country, and a brief account of the English system may be of interest. You in America have to think in terms of three levels, the federal, the state, and the local. Despite very wide differences at the local level, we in England have only two, the central and the local, with which to concern ourselves.

While many government departments have health and medical functions, traditional public health and the National Health Service are both the responsibility of the Ministry of Health. This is now thirty years old, its functions stemming in the main (but not entirely) from those of the Local Government Board. The Ministry not only has medical functions but is responsible still for local health government in the widest sense. Housing, water supplies, and National Assistance or Welfare (the descendant of the Old Poor Law, now abolished) are among the more important of its non-medical functions.

The general pattern of the British Civil Service is well known. Executive functions are in the hands of lay administrators, the technical (including medical) civil servant being advisory. While it is an unwritten law that the

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lay administrator does not ignore expert advice, he sometimes used to refrain from calling on it, but his modern way of doing so, very rarely used, is to consult another expert! And the system, as may be imagined, has given rise on occasion to friction and difficulty. Thus the great Sir John Simon, irked by what he considered the unfair discretion of his administrative colleagues to refrain from calling for expert advice, voluntarily retired from his post as the first Chief Medical Officer of the Local Government Board at the early age of 60. Sir Arthur Newsholme, Chief Medical Officer from 1908 to 1919, also girded at the system: "An impartial and thorough inquiry as to whether in each Government Department the relation between secretarial and technical officers is as conducive to the public interest as it might be, would be more fruitful in public good than any of the numerous Royal Commissions and Departmental Committees of investigation which have reported on governmental problems."[1] He further quotes Lord Sydenham with obvious relish: "It should be an axiom in government administration that no one should be permitted to have anything to do with any question on which he could not bring special knowledge to bear. This axiom prevailed in all well managed private businesses. But his own experience, in some government matters, had been that one had to fight for a necessary improvement through an ascending series of officials, each knowing less than the last, until one reached the deciding authority who knew nothing at all. This was euphemistically called the 'chain of responsibility.'"[2]

But all this is now a tale of "old unhappy, far-off things and battles long ago." Sir George Newman, Newsholme's successor and first Chief Medical Officer of the Ministry of Health, takes up the tale,[3] and records how this constant potential cause of friction was removed. The Chief Medical Officer was granted the pay and status of the permanent Secretary of the Ministry without the duty of exercising any of the administrative functions of the Secretary. This gave him direct access to the Minister for submission of proposals and discussion of any matter within his responsibility. "This was an end of all talk or assumption that either the administrative or the professional civil servants were in a position of subordinate or of superiority to the other section." While the rights of the Chief Medical Officer remain as stated by Newman, his pay is now slightly less that that of the Permanent Secretary.

Newman also mentioned two other methods by which science can be given its rightful place in the administrative sphere—first the "functional board" of senior administrative officers to review administrative machinery and insure that the value of the expert civil servant is being secured and maintained, and secondly, the small Advisory Committee of outside experts appointed and approved by the Minister. Much use is being made of the second method in the administration of the National Health Service. Further developments in modern government have led to the filling of administrative offices by the scientists themselves as in the Secretaryships of the Medical and Agricultural Research Councils.

Newman's view of the service of which the medical department of the Ministry of Health is an integral part is shown in the following quotation: "The Civil Service is both non-political and non-partisan and, moreover, is democratic in structure, recruitment, and control. Both Parliament and the Local Authorities are vigilant of its integrity as an independent and disinterested institution, but they are equally vigilant to see that it does not become autocratic or despotic, and they have ample powers to prevent any tendency in such a direction. The Service itself is watchful of its

own tradition, and by its constitution under Orders of the Privy Council in 1855, 1870, and 1920, it is the zealous custodian of its own privilege and independence."[4]

This happy resolution of an old difficulty which Newman records, and the fact that the administrative and medical staffs of the Ministry of Health now work in a harmony approaching a symbiosis, is of course particularly important in the era of a national health service. I have not personally heard a single suggestion of any kind of interference with the full clinical freedom of doctors providing that service. And this essential professional freedom is further safeguarded, even if the administrative set-up is made more complex, by the statutory provision for a Central Health Services Council and Standing Advisory Committees. Of the latter, there are now a series of nine: medical, nursing, maternity and midwifery, dental, mental health, tuberculosis, ophthalmic, pharmaceutical, and cancer and radiotherapy, which have affiliations with both the Minister and the Central Health Services Council.

The medical department of the Ministry is itself organized in a series of divisions.[5] These deal, in brief, with general public health and statistics, maternity and child welfare, general epidemiology, food and nutrition, the National Health Service, the Insurance Regional Medical Service, dental health, nursing and midwifery services, the Board of Control (certain aspects of mental illness), and the Welsh Board of Health. The Ministry also has 10 regional offices for local contact with the Regional Hospital Board services and certain local government services, and 4 for medical matters arising from National Insurance (fitness for work, etc.). Its work in relation to the local authorities is controlling (by Orders and Statutory Instruments): advisory (by Circular and Memoranda) and inspectorial. As it sanctions loans and pays grants up to 50 per cent for personal health service work, it needs, and has, detailed knowledge of local services. I have alluded in another paper, to the Statutory requirement imposed on all local health authorities to submit to the Ministry "proposals" for carrying out their duties under the National Health Service Act.

Turning now to English Local Government, its basic principle was defined in the Report of the Royal Sanitary Commission of 1869. "The principle of local self-government has been generally recognized as of the essence of our national vigor. Local administration, under central superintendence, is the distinguishing feature of our government.

"The theory is, that all that can, should be done by local authority and that public expenditure should be chiefly controlled by those who contribute to it.

"Whatever concerns the whole nation must be dealt with nationally, while whatever concerns only a district must be dealt with by the district.

"The spirit of that self-government which Englishmen have always vindicated to themselves through every developing period of their history, has led to the growth of many discrepancies in their institutions and to many disconnected and even conflicting laws. Imperfect local administration has been the natural result. Local administration must nevertheless be maintained, but it should be at the same time simplified, strengthened and set in motion."

It is nearly eighty years since these words were written, but the developments in both local and national services during that period have conformed to the traditions so clearly enunciated.

Local public health administration is in the hands of two main types of local authority, major and minor. The major again fall into two groups: county boroughs, large urban aggregates of the city type, usually long established; and

counties. The minor authorities consist of smaller units—boroughs, urban and rural districts which together make up the county. The county borough is an all-purpose authority, self-contained for local government purposes, and consequently carrying out all public health functions. In the counties, local government functions are shared between the major and minor authorities. A broad but not hard and fast line of division of their public health duties, is that essentially local functions such as environmental hygiene are undertaken by the minor authorities. The personal health services and services such as education, are administered by the county, which has power in addition, to aid from its own rate funds, the minor authorities in such things as water supply. Members (Councillors) of local authorities become so by popular election and nowadays affiliation to one or other political party is usual. In most of the country one-third of the members of the Council retire each year, some continuity thus being secured. In London, elections are triennial, all the members retiring together. This applies both to the County Council and to the Metropolitan Borough Councils. Every council sub-divides its work among committees, elected by the whole Council and responsible to the Council.

Public Health, Education, Town Planning, Police, Water, Welfare, Housing and Finance will serve as illustrations of local services, each important enough to justify the attention of a special committee. In the large authorities, further breakdown is essential and each main committee will appoint subcommittees for special sections of its work. Each committee elects a chairman, usually from the ranks of the political party holding a majority, and it is this public representative and his committee who are responsible for their particular local service. Whatever credit is going they take (and rightly take) and to be fair, they also shoulder any public criticism there may be.

Naturally they are not experts, so they are advised on policy by chief officers, each an expert in his own field and at the head of a department which is often very large. These departments carry out their Council's policy with the same kind of efficiency and impartiality as is associated with the British Civil Service. Every type of local authority appoints a medical officer of health, the tendency over many years being to appoint a whole-time officer. But over the same span of years there has also been a tendency to vest functions in, or transfer them to, the major local authorities. This is particularly true in the fields of education, welfare, and health. Thus, the National Health Service Act vested the maternity and child welfare services in the hands of the major local authorities, so reducing the number of authorities directly responsible for it from over 400 to 145. This tendency naturally makes it difficult for the smaller authorities to employ a whole-time health officer. The principle of the whole-time officer has consequently been maintained, with the full support of the British Medical Association, by the minor local authorities joining with the county council in a joint appointment, the officer acting for part of his time as assistant county medical officer and for the remainder as medical officer of health of one or more urban or rural districts in the county. This has the great advantage of keeping the officer in touch with the whole field of public health, environmental and personal, and the further advantage of reducing the number of posts with purely environmental responsibilities, which are today intrinsically less attractive to a medical man.

It is important in any consideration of British public health administration to appreciate that the health officer, whether central or local, is a "career officer." This branch of medicine is

deliberately chosen, usually early in a medical man's career, and he proceeds to equip himself by acquiring a post-graduate diploma in public health. For the position of Medical Officer of Health of the larger authorities, such a diploma, registered with the General Medical Council, is a statutory requirement. All health officers except possibly those intending to specialize in fields such as tuberculosis or venereal disease in fact acquire it. Once in the service as an Assistant Medical Officer, he gains experience (and promotion) by moving from post to post, taking his superannuation rights with him.

Appointment as Medical Officer of Health is subject to the approval of the Minister of Health, and dismissal is only possible with his consent. As the office constantly involves what some people would regard as encroachments on the rights of property (expenditure on house repairs as the result of statutory notices, slum clearance, condemnation of food, etc.) such protection is a valuable safeguard. It extends also to the Sanitary Inspector. On the position of the Medical Officer of Health, let me again quote Sir Arthur Newsholme,[6] who spoke with the authority of personal experience as a Medical Officer of Health as well as that of Chief Medical Officer. "The Medical Officer of Health is the expert adviser, as well as the executive officer of the committee charged with the public health work of the Town Council; and much of his success as an administrator depends on his persuasiveness and reasonableness, and on his capacity to indoctrinate the members of his committee with his ideals and ambitions for reform. In securing maximum success, he has to deal not only with the Town Council, but even more with the Councillors as individuals, and to take every opportunity to secure their friendly interest in the work and to help them to master its principles."

What changes has the National Health Service Act produced in the work of the Medical Officer of Health? I have described in a paper before another Section, with particular reference to London, what the Medical Officer of Health and his team have actually done in the first year's working of the Act.[7] Anyone interested in preventive medicine would agree that his program remains both full and attractive. But providing a complete medical service for fifty million people is in the literal sense of the word a great work. There were many conflicting interests to reconcile and the scheme, bold and imaginative as it is, has inevitably left some people with a feeling of hard usage. This is perhaps particularly true of the Medical Officer of Health of the so-called minor authorities who, in his own right, is confined largely to environmental duties. Any association he retains with the personal health services is as assistant to his county colleague. Previously, the Medical Officer of Health had administrative responsibility for general, children's, maternity, mental, infectious, and tuberculosis hospital beds. The argument for the unity of all clinical medicine has meant his losing these, and I for one accepted the necessity at the time the service was introduced. But it is possible to argue that the satisfaction of this major unity fractures certain lesser unities. Thus, the Regional Board is responsible for the treatment of tuberculosis, whether in the sanatorium or the tuberculosis dispensary, while the local health authority is responsible for its prevention and aftercare. Similarly, but perhaps less importantly, the Medical Officer of Health is notified of infectious disease and is responsible for its epidemiological control, but no longer has control of the infectious disease hospital beds. Coöperation between the various branches of the service is of great importance and there are plenty of signs that it is not lacking. The Medical Officer of Health's real difficulty

in these matters is perhaps mental—or sentimental. The services in question were entirely of public health growth and parting with the institutional side of them was not easy. It is some consolation that more than ever the clinician is acquiring a keen realization of his responsibilities for prevention as well as for treatment. This is particularly noticeable in the geriatric field. A further partnership of promise lies in the health center, where the general practitioner and the health worker will share a common roof and, one hopes, a common outlook. This, however, lies in the future rather than the present, and much hard experimental work will still be necessary.

One tendency, possibly temporary, should be noted in conclusion. The interest of the young graduate at present centers in the clinical field, and fewer students are taking public health training. The explanation of this may be in part financial. Nevertheless the logical culmination of the last century's progress in public health and social medicine in Britain was the National Health Service. There is nothing in British history to indicate that it will not modify itself to meet weaknesses and strains as these reveal themselves. Continued evolution is certain. If the demand for spectacles and teeth has exceeded expectation it is possibly a proof not only that the need was there, waiting to be met, but also that British enterprise is not yet dead! And whatever the temporary effect of the National Health Service in reducing the attractiveness of public health to the neophyte as a career, there is no doubt that the preventive idea will ultimately permeate the whole of medicine and that the Medical Officer of Health still has an essential part to play in the common task.

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