The Local Public Health Officer in Great Britain Today

By SIR ALLEN DALEY, M.D., D.P.H.

The British public health service comprises about 2,000 full-time medically qualified health officers, the vast majority of the officers in local posts that between them cover the health needs of all parts of the country.

In addition, large numbers of medical officers have part-time work as specialists, clinic workers, and chest physicians in health departments and as officers in children's homes and welfare institutions.

Of the full-time officers, about 60 are in the Ministry of Health of England and Wales. The local health government in England and Wales has 145 major units—83 county boroughs and 62 counties—called the "local health authorities." Each has a medical officer of health—a term corresponding to health commissioner or health officer in the United States.

The 83 county boroughs, corresponding to cities, are "all purpose" authorities. Their health officers have responsibility for all the public health work of their cities, which range in population from just under 100,000 to more than 1,000,000.

Sir Allen Daley, a medical officer of health in England for more than 40 years and with the London County Council from 1929 until his retirement in February 1952, served as associate health officer of the Baltimore City Health Department from March to July 1952. He presented this paper before the health officers section of the Southern Branch of the American Public Health Association at the annual meeting in Baltimore, Md., April 17, 1952.

The 62 counties, responsible mainly for the personal health services such as maternity and child welfare and school health, have a complex system of health administration. Many are predominantly rural, cover wide areas, and contain a number of small towns. Others, like the London County Council, and the Middlesex County Council, which is on the fringe of Central London, are predominantly urban and have large populations.

Each county is subdivided into sanitary districts. Larger counties are also divided into divisions for health administration purposes.

In all of England and Wales there are 1,400 sanitary districts. The average number per county is about 17. But some of the small counties with populations of less than 100,000 have only two or three, and some of the larger ones with populations of more than a million have 40 or 50. Each of these sanitary districts must appoint, by law, its own health officer. He has responsibility, independent of the county health officer, for general sanitation, purity of food, and the control of infectious diseases.

To administer the divisions, the county appoints a divisional health officer who is on the staff of the county health officer and is subordinate to him. In counties with large populations or covering wide areas, such as London with its large population or Lancashire, which is more than 100 miles long, the counties have decentralized their functions, and it is now common for a district health officer to be also an assistant county health officer. This assignment gives him a full range of duties. He acts

independently as a district health officer for environmental hygiene, but as the agent of the county health officer for the personal health services in his area. The theoretical objection to his serving two or more masters is not serious in practice. This complication does not occur in the county boroughs (the large cities), where the health officer is assigned the whole field.

The London County Council

The health administration of the County of London is rather complex. This area of Central London, with its population of 3.5 million people is known as the London County Council, or the L. C. C. It has nine divisions for the purpose of county health administration, each with its divisional health officer responsible to the county health officer.

Within the same London County Council area there are 28 sanitary districts, or metropolitan boroughs as they are officially called, each with its own medical officer of health. Thus, a division includes from two to five sanitary districts. The districts (or boroughs) range in population from 30,000 to over 300,000. As so often happens, this disparity depends on history, the original boundaries dating back for centuries. In addition to the 28 sanitary districts, or metropolitan boroughs, there is, within the County of London, the ancient City of London with an area of 1 square mile, compared with 117 square miles in the County of London. It is, technically, a sanitary authority, though with wider functions than the 28 metropolitan boroughs, and its medical officer of health is always a senior and distinguished member of the public health service.

Outside the County of London there is the "overspill" population which, particularly during the past 50 years, has overflowed the boundaries of the London County Council. This overspill population is now about 6,000,000 and together with the County of London forms an urban aggregate of nearly 10,000,000 people, colloquially known as "Greater London." It is administered as one unit for police and traffic purposes, but no political party has had the courage to try to get sense into its problems of health administration, and the "outer fringe," as the area outside the County of London is called, contains three county boroughs, the county of Middlesex, portions of five other counties, and a host of sanitary districts.

Transfer of Functions

The trend is to transfer functions from the smaller district units to the larger county authorities, and from the large units—counties and cities—to the central government. For example, the maternity and child welfare work formerly done by the districts has been transferred to the counties, and all hospitals and the clinical part of tuberculosis and venereal disease work has been transferred from the counties to the central government.

The only functions now remaining with the districts are environmental hygiene in its broadest sense, and also the purity of water, milk, and food, the receipt of notifications of infectious diseases, and prevention of the spread of those diseases. There are encroachments even in this limited field. Generally, engineers are put in charge of water and sewage disposal undertakings and of the collection and disposal of garbage and trash for which many health officers were at one time responsible. Further, some counties, such as London, are given responsibility for major rehousing. In epidemiology, the district health officer must send to the county health officer copies of the notifications of infectious diseases within 36 hours of their receipt. In London, the County Council has power to step in and take over the work if the district defaults in its duty.

The counties have many important duties in the field of personal health. Maternity and child welfare includes receipt of notifications of birth, public health nursing, a midwifery service and antenatal clinics, infant welfare clinics, day nurseries, and recuperative holidays. Counties also provide school health service which, on the whole, is more highly developed than in the United States; vaccination, and immunization; a dental service for mothers and children; a home nursing and domestic help service; a general program of prevention and aftercare of all types of disease; an ambulance service not only for accidents but also for transport to and from hospitals; ascertainment and non-

institutional care of the mentally defective; a 24-hour service for taking into custody persons of disordered mind, and a host of other functions.

Impact of Nationalized Hospitals

In Britain, it is common form to administer by the horizontal, as opposed to the vertical system—that is, the lawyer, the doctor, the engineer, and the architect do the legal, medical and nursing, the engineering and the building work for the entire local government unit. By contrast, in the vertical system, the education department, for example, would have its own doctor and architect on the staff of the education officer or superintendent of schools. Under the horizontal system, the functions of health officers, who had responsibility for the municipal hospital service, were expanding somewhat rapidly until the hospitals were nationalized in 1948.

Some health officers transferred to administrative positions in the hospital service. Most, however, remained in the health service, and many regarded the nationalized hospital service as a major inroad on local health administration. Although the advantages to the local health officer of direct control of communicable disease hospitals and sanatoriums, and of all the work of tuberculosis dispensaries and venereal disease clinics are obvious, it is not so clear that he need concern himself with the details of the administration of general or mental hospitals. There is, however, still much important work for the health officer to do. He must study morbidity in his area and see what can be done to reduce it, particularly that due to psychoses and psychoneuroses. The cost of the curative services is heavy and it is obvious that preventive measures must be supported to an increasing extent.

The importance of "social medicine" is being recognized. Problems of the care of the aged now face the health officer. In some areas, the health officer has been appointed welfare officer as well because the care of the aged and infirm interlocks with medical and nursing problems.

The recent changes, however, have had an unsettling effect on the public health service, and a couple of years ago only a handful of students in the schools of public health expressed a desire to become health officers in Britain. Most of the public health students were destined for the colonial services or the medical departments of the armed forces.

Until World War II, there was no shortage of good recruits for the health departments. Apart from those attracted to this work for its own sake, some entered it because it gave a salaried post on a full-time basis to a man without the capital then necessary to buy a general practice or on which to keep himself while preparing for a specialist career. With the advent of the National Health Service Act, all this has changed. The sale and purchase of general practices has been prohibited by law, and, except for the purchase of a house, capital is not now needed to set up in practice. Interns and residents are paid a living wage; specialists are paid for their hospital work and at a level substantially above that of the average full-time health officer.

Salaries Fixed

Before the war, health officers were reasonably content with their salaries. Although a minimum salary for each type of post had been settled on a national basis in 1929, there was local option, and in many areas much more was paid than the minimum. The National Health Service Act provided that the Government would reimburse local health authorities half the salaries of their medical staffs. The counties always had paid half the salaries of the district health officers. The act, therefore, gave the Government greater control over salaries, and committees were set up to fix salaries of medical and nursing staffs on a national basis. The employing and the staff sides could not agree. The health officers maintained that they and their assistants were specialists and should be paid the same as hospital specialists. The employers said:

> Medical administrators' salaries should be similar to those of other professional administrators in the local government service, such as the finance officers, engineers, and architects. Local governments would have to increase substantially the pay of all their professional staffs if the doctors' rates of pay went up to the hospital scales and local governments could not afford it.

Many assistants in the health departments were doing medical work more analogous to that of the general practitioner than of the clinical specialist.

The dispute finally went to arbitration, and, by and large, the arbitrator agreed with the employers. Apart from the largest cities and counties, health officers' salaries are lower than those of clinical specialists, and those of assistant health officers and directors of bureaus are substantially lower than those of similar grades in hospitals. Salaries of the heads of the departments are based on the populations of their areas, although some discretion is given depending on the range of duties. It is only in the largest cities with populations over 600,000 that complete discretion as to the rate of pay is given. The staff side had felt that in small areas the employers could not be trusted to pay reasonable salaries unless they were forced to do so by the National Government but that in large areas the employers could be relied upon to pay enough to attract a good man. Many health officers received increases of pay as a result of the award, but the standard pay for new entrants to the service, which cannot be exceeded, is unattractive. The deputies of health officers receive two-thirds of the salaries of their chiefs.

The entrants to the service are supposed to have had at least 3 years of medical work after graduation and to have taken the diploma in public health, but many now, particularly those engaged in school health and clinic work, have had no specialized public health training, and are, therefore, ineligible for posts of health officer. More and more of those now entering the service are married medical women who use this as a method of augmenting the family income.

In my opinion, the salaries of medical officers of health are sufficient to attract good people, but unless the pay in the lower ranks is increased Great Britain will soon be short of men qualified to fill the senior posts.

Nonpolitical Appointments

A senior public health officer usually has done 2 or 3 years' hospital work after graduation—often he has also had a period of general practice. He has taken the diploma in public health after a year of academic work at his own expense. He has entered the service as an assistant medical officer of health, doing school health, or maternity and child welfare, or chest clinic work. He has moved about the country, paying his own removal expenses, gaining experience in different fields and different areas, and has obtained, eventually, the post of medical officer of health of a small city or county. The posts are usually advertised, and he progresses to larger cities or counties, taking his pension rights with him.

The actual appointments are made by the city or county councils concerned, after interviewing selected candidates. Canvassing, direct or indirect—that is, the seeking of support by influence—disqualifies. Allegiance to any political party is frowned upon, and health officers take no part in politics, serving with equal loyalty any political party elected by the people.

The mayors of cities and chairmen of county councils are unpaid. They, too, are above politics during their term of office, which is usually for a year only. They are the social, and not the political, leaders of their communities and preside over the meetings of their councils.

The chief officers of local government, such as the health officer, report to committees of the council, and policy and finance are in the hands of these committees, the members of which are unpaid. The majority party appoints a "leader of the council" and the minority a "leader of the opposition." The town clerk or county clerk, a lawyer, coordinates the work of the various departments. He corresponds to a mayor or governor in the United States, except that he is nonpolitical; he does not decide policy or finance or make appointments—these are the functions of the elected members who operate through committees—and he remains in office until he goes to another area or retires on reaching the age limit.

Summary

1. Until World War II, the public health service in Britain was an attractive career, reasonably paid, and contained men who had the confidence of their councils and of the medical profession.

2. They had heavy responsibilities, including the administration of hospital services.

3. Since the National Health Service Act nationalized hospitals, there are no municipal hospitals under local control, and hospital clinicians receive better salaries than public health workers.

4. The fixation of rates of pay on a national basis has not been an unmixed blessing. The profession wanted fixed rates so that local governments would be required to pay reasonable salaries, but they wanted minimums only to be fixed. Arbitration of the issue fixed maximums as well, except for the chief health officers of the largest authorities. This has meant that some officers are not receiving as much as they would have received had the local government units been free to pay what they liked.

5. Some feel that, since the main problems of environmental hygiene have been dealt with and free medical treatment by general practitioners and hospitals is available for all, there is little for the health officer to do.

6. My own view is that, despite the undoubted contraction in some fields, there are new and important functions unfolding, such as looking beyond the confines of epidemic diseases, considering all forms of morbidity, and devising methods of reducing or preventing them. Preventive work should include methods of rehabilitation and aftercare, and the education of the public in such matters, for example, as the prevention of accidents in the home. Psychiatric illness and the problems of old age and chronic sickness must be tackled. Health officers also have important functions as liaison officers between the various branches of the health service, that is, the hospital and general practitioners' services. To be successful they must have good standing in their profession. All this is in addition to the duty of controlling the spread of infectious diseases for which a trained epidemiologist is essential.

7. In contrast with conditions in the United States:

The health officer is never a political appointee. He is a career officer who remains in office despite changes in local political power. Incidentally, a British health officer has security of tenure and cannot be discharged except with the concurrence of the National Ministry of Health.

Except at the London School of Hygiene, I doubt if the academic training of public health officers in Great Britain is as good as in the United States.

Even with the loss of hospital administration, the British health officer's range of duties in a local health unit is somewhat greater than in the United States. However, the combining of sanitary districts and participation in the work of the county are essential to attract and keep good men.

Trained health officers serve all parts of Britain.

When a British health officer moves from one authority to another, or to or from a university or hospital appointment, he takes his pension rights with him.

The British health officer is responsible not to one man, the mayor or governor as in the United States, but to the city council or county council as a whole.

Generally, there is a uniform standard of salary for similar posts throughout Great Britain.

8. The points of similarity are:

The senior posts, particularly in areas where there is continuity of service, are held by first class, experienced, and respected health officers.

There is a shortage of good candidates for the junior posts associated, in both countries, with inadequate pay, and due, in both countries, to linking rates of pay with those of other local government officers and not with those of other physicians.