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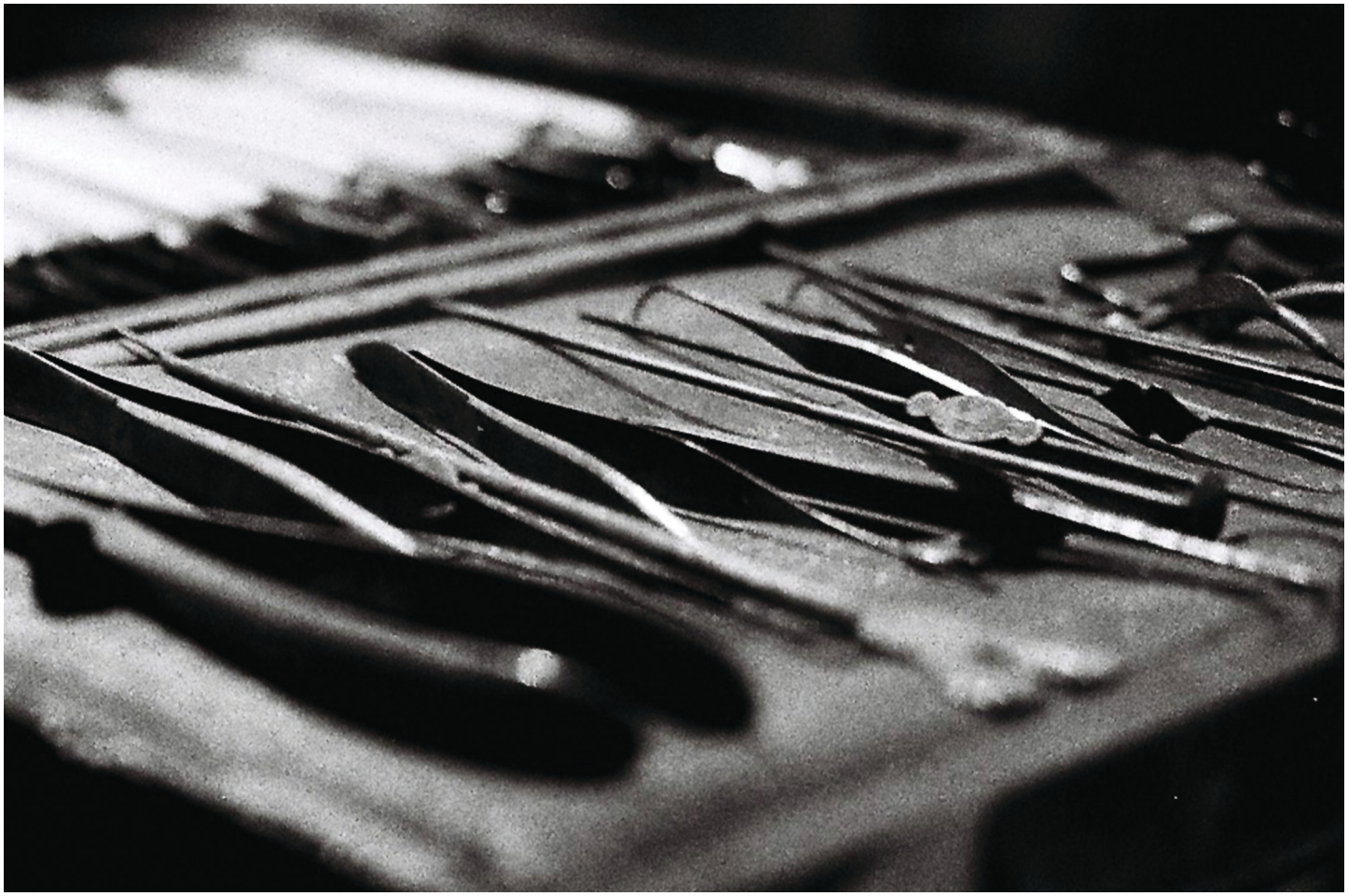
Medicine transformed: on access to healthcare



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Contents

Introduction

Access to healthcare is important to all of us. Did the arrival of state medicine in the twentieth century mean that everyone had access to good medical services? If you fell sick in 1930 where could you get treatment – from a GP, a hospital, a nurse? This course shows that in the early twentieth century, access to care was unequally divided. The rich could afford care; working men, women and children were helped by the state; others had to rely on their own resources.

This OpenLearn course provides a sample of Level 2 study in Arts and Humanities.

Learning Outcomes

After studying this course, you should be able to:

- describe the wide range of methods of promoting health, preventing disease and providing care that were available to patients of different social groups and classes
- demonstrate an awareness of the inequalities of services – in terms of both quality of care and access to different services – open to different social groups and classes
- assess the significance of the roles of central and local governments, the private sector and voluntary associations in providing medical services
- understand the concept of ‘medicalisation’ and assess the degree of power doctors had over people's lives in the early twentieth century.

1 Access to healthcare, 1880–1930

The late nineteenth and early twentieth centuries have often been described as a period of progress, when the poorer classes gained access to a whole range of medical services previously reserved for the wealthy. In the past, this opening up of care was largely attributed to the state. Across Europe, central and local governments created health insurance schemes and new welfare services to provide the poor with access to care, from general practitioners (GPs) to outpatient and hospital care, and treatment for specific complaints such as tuberculosis and venereal disease. This movement culminated in the 1940s, when it was the boast of the British government that the National Health Service provided care for all ‘from the cradle to the grave’. However, more recent studies by historians of medicine have shown that improved access to health services was also provided through charities. Old voluntary organisations, such as hospitals and dispensaries, expanded their work and strove for greater efficiency, employing professional administrators. New charities were founded, providing novel services, including help for mothers and babies. Improved access to healthcare also came about through private insurance schemes to provide GP and inpatient care to the working classes.

While historians of medicine agree that this period saw greater provision of medical services, especially for the poorer classes, some researchers have questioned whether improved access to care was an unalloyed good. They have argued that not everyone benefited equally from improved services. Improvements in access to care were unequally distributed. New medical services were often limited to the very poorest, or to particular groups, such as working men or women and children, and levels of provision varied between countries and regions. Provision of care did not guarantee a high standard of service: detailed research by some historians has shown that the poorer classes often received a lower quality of care than their wealthier counterparts. Others have argued that there were drawbacks to more accessible medical services. They have described the early twentieth century as a period of ‘medicalisation’. As patients gained greater access to medical professionals – doctors, nurses and health educators – they became passive consumers of medical services. At the same time, the medical profession no longer simply dealt with the sick, but increasingly took a role in monitoring the lifestyle and behaviour of healthy people. As a result, people became increasingly dependent on medical practitioners to guide their lives.

In this course, I explore these issues through a study of the health-care services available in Britain at the end of the nineteenth and in the first decades of the twentieth centuries, using a wide range of sources. Where material is available, I make comparisons with the care available elsewhere in Europe. I cover all aspects of healthcare – from disease prevention, through care in the home, general practitioner services and finally care in institutions. I explore the access to medical services among different social groups and assess how much control practitioners had over their patients' lives by 1930.

2 Patterns of disease

Before looking at how people dealt with ill health, you need to know what sort of medical conditions were prevalent. Between the nineteenth and twentieth centuries, all over Europe, the prevailing pattern of mortality changed. Infectious diseases, which had killed huge numbers of people, were gradually brought under control. As life expectancy increased, degenerative diseases, associated with old age, began to cause more deaths. However, although people were living longer, they actually spent more time off work because of illness. James Riley's studies of the records of friendly societies, which offered health insurance (these are discussed in more detail later), have shown that workers were no longer dying from infectious diseases. Instead, they survived illness, but spent a long time recovering their health and strength (Riley, 1989, pp. 159–92).

The friendly society records show that the complaints that caused workers to take time off were not the same as those that dominate mortality statistics (Table 1).

Table 1 Comparison of mortality with sickness recorded by friendly societies in England and Wales

Leading causes of death in England and Wales among men, in 1908		Leading causes of sickness in three friendly societies, 1896–1919	
Cause	**% of total**	**Cause**	**% of total**
Heart disease	14	Accidents	16
Tuberculosis	14	Poorly identified	13
Old age	8	Influenza and catarrh	13
Cancer	8	Bronchitis	9
Bronchitis	7	Rheumatism	4
Pneumonia	7	Lumbago[1]	4
Cerebral haemorrhage	5	Gastritis[2]	2
Accidents	5	Carbuncle[3]	2
Bright's disease[4]	3	Tonsillitis	1
Influenza	3	Skin ulcers	1
Apoplexy	2		

[1]Lower back pain, caused by muscular inflammation or arthritis

[2]Inflammation of the stomach lining, causing pain and discomfort after eating

[3]A local infection, similar to, but larger than, a boil

[4]Now recognised as a number of kidney diseases, all associated with the presence of albumin in the urine

(Adapted from Riley, 1997, pp. 191–2, Tables 7.1 and 7.2)

If we ignore accidents and ‘poorly identified’ complaints, the most common ailments among the working-class men insured by the friendly societies were respiratory infections – influenza, colds and bronchitis – followed by joint and muscle problems, such as rheumatism and lumbago. Few workmen reported sick with degenerative diseases. Nor did they take time off for tuberculosis (TB), one of the major killers at this time. TB was a

chronic, but not disabling, disease, and men were able to work until they developed advanced symptoms.

Friendly societies insured a select group – fairly young, fit, working men – so their records are not representative of the whole population. General practitioners saw a larger cross-section of society. Records from their practice suggest that they treated a fairly similar range of complaints to those recorded by the friendly societies – respiratory infections, rheumatism and digestive complaints, such as dyspepsia and diarrhoea. GPs did not spend much time treating degenerative diseases since they could do little for such conditions. Their case records show how patterns of disease varied by class, area and season. Middle- and upper-class patients consulted doctors about obesity, gout and nervous complaints – conditions that were rarely reported by working-class patients. The poor suffered from rickets (a consequence of a poor diet), dysentery and diarrhoea (reflecting the difficulty of keeping food clean and fresh) and infectious diseases. GPs working in industrial areas had to deal with the results of accidents and occupational diseases: miners, for example, who worked in a damp and dusty environment, suffered from high levels of bronchitis, pneumonia and pleurisy. Everywhere, the incidence of respiratory diseases increased in the winter months, while digestive complaints were more frequent in the summer (Digby, 1999, pp. 192–3, 208–14).

Men were more likely than women or children to visit a GP (for reasons I discuss later), but not because women and children were any healthier. Children continued to suffer from a range of infectious diseases – tonsillitis, scarlet fever, chickenpox, whooping cough, measles and mumps. A survey of the health of working-class women in the 1930s found that they suffered from headaches, constipation, anaemia, rheumatism, gynaecological problems (often associated with childbirth), bad teeth, and ‘bad legs’, resulting from varicose veins, ulcers and phlebitis (inflammation of the veins) (Spring Rice, [1939] 1981, p. 37).

While people suffered from a wide range of complaints, two diseases prompted particular public concern – tuberculosis and venereal disease (VD). Both were seen as causes of national degeneration, causing high levels of disease which weakened the population and led in turn to the birth of feeble children (Figure 1).

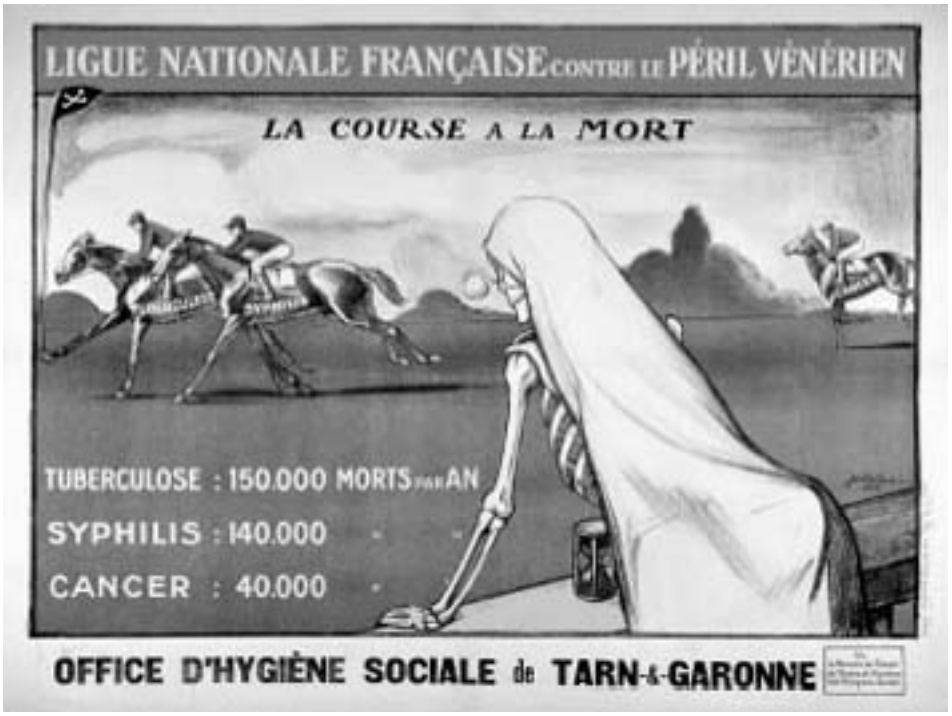


Figure 1 This poster, issued in 1926 by the National French League against the Danger of Venereal Disease, neatly encapsulates the perceived risks associated with three diseases in the 1920s. Death watches a three-horse race, in which Tuberculosis (150,000 deaths per year) narrowly beats Syphilis (140,000 deaths per year), while Cancer causes only 40,000 deaths. These mortality statistics do not correspond to those recorded by the Registrar-General for England and Wales; in 1910, deaths from tuberculosis were thirty-two times greater than those attributed to syphilis. However, the Registrar-General's report acknowledged that there was a serious under-reporting of syphilis deaths by doctors, who did not wish to stigmatise their patients, and so recorded syphilis deaths under other disease categories. Wellcome Library, London

There was also a widespread belief among the public and medical practitioners that the pace of modern life – in which information flashed through the air by telegraph, and people travelled by train and steamship at previously unimaginable speeds – caused ill health. The modern lifestyle was associated with physical disorders, including dyspepsia, diabetes and liver complaints. It was also blamed by some practitioners for an apparent epidemic of nervous diseases, such as hysteria and neurasthenia. Symptoms of anxiety, depression, insomnia, pain, involuntary movements and nervous tics were believed to result from the strain of modern life on the nervous system. In Russia, neurasthenia was associated with a cultivated ‘western’ lifestyle (Goering, 2003).

3 Preserving health

3.1 Introduction

Surrounded by the ever-present threat of ill health, not surprisingly, people expended a good deal of time and energy on trying to stay well. The late nineteenth century saw a new emphasis on promoting health, which was defined as ‘a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity’ (quoted in Riley, 1997, p. 199). Health was not simply a desirable end in itself. The pursuit of health was portrayed as a moral duty: parents had a responsibility to protect both the health of their children and their own health, so that they could support their families. Health also became a political concern: the future strength of the nation was seen to rest on the good health of children – the future generations of soldiers and workers. At the beginning of the twentieth century, popular beliefs about the best means of preserving health were little different from those prescribed two thousand years earlier in classical Greece – good diet, fresh air, exercise and cleanliness. Such a lifestyle would keep the body in the best possible condition to fight off germs and diseases.

3.2 Health and wealth

While all classes regarded good health as desirable, access to various means of preserving or promoting it varied according to economic circumstances. For the upper and middle classes, with substantial amounts of disposable income, a wide range of options were available. They could access information about how to protect their health through books and articles in magazines. Many of these books were written (or at least claimed to be written) by doctors and other health-care professionals. An article about pregnancy in the opening number of *Woman* magazine in 1932, for example, was allegedly written by ‘Mumsie, the wife of a famous children's doctor’ – a persona neatly combining medical authority and the status of an ordinary wife and mother (Beddoe, 1989, pp. 14–15). The 1920s saw a boom in baby-care books, aimed at middle-class mothers, which not only gave practical advice on feeding, bathing and clothing, but also set out the stages of physical and psychological development, thus unwittingly creating the first generation of mothers worried that their babies walked and talked ‘late’ (Unwin and Sharland, 1992).

Generally, the wealthier classes enjoyed the sort of varied diet thought to promote good health. They could afford meat, fish, fresh fruit and vegetables (Burnett, 1979, pp. 213–39). However, some wealthy individuals worried that they ate too much, and dieting to obtain a slim figure was a well-established activity by the 1920s. Others were concerned that their diet was too rich, and in the pursuit of health adopted simple, more ‘natural’ diets. They stopped consuming alcohol, tea, coffee and meat, and ate fruit, vegetables and cereals (the word ‘muesli’ was adopted into the English language at this time). The popularity of ‘health foods’ (such as ‘Hovis’ wholemeal bread) and vegetarianism grew from the mid-nineteenth century to become a mass movement in Germany and surrounding states by 1900, although it was much less popular in Britain. The quest for a healthy diet was closely linked with other movements – such as unorthodox medicine and feminism, whose supporters argued that overly elaborate diets

tied women to the kitchen (Meyer-Renschhausen and Wirz, 1999). Even ordinary foodstuffs were marketed for their health-giving properties (Figure 2).

Figure 2 In this advertisement, the image, caption and description of Ovaltine, a proprietary brand of malted milk drink, clearly link food with health. The appeal here is to a mother's desire to build up her children's health and strength; the message would have been a poignant one at a time before immunisation, when many children died from infectious diseases. Other advertisements stressed the benefits for adults, promising that a cup of Ovaltine at bedtime would ward off 'night starvation'. Wellcome Library, London

Exercise and fresh air, two more building blocks for good health, would appear to be open to all. However, only the upper and middle classes had the cash and the leisure time to participate in the craze for healthy exercise which began in the late nineteenth century. They could afford to buy bicycles, tennis rackets and golf clubs. They could also, following the German example, go rambling and hiking in the countryside, and pay to attend gymnastic exercise classes. Exercise was clearly gendered. Men and boys took part in team games (such as rugby, football and cricket), athletics and German gymnastics, which made use of apparatus such as vaulting-horses and parallel bars. Such activities were thought to develop a competitive spirit and build strong muscles, desirable qualities in the next generation of workers and soldiers. Women, too, were encouraged to exercise

– not to build muscles, which were regarded as undesirable in the female sex, but to cultivate health. For women, exercise was thought to prevent curvature of the spine, chlorosis (a mysterious complaint, whose main symptoms were tiredness and a pale complexion) and hysteria, and a strong, fit body was thought to guarantee easy births and healthy offspring. Cycling, tennis, golf, team games requiring skill rather than strength (such as hockey) and Swedish gymnastics, which involved stretching the body with the aim of developing flexibility and coordination, were seen as beneficial forms of female exercise (Fletcher, 1984, pp. 1–55; Stewart, 2001, pp. 151–72).

3.3 Hygiene

Good hygiene – a clean home and a clean body – would also appear to have been available to all classes, but again, it was easier for the wealthier classes to achieve these goals. Newer houses, with bathrooms and laundries, modern plumbing and sanitary facilities, and servants to do the hard work, ensured that the middle and upper classes could enjoy regular baths (hot and cold), clean clothes and clean homes.

Exercise and good personal hygiene were not just a means of protecting health but were also pursued for aesthetic reasons. Women, for example, took exercise to promote grace and suppleness, and bathing was presented as a way for them to pamper themselves with scented soaps and oils, not just to get clean (Stewart, 2001, pp. 65–72). The *Ladies Diary and Housekeeper* for 1917 provided beauty hints, allegedly written by ‘an eminent MD’, who suggested that ‘a cheerful disposition’ would prevent wrinkles and gave a recipe for a cream to soothe the blistered hands of overenthusiastic sportswomen. A revolution in women's clothing came about through a similar mixture of aesthetics and concerns about health. By the 1900s, tightly laced corsets were seen as a hazard to health, squashing women's internal organs (thus threatening the health of future babies) and preventing them from inhaling health-giving fresh air. Very long skirts also prevented women from taking exercise. Despite objections from some men, who found women wearing culottes or bloomers ‘manly’ and rather disgusting, women increasingly wore lighter clothing with shorter skirts and flexible stays and brassieres. By the 1920s, short tennis dresses were even considered to be chic (Stewart, 2001, pp. 72–4, 169). At this time, men's clothing also became lighter (Figure 3).

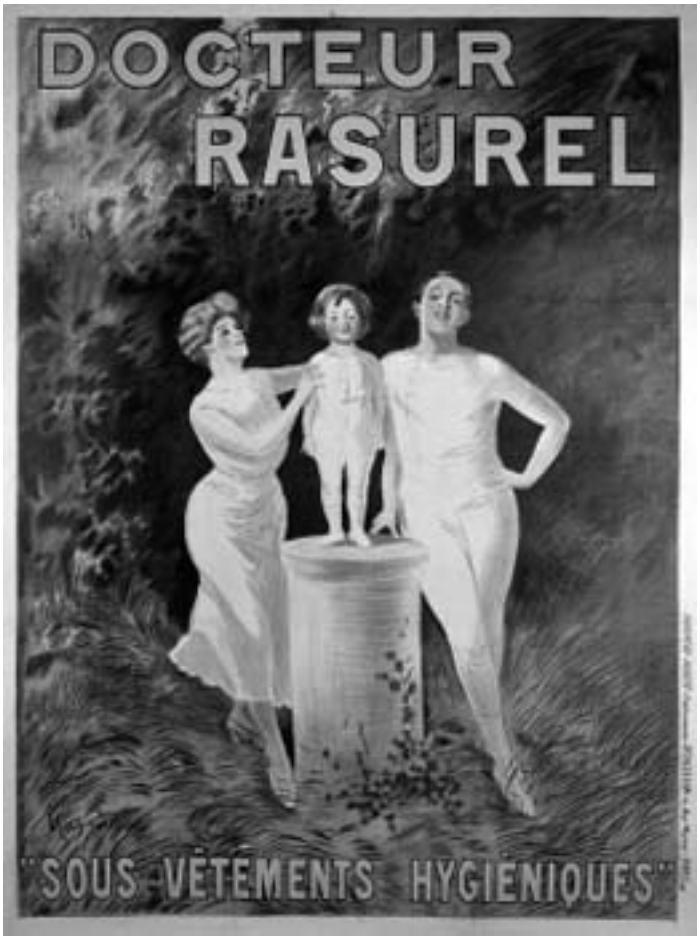


Figure 3 Advertisement for Dr Rasurel's hygienic underclothing, 1906. Note the associations between the clothes being advertised and health. The reader is assured that the clothes are 'hygienic'; they carry the name of a doctor, and the family pose surrounded by green plants, presumably in the open air. Rural settings were always seen as being more healthy than the urban environment. Wellcome Library, London

3.4 Health and the working class

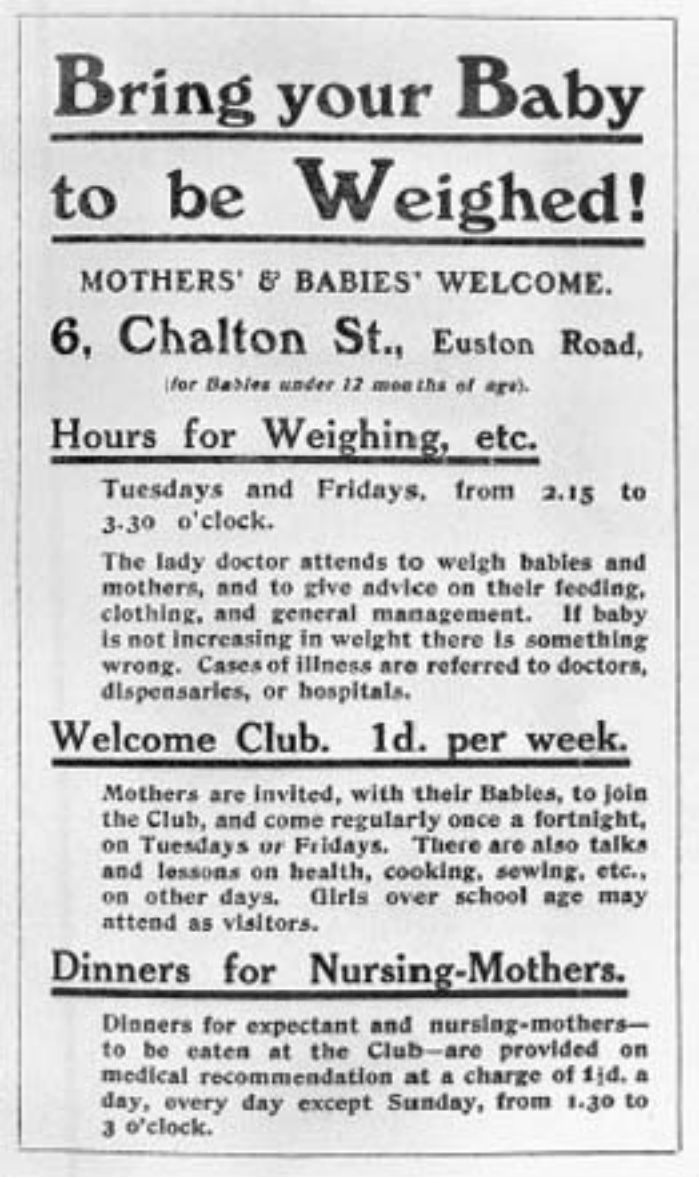
However, for a large proportion of the population, altering diet, clothing or behaviour in the pursuit of better health was well nigh impossible. The working classes, who made up the vast majority of the population, survived on tight budgets. In 1913, the typical workers' wage of £1 per week just covered the essentials of food and rent, and left limited opportunities to follow a healthier lifestyle (Pember Reeves, 1913). The staples of the working-class diet were white bread, margarine and tea. These cheap foods filled up hungry stomachs, but did not provide a balanced diet (Burnett, 1979, pp. 182–212). In 1901, one-quarter of the population were not getting enough to eat: as late as the 1930s, research showed that half the British population were eating a diet deficient in some vitamins and minerals (Burnett, 1979, pp. 245, 301–19). Just as members of the poorer classes found it difficult to afford a good diet, they also lacked the money, time, equipment and transport, never mind the energy after a long day at work, to take exercise. Personal hygiene too was difficult to achieve. Many working-class women struggled to keep their homes clean, but the poor condition of their houses, the lack of a bathroom and often hot water, and shared laundry facilities meant that the poor were inevitably dirtier than the

middle classes. Doctors and midwives going into poor homes sometimes complained of the smell of their patients.

By the beginning of the twentieth century, for the first time governments and charities stepped in to try to improve the diet, exercise and hygiene of the poorest sections of society. While organisations all over Europe shared the goal of guaranteeing the physical health of the nation, the level of provision varied between different countries, reflecting national political agendas.

3.5 The health of mothers and children

The health of mothers and infants was one target for action. France was among the first to introduce infant welfare schemes, as low birth rates, high infant mortality and defeat in the Franco-Prussian War led politicians to fear for the future strength of the nation. Diarrhoea among bottle-fed babies was singled out as a preventable cause of high infant mortality. From the 1890s, charities and local authorities set up infant welfare clinics called *gouttes de lait*, which encouraged mothers to breastfeed, gave out free milk to those that could not, and provided free regular medical examinations to check on babies' development. Charities also provided free meals to pregnant women and the mothers of small children. To improve the health of older children, municipal authorities set up school canteens to provide free and subsidised meals. These schemes proved very popular: in Paris in 1901, over 1,400 babies were brought to clinics: in some towns, up to one-third of all mothers and infants attended. Government bodies in Britain looked to France as a model of good practice, but did not simply copy French child welfare programmes, fearing that to provide food would usurp the role of the family breadwinner and overstep the proper limits of action. Hence, the few 'milk banks' set up in Britain around 1900 offered subsidised rather than free milk. Instead, charities focused their efforts on education. Lectures and demonstrations on 'mothercraft' were offered at welfare centres (Figure 4). In Britain, efforts to provide free school meals for older children were hindered by the same reluctance to interfere in family life. Even after they were given powers to provide school meals in 1906, many local authorities were reluctant to do so and, by 1912, only around one-third of local authorities provided school meals (Dwork, 1987, pp. 93–166, 167–84).



Bring your Baby to be Weighed!

MOTHERS' & BABIES' WELCOME.

6, Chalton St., Euston Road,

(for Babies under 12 months of age).

Hours for Weighing, etc.

Tuesdays and Fridays, from 2.15 to 3.30 o'clock.

The lady doctor attends to weigh babies and mothers, and to give advice on their feeding, clothing, and general management. If baby is not increasing in weight there is something wrong. Cases of illness are referred to doctors, dispensaries, or hospitals.

Welcome Club. 1d. per week.

Mothers are invited, with their Babies, to join the Club, and come regularly once a fortnight, on Tuesdays or Fridays. There are also talks and lessons on health, cooking, sewing, etc., on other days. Girls over school age may attend as visitors.

Dinners for Nursing-Mothers.

Dinners for expectant and nursing-mothers—to be eaten at the Club—are provided on medical recommendation at a charge of 1½d. a day, every day except Sunday, from 1.30 to 3 o'clock.

Figure 4 Leaflet advertising the new Mother's and Babies' Welcome in St Pancras, London, 1907. A charity, founded in 1907, the St Pancras Welcome offered a comprehensive range of services to mothers and babies. These were not free, but available for a small fee. Wellcome Library, London

Historians are divided over the impact of such policies. Some have argued that the authorities in Britain chose to provide education, rather than food, as a cheap but ineffective solution to the problem of child poverty. They have portrayed education in 'mothercraft' as patronising and often impractical. Other researchers, such as Deborah Dwork, are more sympathetic, arguing that, given the government's reluctance to interfere in the family, education was a practical and effective way of helping mothers, and one which the mothers themselves appear to have found useful (Figure 5).