Michael

Publication Series of The Norwegian Medical Society

Social determinants of health and health-care

3/06

Vol. 3 / 3 / 2006

Michael Skjelderup

Michael is a publication series named after professor *Michael Skjelderup* (1769-1852), one of the fathers of Norwegian medicine. He was born in Hof, Vestfold in Norway as the son of a priest, and was raised in the Norwegian countryside. Because of severe speech disturbances as a boy he did not get proper schooling, but was at last accepted as an apprentice in an apothecary's dispensary in the city of Fredrikstad at the age of 16. During his youth he tried through hard work and by means of an intensive self-discipline to overcome his handicap, and he really succeeded, except for in stressed situations.

Lacking a student examination, an academic training seemed out of question, in spite of his obvious bright mind. However, in 1789 he was admitted to the new Surgical Academy in Copenhagen, where academic qualifications were not required.

From now on, his career flourished. He passed the surgical examination with the highest grade in 1794, entered positions in Copenhagen hospitals and at the University, where he defended his doctoral thesis in 1803 and was appointed professor in 1805.

The first University in Norway was founded in Christiania (now: Oslo) in 1811. Medical teaching was supposed to commence from the very beginning, and from 1814 the new medical faculty could offer medical training. Michael Skjelderup was appointed its first professor 1813, and started his teaching, mainly in anatomy in the fall of 1814, after a dramatic war time sea voyage from Denmark across the waters of Skagerrak where hostile Swedes fired at his swift sailing vessel.

As a University pioneer, he became active in several medical fields. Among other achievements, he published an authoritative textbook in forensic medicine in 1838. When he resigned in 1849, eighty years old, he had seen all Norwegian trained medical doctors in his lecture room.

Skjelderup was instrumental in building a scientific medical community in Christiania. Together with his University colleague Frederik Holst (1791-1871) he founded the first Norwegian medical journal *Eyr*, named after a norse medical goddess, in 1826. A reading club of physicians established in 1826 was formalized into an association in 1833, the still existing Det norske medicinske Selskab (The Norwegian Medical Society), which over the decades to come played an important role in the development of the health services and of a national medicine.

Michael is devoted to the memory of the man who first realized the importance of a regular, national medical publication activity in Norway and implemented his ideas in 1826. *Michael* is published by the same association as was founded by Michael Skjelderup and his colleagues – Det norske medicinske Selskab.

The editors

Christoph Gradmann

Hospitals 1860-1910: Dynamics of growth

Michael 2006;3:133–4.

Few medical institutions changed as radically as hospitals did in the 19th century. Many of the hospitals around 1800 would more remind modern observers of old age pension homes or asylums. However, from this time onwards they gradually developed into institutions where the whole setup increasingly had the treatment and even the cure of diseases as their main objective. At the same time hospitalisation periods grew shorter; the patient should not remain but recover when admitted to a hospital.

This process was by no means homogeneous. While some hospitals retained their pre-modern structure till the early 20th century, it was in particular in newly founded institutions, often to be found in the rapidly growing urban settlements of the period, that the modern hospital features had their early appearances.

Minuro Yasumoto's study[1] provides insight into a half century of history for one of those new institutions, the North Ormesby Hospital in Middlesbrough, which was founded in an industrial North Yorkshire town in 1859 as a voluntary hospital. Here, a fine set of records has survived and provides detailed insights into this historical process. North Ormesby Hospital was clearly intended to be a place for treatment. Its activities reflected the exposure of health hazards that an industrial town of the time offered its inhabitants: Fractures, bruises, burns etc. made up for most of the cases treated.

The archive material that Yasumoto was able to consult, also sheds light on the moral and financial economy of the hospital. While Christian charity provided the moral backbone, the financial basis was made available by

[1] Yasumoto M. Medical care for industrial accidents in a late 19th century British voluntary hospital – Self help, patronage, or contributory insurance? *Michael 2006;3:135–56.*

local workers, usually in the form of individual monthly subscriptions. As Yasumoto puts it, the institutional structure "consisted of the co-existence of the so-called 'mixed economy' of medical service provision with a charitable principle on the one hand, and a sort of contributory quasi-insurance arrangement, supported by both industrial and labour concerns on the other hand". Local industries, however, sufficed with encouraging their workers to make subscriptions and usually refrained from making any financial contributions of their own. As a result, North Ormesby Hospital was effectively funded by local workers.

This peculiar structure of a local institution pushed forward by local interest groups, could serve to remind us about an important aspect of the history of the so-called welfare state: While the administration of welfare and public health was taken over by the state in most Western societies of the 20th century, the state played only a minor, if any, role at the outset of the development of modern welfare and public health some places, e.g. on the British Isles. Many of the innovations that the 19th century saw in this field should better be understood as a result of bottom up initiatives from local movements in the society.

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Minoru Yasumoto

Medical care for industrial accidents in a late 19th century British voluntary hospital – self help, patronage, or contributory insurance ?

Michael 2006; 3:135–56.

Summary

This paper presents a case study of the available medical care for industrial accidents in a late nineteenth century British voluntary hospital, North Ormesby Hospital near Middlesbrough in the North Riding of Yorkshire. It is mainly concerned with the implications of the medical care provided by the institution, and the complex nature of welfare instruments through which the working population of the area ensured their safety-net, given that the hospital was supported largely by subscriptions from the industrial workers throughout the period under review. Since its erection in 1859, the hospital came to rely heavily on the collections raised by the workers of the iron & steel and railway companies in Middlesbrough. Based on the examination of the Council Meeting Minute Books, the Case Books and the Annual Reports of the hospital during the period, it concludes that the funding of medical care provided by a local voluntary hospital was a composite of different factors, i.e. self-help promoted among the working population, patronage or paternalism of management towards workers together with an intent for securing a robust and efficient labour force, and an early form of contributory insurance.

Aims

Recent investigations in modern British medical history tend to indicate that health care during this period came in many guises and was offered through a multiplicity of institutional forms. They also suggest a complex network of overlapping systems for insuring against the health risks, from solidaristic friendly society membership to contractual medical aid companies.[1] Thus any simple assertions about the development of British medical

welfare, for instance, from private to public, or local to national, must be erroneous as Professor Paul Johnson has pointed out.[2] We should recognise a great variety of welfare instruments prevailing in Britain before or even after Beveridge.[3]

This paper is intended to present a case study of the available medical care for industrial accidents in a late nineteenth century British voluntary hospital, North Ormesby Hospital near Middlesbrough in the North Riding of Yorkshire. It is mainly concerned with the implications of the medical care provided by the institution, and the complex nature of welfare instruments through which the working population of the area ensured their safety-net, given that the hospital was supported largely by subscriptions from the industrial workers throughout the period under review. Therefore it would be proper to say at the beginning that from its foundation this hospital had been organised on a different basis in fund-raising from the voluntarism in the sense of the eighteenth century philanthropic and charitable principle.[4]

The Council Meeting Minute Books of the hospital from 1867 to 1907[5] are consulted in order to analyse the relationship in interests between the medical institution, the town's staple industries of iron & steel and railway, and their workforces. The Case Books from 1861 to 1870[6] and from 1883 to 1908[7] as well as the Annual Reports of the hospital[8] are also examined to reconstruct a profile of the age, gender and occupation-specific morbidity of its patients, and trends in the sources of hospital income.

Morbidity as seen in the hospital records

First of all, let us consider overall figures for morbidity as seen in the hospital records, in the two periods, immediately after its erection from 1861 to 1870, and from 1883 to 1908. In both periods, a male bias in the in-patients is apparent, but in the later period, the bias became slightly less salient with males accounting for 67per cent of the total 15,137 in-patients as compared to 72 per cent of the total 1,454 in the earlier period.[9]

Figure 1 indicates changes over time for half a century in the number of in-and out-patients admitted as well as in the composition of surgical and medical cases.[10] From the opening of the hospital, out-patients outnumber in-patients, which seems rather natural, given the accommodation and expenses for nursing care for the in-patients. On average, the number of out-patients was virtually twice that of in-patients, and at the beginning of the twentieth century, there were considerably more of the former than the latter.

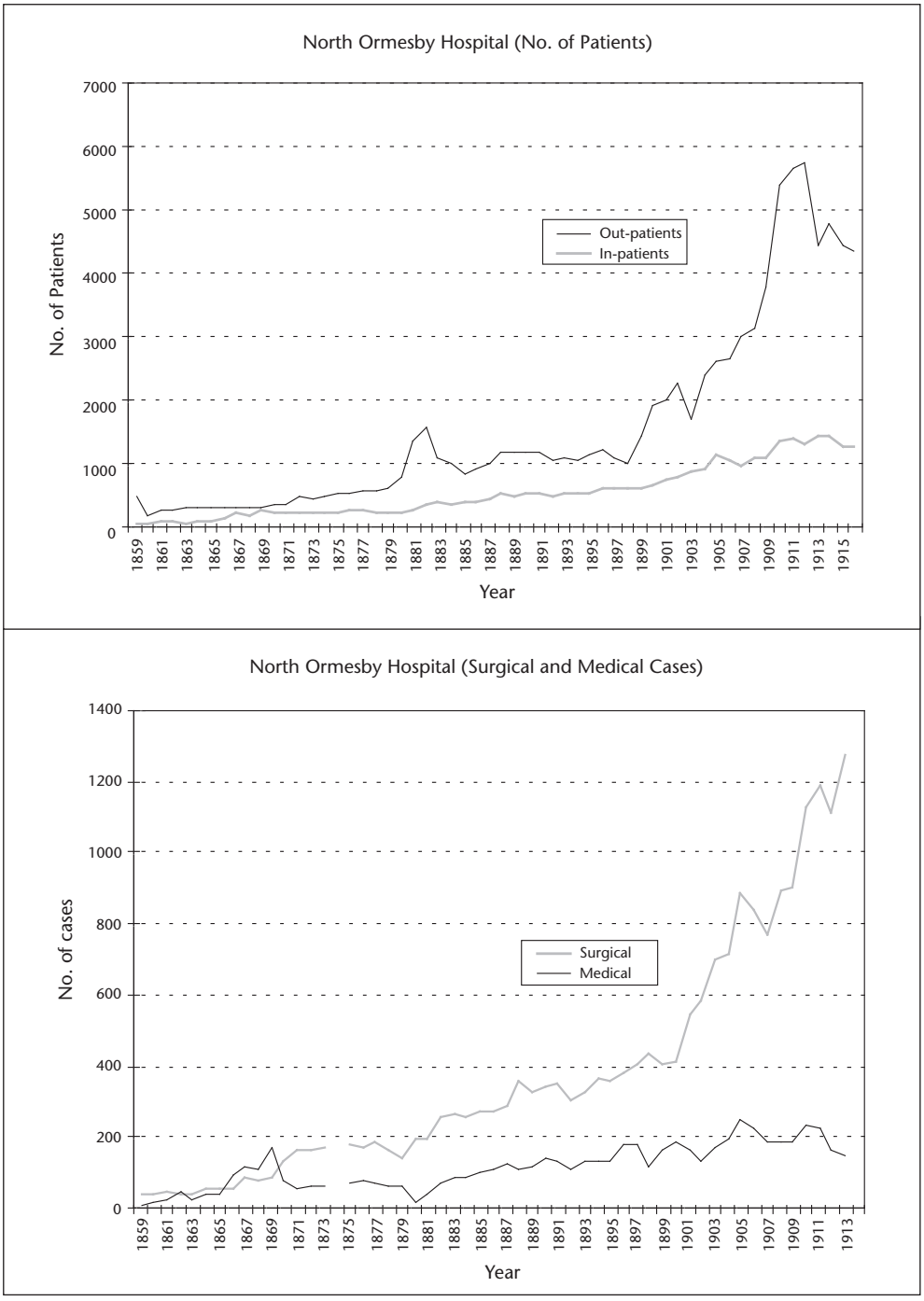

Figure 1: North Ormesby Hospital (Patients)

It is interesting to note that except for a very short period in the late 1860s, the hospital accommodated many more in-patients suffering from surgical rather than internal, medical illnesses. This seems to reflect one of the features of morbidity as seen among the people living in the Middlesbrough area in the late nineteenth century, especially among males.

If we look at gender- and age-specific distributions of the in-patients (See Figure 2), we will notice that between the two periods, there occurred some remarkable changes in the age structure of the in-patients. In the first

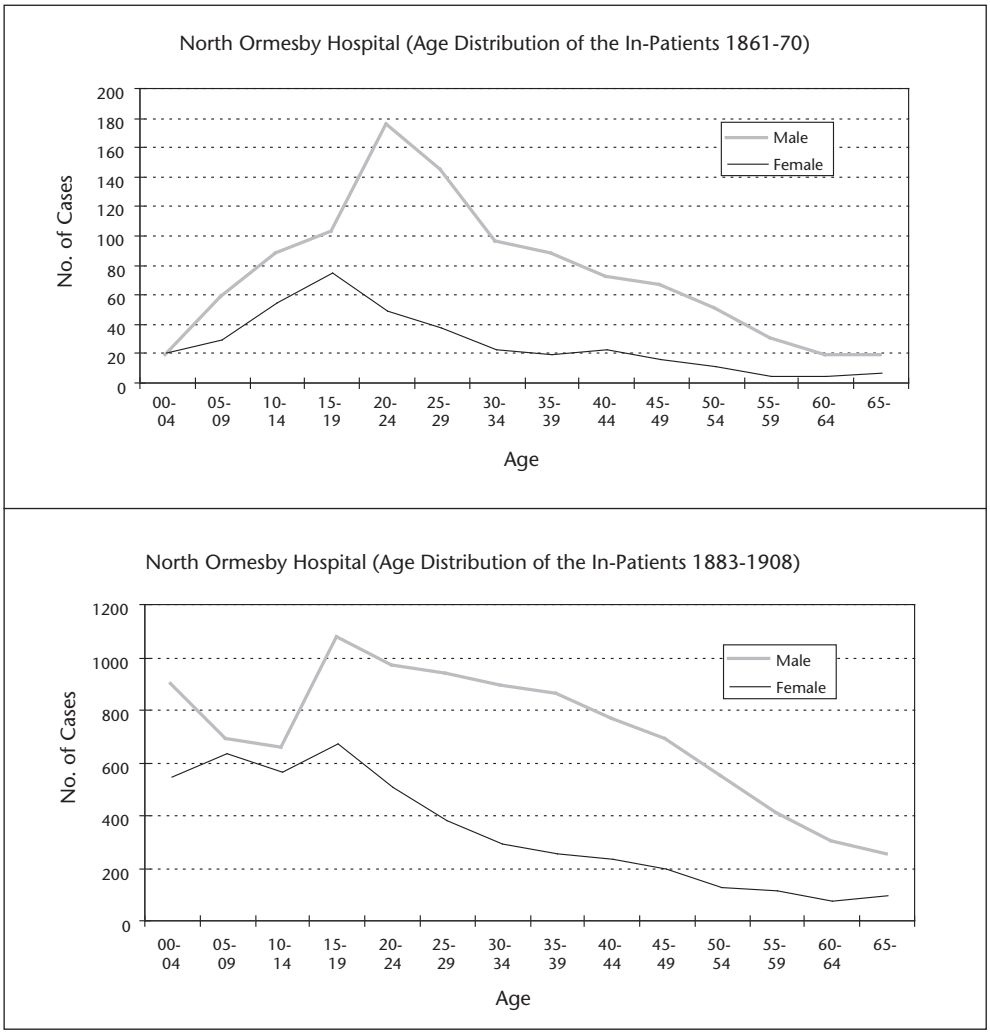

Figure 2: North Ormesby Hospital (Age Distribution of the In-Patients)

period, the highest point for males appears among the age groups of 20 to 24 and then of 25 to 29, whereas in the second period, a peak is found in younger age group of 15 to 19 with older age groups from 20 to 24 onwards showing higher levels throughout. The other marked change is discernible in the distributions of infant and child patients, especially in the male age group from 0 to 4 years of age, which in the second period occupy significant proportions.[11]

This is likely to be accounted for partly by the changes in the age structure of the population from the 1880s onwards, dependent upon the decreasing in-migration of the age groups of 20 to 24, and from 25 to 29, due to the staple iron & steel industry of the town being somewhat diminished.[12] It also seems to have been caused by the fact that towards the end of the nineteenth century, not only did adult males have a claim to the care provided by the hospital, but their wives and children could also increasingly expect to be received into the hospital as appropriate. From 1866 onwards, a special ward for sick children had been set apart.[13] These facts suggest changes occurring between the two periods in the fundraising policy of the hospital. For instance, the changes might have resulted from the hospital's efforts to increase contributors by providing greater access to their dependants.[14]

The most frequent cause of admission for males in the first period is, as is shown in Table 1, from accidents; for instance, injuries, burns, and fractures, whereas women are mostly admitted for internal diseases, such as rheumatism, abscess, and debility. In the second period, the picture is almost similar. For males, surgical cases are also predominant with frequent ailments being compound and simple fractures, burns, bruises and contusions, whilst females are frequently admitted from ulcer, chorea, anaemia, tonsils and adenoids, and tuberculosis, all of which are internal and medical illnesses. Duration of in-patient treatments for females in later period, 34.4 days on average, was slightly longer than that for males, 31.1 days on average, which seems to indicate decreased emphasis upon the acute sick for women.[15]

For the accidental cases, injuries to feet, legs, ankles and backs are conspicuous. These injuries were mainly due to workplace accidents both in the iron works, and upon the railways. As the compilers of the annual reports of the hospital during the period often grieved, the burns were of the most frightful kind, chiefly from molten iron.[16] Compound and simple fractures together with burns and injuries account for almost half of the causes of death in the first period, whilst in the second period, the most frequent causes of death are also from accidental cases of frac-

Table 1: Morbidity as seen in the Hospital Records

(1861–1870)			
Male		**Female**	
injury	191	rheumatism	28
burn & scald	125	abscess	27
fractures	122	debility	26
rheumatism	82	ulcerated legs, etc.	24
abscess	49	burn	20
ulcerated legs, etc.	47	injury	14
crushed legs, etc.	35	conjunctivitis	13
bronchitis	29	bronchitis	12
conjunctivitis	21	chorea	11
phthisis	20	synovitis	11
others	255	others	165
Total	**976**	**Total**	**351**

(1883–1908)			
Male		**Female**	
fractures	1,082	ulcer	253
burn & scald	689	chorea	193
bruise	502	anaemia	177
contusion	327	tonsil and adenoid	177
ulcer	304	tuberculosis	169
inguinal & other hernia	234	abscess	149
abscess	223	gastric ulcer	135
tuberculosis	223	burn & scald	114
crush	210	eczema	92
rheumatism	206	necrosis	92
laceration	204	rheumatism	90
pneumonia	150	carcinoma & cancer	82
bronchitis	141	fractures	79
sprain	131	keratitis	70
necrosis	127	dyspepsia	63
others	5,315	others	2,872
Total	**10,068**	**Total**	**4,807**

North Ormesby Hospital, Case Book, 1861-1870, Teesside Archives, H/NOR 10/1, North Ormesby Hospital, Case Books, 1883-1888, 1885-1908, Teesside Archives, H/NOR 10/2, 3

Table 2: Causes of death

Male					
1860 – 1870			1883 - 1908		
	No	%		No	%
compound & simple fractures	15	26.3	compound & simple fractures	90	15.8
injury	7	12.3	pneumonia	52	9.2
burn & scald	6	10.5	burn & scald	37	6.5
phthisis	6	10.5	phthisis & tuberculosis	25	4.4
abscess	4	7.0	strangulated hernia	12	2.1
bronchitis	3	5.3	bronchitis	12	2.1
others	16	28.1	others	340	59.9
Total	**57**	**100.0**	**Total**	**568**	**100.0**
Female					
phthisis	2	25.0	tuberculosis	16	7.0
burn & scald	1	12.5	burn & scald	15	6.5
			cardiac diseases	9	4.0
			strangulated hernia	9	4.0
			cancer	7	3.0
others	5	62.5	others	173	75.5
Total	**8**	**100.0**	**Total**	**229**	**100.0**

North Ormesby Hospital, Case Book, 1861-1870, 1883-1888, 1885-1908, Teesside Archives, H/NOR 10/1, H/NOR 10/2, 3.

tures and burns, comprising 22 per cent of the total deaths of 568 (See Table 2).

Hospital mortality in both periods was more than 5 per cent on average with a male mortality of 6.0 per cent (See Figure 3).[17] This was clearly higher than those observed in other voluntary hospitals, for instance, 3.1 per cent for the male in-patients in the General Infirmary at Leeds at the beginning of the 19th century.[18] Consumers of medical services, chiefly of the male manual workers employed in heavy industries, living in a physically hazardous environment, had a strong influence upon the hospitalisation in this area.

Fund-raising

Figure 4 indicates the proportions of the subscriptions and donations offered by the employees of various firms in the Middlesbrough area of all the ordinary subscriptions and donations received by the hospital.[19] It is impressive to note that workers' contributions to the hospital fund were con-

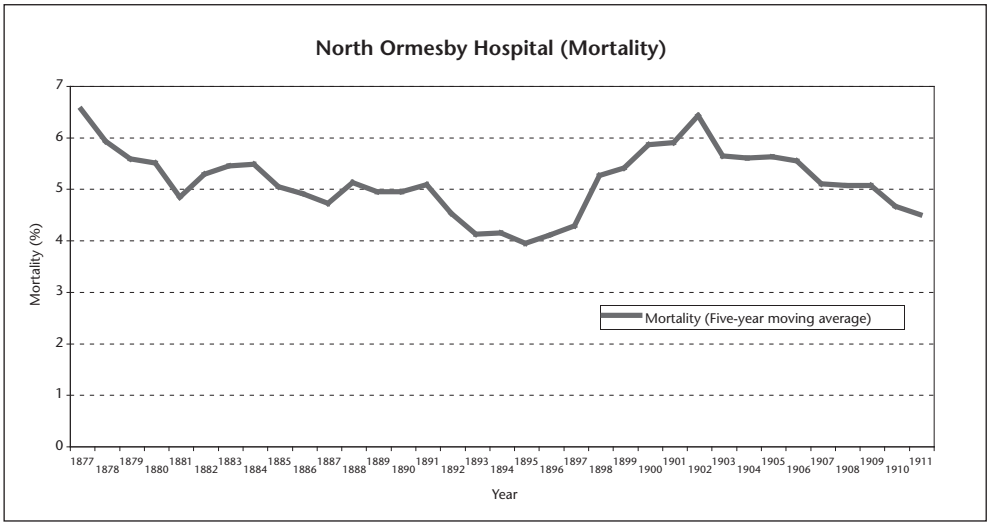

Figure 3: North Ormesby Hospital (Mortality)

siderable throughout the period. Their contribution accounts for more than half of the hospital funds on average. Towards the end of the 19th century, shares of the hospital's ordinary income derived from workers' subscriptions rose rapidly to more than 60 per cent. At the beginning of 20th century, the hospital was run almost entirely from workers' subscriptions. Thus it could safely be said that throughout its history from 1859, this hospital relied to a great extent on the workmen's contributions for its fund-raising.[20]

The same tendencies were seen in the institutions of other heavy industry areas, like Glasgow, Sheffield, Sunderland, Newcastle or Swansea, where accidents, emergencies and environmental diseases were prevalent.[21] Yet, even compared to these institutions, North Ormesby Hospital's sources of income were extremely concentrated on the collections from these heavy industry workers, which is probably rare in the history of British hospital development during the period under observation.[22]

Differences in the finance and fund-raising activities between this institution and other hospitals are worth noting. Table 3 compares the subscribers for North Ormesby Hospital in 1876 to those for the General Infirmary at Leeds in 1857.[23] The proportions of subscriptions collected from the employees in the Middlesbrough area account for as much as 65 per cent of all the subscriptions, whereas those from the companies cover less than one-tenth of the contributions from the workers, that is, only 5.5 per cent. As for individuals, the amounts from the peerage and

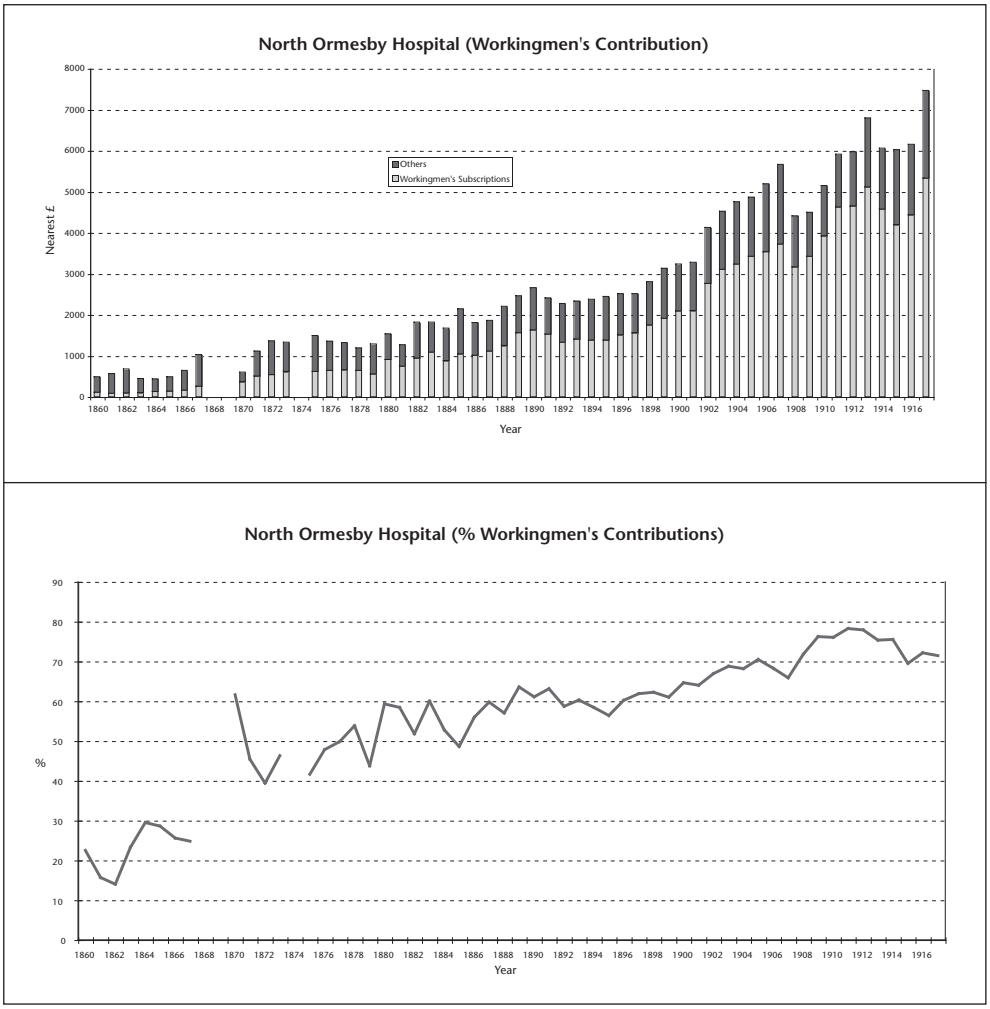

Figure 4: North Ormesby Hospital (Workingmen's Contributions))

gentry comprised 9 per cent, whilst the ordinary lay people contributed 4 per cent.

In contrast to this pattern of fund-raising, Leeds General Infirmary shows a more even distribution in subscriptions. As the General Infirmary at Leeds didn't adopt contributory scheme procedures, it did not receive any contributions from workmen as a body. Rather the Infirmary relied much more on the wealthy landed interests in the West Riding of Yorkshire. The peerage and gentry contributed 22 per cent of all the subscriptions to the Infirmary.

Table 3: Hospital Fund-raising (North Ormesby Hospital and General Infirmary at Leeds)

North Ormesby Hospital 1876				General Infirmary at Leeds 1857			
Subscribers	**No. of Cases**	**Amount £**	**%**	**Subscribers**	**No. of Cases**	**Amount £**	**%**
Companies	10	53.4	5.5	Companies	174	482.5	20.8
Friendly Societies	3	12.6	1.3	Friendly Societies	9	29.4	1.3
Poor Law Unions	2	12.6	1.3	Poor Law Unions	7	45.2	2.0
Overseers of the Poor				Overseers of the Poor	11	45,2	2.0
Other Organisations	3	4.4	0.4	Other Organisations	4	40.3	1.7
Individuals				Individuals			
Aristocrats	3	17.1	1.8	Aristocrats	23	123.4	5.3
Gentry	19	68.1	7.0	Gentry	119	390.3	16.8
Ecclesiastical	7	12.6	1.3	Ecclesiastical	45	110.5	4.8
Lay Mr.	18	23.3	2.4	Lay Mr.	396	761.3	32.9
Mrs.	10	13.6	1.4	Mrs.	93	202.4	8.7
Miss	9	7.8		Miss	40	86.1	3.7
Workers at various Co.		631.8	65.0				
Hospital Sat. & Sun. Fund		114.5	11.8				
Total		**971.8**	**100.0**		**921**	**2,316.6**	**100.0**

The Eighteenth Annual Report of the Cottage Hospital, North Ormesby, Middlesbrough, 1876, pp 10-13, The Annual Report of the State of the General Infirmary at Leeds, from September 29th, 1856 to September 29th, 1857.

Also among the important supporters of Leeds General Infirmary were the rising bourgeoisie of manufacturers and merchants, the petite bourgeoisie consisting of shopkeepers and professionals, as well as other middle class people. Thus contributions from these lay individuals are of primary importance, forming more than 40 per cent. They seem to have exploited the voluntary hospital system, seeking some sort of respectability and patronage which a recommendation to hospitals might have brought, in return for subscribing to a fund for medical facilities. More importantly, subscriptions collected from industrial concerns, mainly the textile companies based in the Leeds area, account for 21 per cent of total subscriptions.[24]

On the other hand, with the exception of Snowden and Hopkins Iron Works, having subscribed a total of 5 pounds sterling, no companies made any contributions in 1860 in the locality in question.[25] So that, in fact, workers originally financed this hospital themselves. In order to show the relative importance in contributions to the hospital covering the period

Table 4: Company and their employees' Contributions to North Ormesby Hospital (1860-1881)

Name of Company	Company Contribution		Employees Contribution		Total amount	
	£	%	£	%	£	%
Cochrane & Co.	9 *	5.6**	152	94.4	161	100.0
Bell Brothers	14	23.0	47	77.0	61	100.0
Gilkes, Wilson, Pease & Co.	10	25.0	30	75.0	40	100.0
Clay Lane & South Bank Iron Works	0	0.0	55	100.0	55	100.0
Gjers, Mills & Co.	0	0.0	15	100.0	15	100.0
Samuelson & Co.	5	100.0	0	0.0	5	100.0
North Eastern Railway	10	28.6	25	71.4	35	100.0
	48	12.9	324	87.1	372	100.0

*: Average £ per annum **: % contribution to each company
North Ormesby Hospital, The first to fiftyninth Report of the Cottage Hospital, North Ormesby, Middlesbrough, 1860 – 1881.

from 1860 to 1881, proportions of the total contributions provided by the companies and their employees are shown in Table 4.[26]

Throughout the period, the total contribution from six major iron works and the local railway company amounted to less than one-seventh of the amount from their employees. Among them, Clay Lane and South Bank Iron Works and Gjers, Mills and Co. made no contributions at all, whereas their workers contributed totals of 55 and 15 pounds sterling respectively on average. The fact seems rather striking when we consider the number of patients sent in by these companies.

Among the companies sending their employees and their families to the hospital, Cochrane and Co., sent the highest number, as much as 30 per cent of all the male patients suffering from surgical cases, and 17 per cent for the male medical cases in the first period.[27] They recommended 13 per cent of the male and 9 per cent of the female in-patients in the second period (See Tables 5 and 6).[28] However, this company contributed a total of only 9 pounds sterling on average, throughout the period. By contrast, their employees subscribed as much as 152 pounds sterling on average.

It was often reported in the Council Meeting Minutes Books during the period that 'The Council would contrast the sum contributed by the working men with the small sum, which has been contributed by the employers of labour' or that 'working men who have so nobly assisted themselves deserve a little more encouragement at the hands of those who are owners of capi-

Table 5: Recommenders (Companies)
North Ormesby Hospital (1860 – 1871)

Male Surgical Cases					
Companies				**Diseases**	
Names of companies	**Occupations**	**No.**	**%**	**Names of diseases**	
Cochrane & Co.	Ironworks	163	30. 9	Injury	135
Bell & Brothers Co.	Ironworks	36		Burn & Scald	97
Gilkes, Wilson & Co.	Ironworks	22		Fracture	82
Hopkins & Co.	Ironworks	22		Crush	29
Backhouse, Dixon & Co.	Shipbuilding	20		Contusion	7
Bolckow, Vaughan Co.	Ironworks	16		Wounds	6
Stockton & Darlington Railway Co.	Railway	15		Others	18
Jones, Dunning & Co.	Ironworks	12			
Other Companies		58			
Total		372	69.9	Total	374
Others		33	6.2		
No recommendations		127	23.9		
Total		**532**	**100**		
Male Medical Cases					
Companies				**Diseases**	
Names of companies	**Occupations**	**No.**	**%**	**Names of diseases**	
Cochrane & Co.	Ironworks	75	17.0	Rheumatism	40
Gilkes, Wilson & Co.	Ironworks	19		Ulcerated legs	27
Bolckow, Vaughan Co.	Ironworks	14		Abscess	19
Bell & Brothers Co.	Ironworks	13		Bronchitis	11
Backhouse, Dixon & Co.	Shipbuilding	11		Phthisis	6
Hopkins & Co.	Ironworks	11		Pneumonia	6
Other Companies		30		Diseases	6
				Inflammation	6
				Others	53
Total		173	39.0	Total	174
Others		73	16.4		
No recommendations		198	44.6		
Total		**444**	**100**		

North Ormesby Hospital Case Book, 1861 – 1870, Teesside Archives, H/NOR 10/1.

Table 6: Recommenders to North Ormesby Hospital (1883-1908)

Recommenders	Number of Patients admitted	%
Male		
Cochrane & Co.	1,277	12.7
Emergency	539	5.4
Raylton Dixson & Co.	477	4.7
Cargo Fleet Iron Works	410	4.1
North Eastern Railway	357	3.5
Wilson, Pease & Co.	344	3.4
Bolckow & Vaughan Co.	285	2.8
Sadler & Co.	269	2.7
Anderston Foundry	239	2.4
Normanby Iron Works	237	2.3
Dorman Long & Co.	208	2.1
Bell Brothers	186	1.8
Clay Lane Iron Works	126	1.3
Accident	86	0.9
Others	5,028	49.9
Total	**10,068**	**100.0**
Female		
Cochrane & Co.	428	8.9
Emergency	204	4.2
Bolckow & Vaughan Co.	180	3.7
Dorman Long & Co.	178	3.7
North Eastern Railway	162	3.4
Cargo Fleet Iron Works	129	2.7
Anderston Foundry	118	2.5
Wilson, Pease & Co.	101	2.1
Sadler & Co.	99	2.1
Raylton Dixson & Co.	77	1.6
Normanby Iron Works	77	1.6
Bell Brothers	73	1.5
Clay Lane Iron Works	34	0.7
Accident	8	0.2
Others	2,939	61.1
Total	**4,807**	**100.0**

North Ormesby Hospital, Case Books, 1883-1888, 1885-1908, Teesside Archives, H/NOR10/2, 3

tal'.[29] The Council Meeting Minutes Books also noted 'the Owners of Works whose subscriptions have not covered the cost of patients sent in by them'.[30] Although it looked as if the ironmasters and railway company began to support joint contributory sick-pay schemes, companies' contributions were clearly minimal as compared to those provided by their workers.[31]

Hospital management

The North Ormesby Hospital was founded in 1859 as a Cottage Hospital from the deep concern of its founder, Sister Mary of the Christ Church Sisterhood, over the lack of nursing care for those injured by the boiler explosion in the previous year at the Ironworks of Snowden, Hopkins and Company in Middlesbrough. It is interesting to note that whilst the hospital retained its religious, philanthropic or charitable influences [32] throughout the period under review, shortly after its erection, as we have seen, it came to rely on the money raised by the workers of the iron & steel, and railway companies. With this point in mind, we would like to consider the internal organisation of the hospital and how it was run.

At the outset, the promoters of the hospital must have tried to remain neutral in regard to opposing interests, and diligently pursued their own aims to establish an independent medical institution. Thus, they not only organised a workers' association named "The Working Men's Committee" in the hospital for the purpose of obtaining workmen's cooperation in aid of fund-raising, but also asked the employers of the area to make an arrangement for their workmen to contribute a small amount of money to the hospital.[33]

Moreover, the promoters called at the iron works themselves with the view to obtaining weekly contributions from the workers.[34] They undoubtedly urged the ecclesiastical community of the area as well to contribute, setting up various schemes including medical charities of the Hospital Saturday and Sunday Funds.[35]

Yet increasingly in terms of contributions to the fund-raising as well as of the number of patients admitted, this hospital came to function substantially as a worker's medical centre to treat accidental cases which were of almost daily occurrence owing to the dangerous nature of the work they were engaged in. Immediately after its erection in 1859, and before the formation of the Hospital Council in 1866, workers employed by four of the major iron companies of this area, Cochrane, Bolckow & Vaughan, Samuelson, and Snowden, contributed 110 pounds sterling, which accounts for as much as 23 per cent of the hospital's ordinary income.[36]

From the hospital's foundation, workers employed in these heavy industries took the initiative in establishing a system or organisation in the

hospital for collecting subscriptions, as suggested by a remark in the Council Meeting Minutes Books. It was reported that a deputation of the Working Men's Committee in the hospital 'made some suggestions as to improved organisation for collecting subscriptions and for attending to other matters affecting the interests of the hospital'.[37] Then, a sub-committee was appointed to consider the subjects brought before the Council Meeting by the Workmen's deputation, the result of which was a formation of the House Committee in 1870.[38]

It seems likely that the Working Men's Committee in the hospital formed in 1867 ceased to be active in operation at the beginning of the 1870s after it had fulfilled its role of acting as trustees for enabling the working people in the area to form a close relationship to the hospital, and support it with substantial contributions.

The House Committee consisted of 20 to 36 individuals each representing the iron & steel, and ship-building, railway companies and chemical factories, as well as a friendly society. This Committee seems to have provided a better-organised structure than a provisional association of the Working Men's Committee.[39]

Meanwhile, the system of collecting workers' contributions to the hospital fund-raising became more systematized and structured, with the share of the hospital's ordinary income derived from workers' contributions rising to more than 60 per cent, as we have already observed. The working class in the Middlesbrough area tended to regard this hospital as especially their own, and to give it their united and systematic support, presumably with the intent of using it as one of the most important safety-nets available. Hence the Council itself thought highly of the fact that the workers were assisting themselves and promoting self-help.[40]

Self help, patronage, or contributory insurance?

Contributions were likely to have been taken from the workers' wages in each company, and in the earlier period, the Working Men's Committee, or the Working Men's Meeting formed in the hospital, seems to have made an arrangement for their contributions to be subscribed to the hospital. The evidence from the pay books of Bell Brothers, one of the major iron works of the area, shows that skilled, semi-skilled and un-skilled labourers as well employed by the company in the late 1860s, spent approximately 5 per cent of their weekly or fortnightly wages on providing against emergencies.[41]

Bell Brothers made deductions from their workers' wages for house-rent, doctor's fees contracted with the company, payments to sick club, and

the 'Roman Catholic Fund'. 2 pence in contributions to North Ormesby Hospital were taken from their fortnightly wages. Another 4 or 6 pence were deducted to pay for the doctor, together with 1 shilling and 4 pence for the sick fund.

It could be said from this evidence that sick benefit services in the period were independently organised at individual works.[42] The evidence would also seem to indicate that within companies, besides ordinary sick benevolent clubs organised for providing compensation during illness, or for paying for the doctor's fees contracted with the firms, all of which were also financed with the contributions deducted from wages, there was a membership sick club especially designed for sending the injured to North Ormesby Hospital.

In times of sickness, scheme members could call upon this benevolent fund to which they each contributed only a minimal amount of money, say a farthing or a penny per week. If dependants of contributory scheme members needed hospital treatment, they could also apply to the fund. In the present state of our knowledge, the collecting system is not crystal-clear. However, most likely, the contributory scheme members and their dependants could enjoy free treatment in the hospital in return for their weekly subscriptions deducted from their wages. Members might have had to obtain company doctors' recommendations for hospitalisation.[43]

Obviously there were other channels available in this period through which the working class could support themselves in times of hospitalisation, for example as is shown in Table 7. It illustrates how fund-raising and expenditure were undertaken in the Middlesbrough branches of the Amalgamated Society of Engineers and the Steam Engine Makers Society, with those for the hospital in the same year for comparison.[44]

Unionised workers could expect fairly high proportions of the expenditures in medical care from their subscriptions, with as much as 29 per cent for the Steam Engine Makers Society and 9 per cent for the Amalgamated Society of Engineers. Yet especially for un-organised workers outside the formal associations such as trade unions, friendly societies, or other benevolent societies, the system relying on the medical care provided by a voluntary hospital of the area, would seem to have been an important self-supporting sick and accident fund based upon voluntarism.

Other iron and steel companies likewise must have supported a wide variety of welfare services for their workers. Company welfare was in the employers' interests, especially in the iron and steel industry. Reliance upon export markets forced the iron & steel industry to be highly competitive and susceptible to trade cycles. Therefore, company-based or company-

Table 7: Fundraising and Expenditures of Middlesbrough Associations 1876

Amalgamated Society of Engineers No. of Branch members: 228				**Steam Engine Makers Society No. of Branch Members: 15**				**North Ormesby Hospital**			
	£	**s.**	**d.**		**£**	**s.**	**d.**		**£**	**s.**	**d.**
Income											
Contributions etc.	515	11	8	Contributions etc.	21	16	7	Subscriptions	230	6	6
Received from other branches	110	0	0	Received from other branches	36	2	0	Subscriptions from Workmen	646	15	11
Others	36	3	3	Others	3	9	7	Donations	611	5	9
Total	661	14	11	Total	61	8	2	Total	1,488	8	2
Balance Dec. 1875	1,269	18	5	Balance Dec. 1875	21	11	8	Balance Dec. 1875	426	8	4
Grand Total	**1,931**	**13**	**4**	**Grand Total**	**82**	**19**	**10**	**Grand Total**	**1,914**	**16**	**6**
Expenditure											
Travelling	391	4	10	Travelling	2	8	7,5	House-keeping Acc.	1,477	14	11
Unemployed	-	-	-	Unemployed	13	10	0	Medical & Surgical Acc.	87	4	1
Sick	169	5	4	Sick	23	16	4	Furnishing & Repair Acc.	89		14
Funerals	12	0	0	Funerals	5	0	0	Establishment Acc.	284	5	0
Superannuation	4	8	0	Superannuation	-	-	-				
Others	39	12	11	Others	9	3	3,5	Others	5	18	5
Total	616	11	1	Total	53	18	3	Total	1,914	16	6
Balance, Dec. 1876	1,315	2	3	Balance, Dec. 1876	29	19	10	Balance, Dec. 1876	-	-	-
Grand Total	**1,931**	**13**	**4**	**Grand Total**	**82**	**19**	**10**	**Grand Total**	**1,914**	**16**	**6**

Amalgamated Society of Engineers, Yearly Report of Middlesbrough Branch, 1876, Modern Records Centre, University of Warwick, MSS 259/2/1/1. Annual Report of the Income and Expenditure of the Steam Engine Makers' Society, 1876, p. 198.

specific labour management and industrial welfare were important to iron and steel companies.[45]

Labour shortage or labour turnover was really a serious problem in a newly-built, isolated, industrial community exclusively dependent upon a staple industry of iron & steel and railways. As Professor Bob Fitzgerald has pointed out, in such a circumstance, employers tried to create an internal labour market within their firms, not only through improved security of employment but also by the provision of welfare benefits. In competitive industries such as iron and steel with small and medium-scale firms predominant, this tendency was more remarkable.[46]

In addition, a paternalistic attitude made sense, especially among the non-unionised labour in small and medium-sized businesses prevalent in the iron & steel industry during the period under review.[47]

Apart from the company-based private welfare schemes which must have been rather unsystematic and less extensive at this stage, Middlesbrough's own economic structure, that is, a newly-founded town whose economy was extremely concentrated on iron & steel and the railways, gave rise to a peculiar welfare system, as seen here. A mono-industrial structure, with most of the workers enduring almost similar working conditions, was likely to have brought about common interests among the workers. Thus the medical care which prevailed in the area during the period, provided by a voluntary hospital based on contributory schemes rather than on an old subscription-recommendation system, could be said to be a quasi-public means for social security.

Conclusion

In conclusion, let us consider the implications of the medical care provided by a British voluntary hospital in the late nineteenth century based on the case study of the early stage of a hospital system organised on nascent contributory schemes.

It is often suggested that Middlesbrough workers tended to be heavily involved in a range of self help organisations, such as friendly societies, trade unions or other benevolent societies, as for instance Professor Asa Briggs has noted.[48] The tendency seems to have resulted from the fact that it was an entirely new town, planted as late as 1830, and there were no fixed or disposable old endowments, available elsewhere, say, in London, Birmingham, Liverpool, Sheffield, Leeds or Glasgow, or other long-established towns. Thus Middlesbrough's working class had to strive to cater for their own needs, which was likely to have strengthened, among the workers there, a grass-roots solidarity.[49]

Strictly speaking, the system on which the management, finance and fund-raising of a voluntary hospital in this area were all based cannot be said to have originated from this working class grass-roots principle per se. As implied by a remark in the Council Meeting Minutes Books in 1867, iron companies would 'issue notices to their workmen recommending them to contribute a farthing each man weekly to the hospital'.[50] Initially, workers seem to have been rather passive in that they just followed what the promoters of the hospital or the employers of companies in the area tried to set up in terms of managerial, financial, or fund-raising mechanisms of this medical institution.

Nevertheless, once the system was established, workers could identify this hospital as a medical institution promoting their aims; hence they participated actively, as they seem to have welcomed this contributory scheme

which allowed for a certain-degree of grass-roots participatory democracy and encouraged a working-class tradition of self-help as Jose Harris has mentioned.[51] They tended to have regarded this hospital as particularly their own, designed to promote their self-help. Thus they continued to give this institution their united and systematic support to make it a reliable safety-net. The existence of this sort of medical institution in their vicinity could lessen the fear arising from severe industrial accidents due to the hazardous physical environment.

On the other hand, the maintenance and promotion of such a medical institution like the voluntary hospital as seen in this area, which virtually specialised in treating industrial accidents and emergency cases, seemed to have had tangible advantages for the employers, as a means of meeting the needs of their workforces, upon which efficient production depended. Thus, the origin of the medical welfare system in this area was a mixture of indirect company involvement and the encouragement of working-class self-help.

It consisted of the co-existence of the so-called 'mixed economy' of medical service provision with a charitable principle on the one hand, and a sort of contributory quasi-insurance arrangement, supported both by industrial and labour concerns on the other hand.[52] In this sense, what we have been seeing in this system was a composite of different factors, that is to say, self-help promoted among the working population, patronage or paternalism of management towards their workers together with the intention of securing a robust and efficient labour force, and an early form of contributory insurance.

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KEYWORDS: accidental and emergency cases, voluntary hospital, contributory schemes, workers' contributions, iron and steel industries, railways, self help, patronage, safety nets, contributory insurance.

Øivind Larsen

Social determinants of health past and present – impressions from a conference

Michael 2006;3:157–68

Summary

As a joint venture by The Wellcome Trust Centre for the History of Medicine at University College London (UCL), Professor Bernardino Fantini (Geneva) and professor Sir Michael Marmot (UCL), chair of the WHO commission on Social Determinants of Health, a very interesting conference was arranged at the UCL 19.-21. September 2006. The topic was the history of the social determinants of health. One of the main objectives of the meeting was to convey the perspectives of the historians into the planning work of the WHO commission. A series of topics were addressed by means of worldwide examples. The political nature of social determinants of health clearly came to sight in nearly all presentations, as did the inherent conflict between prospects for short-sighted economic development and the long-sighted population based approach which is necessary to achieve broad-scale results in public health. The concluding sessions of the meeting were dedicated to means and methods for this kind of historical research: The PHOENIX-TN network building programme and the witness seminar technique were presented.

History rediscovered

Historians probably never have doubted that their knowledge is a valuable tool when planning for the future. The conference *History of the Social Determinants of Health,* held at the University College London 19.-21. September 2006 by The Wellcome Trust Centre for the History of Medicine in cooperation with Professor Bernardino Fantini (Geneva) and the chairman of the WHO Commission on Social Determinants of Health, proved that this opinion also was shared by researchers from other disciplines and by officials working with practical problems in the field of public health.

The audience consisted of ca. thirty speakers and discussants from different countries, in addition to around forty other participants. Some of

them were historians, but many had other backgrounds. The discussions were vivid and became partly heated when the political sides of the social determinants of health were at issue.

The presentations swept over wide fields as a global history approach seemed appropriate in order to describe general trends in the development of health and living conditions for various populations. Even if generalisations are difficult, it was quite clear that historical processes may have effects that last for generations, and that what we see and do today will have similar future implications.

Learning from differences

In her presentation, Professor Alison Bashford from University of Sydney (Australia) discussed ill-health and social problems after the British colonisation. Although there were differences between the generations in hygienic practices etc., life expectancy dates and other statistics clearly demonstrated that differences between population groups persisted, e.g. between the indigenous inhabitants and the new Australians. She compared the situation in Australia with Papua New Guinea and found that the health conditions there had much in common with those of the indigenous tribes in Australia.

Among many points of discussion which were taken up, was the issue of health equity resulting from prevailing exclusion and inclusion policies. Here also the organisation of the health care system may be an important social determinant for health. Human rights and health equity are closely linked, and she pointed at situations when public health measures intentionally were not applied to aborigines, even when available. But her question remained hanging in the air: - Are we responsible for what happened in the past?

Professor Paul Greenough from the University of Iowa had an even more difficult task in commenting on the situation in Asia as a whole. Obviously, with a continent with huge internal differences, finding a common denominator which could explain e.g. the attitudes towards public health activities, may seem hopeless. However, he chose to discuss the importance of the *family* in Asia. Very often, the most important social group for the Asians is the family. Identification and loyalty is with the family. Individualism is not so prominent, but on the other hand, bindings to the larger groups outside the family are weaker. This special trait of Asian societies may explain many sides of development. In applying public health services, this difference from e.g. Western societies suggests that the family should be the obvious target.

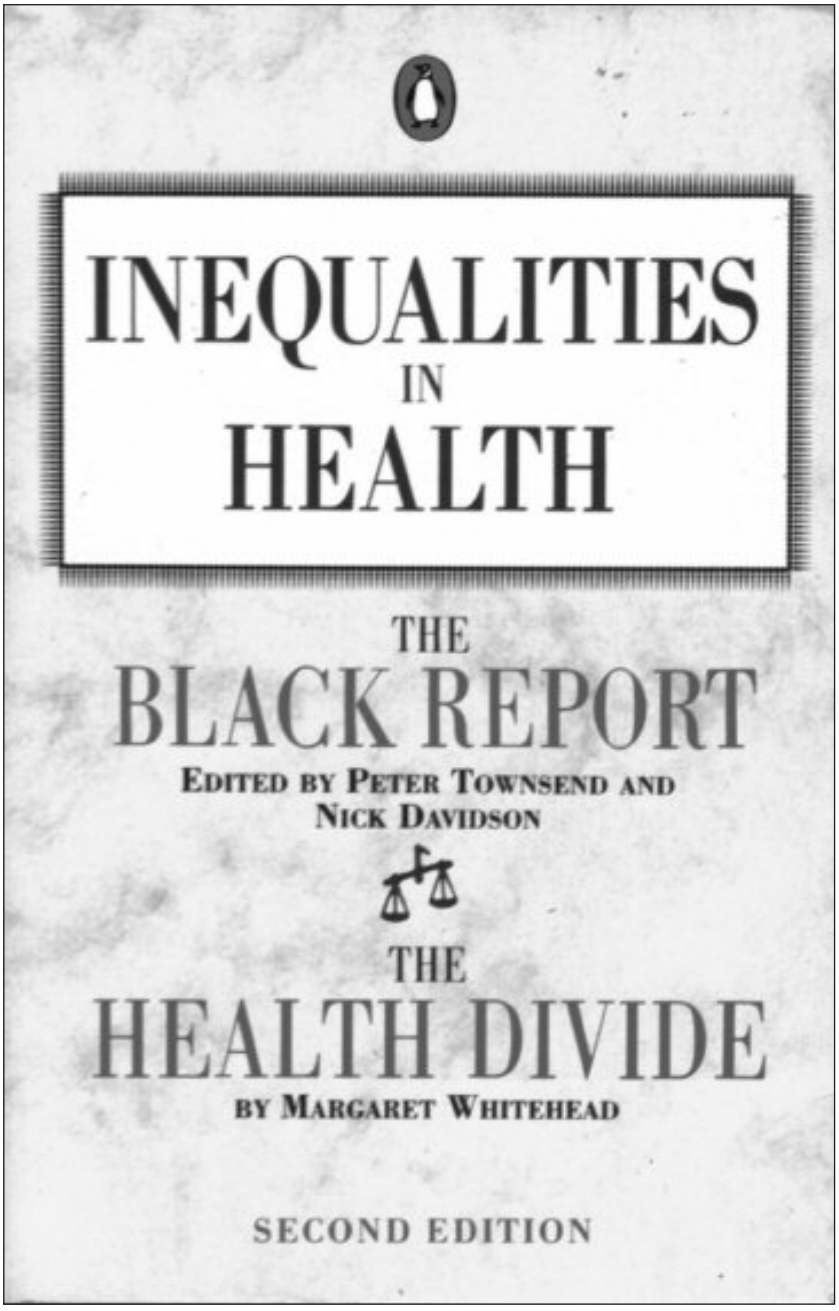

Figure 1: Revealing inequalities in health in modern UK – the Black Report from 1980. This 1992 edition also contains the follow up report by Margaret Whitehead, first published in 1988.

In his comments, Professor Sir Michael Marmot addressed the situation in the new Eastern Europe, where interesting health inequalities came up after the collapse of the communist rule. A striking finding is that the mortality of men has risen as compared to the female population.

New life-styles and new inequalities and differences have created new public health problems.

Public health programmes, resistance and outcomes

It is an ongoing discussion in public health circles to what extent "vertical" programmes, set up and aimed exclusively at one problem, are the most appropriate approach. An alternative method is the launching of "horizontal" programmes on a broader scale, e.g. through the strengthening of primary health care. Here, historical experiences may be useful:

Professor Marcos Cueto from University Cayetano Heredia in Peru had studied the malaria eradication campaigns which were set up as a vertical programme in Mexico from 1950. 42 million people from around 400 ethic groups had to be addressed. The question which might be shed light upon through a historical review, is to what extent the top-down administered "vertical" policy was likely to work.

The malaria campaign was met with different types of resistance. One of them was the cultural clash: In the minds of people, malaria was perceived as a disease of the peasants, a cultural stereotype which linked malaria with fatalism, apathy and poverty. Eradication campaigns were perceived as an attempt to "mexicanize" the indigenous population, and even as a campaign to counteract communism.

An anthropological critique was also heard: The campaign did not pay enough attention to the cultural dimension. There were different conceptions of malaria essentials like *body, fever,* and *blood*. Taking blood smears was feared to lead to weakness, sterility, and even proneness to suffer from the "evil eye". And perhaps blood samples were drawn to assess the health situation of the population before all were destroyed? Or before being sold to the Americans?

The campaign was also criticised from medical circles: A medical doctor argued that it did not take sufficient notice of migration patterns and housing conditions, which might have been an important point, but on the other hand he also denounced the use of DDT because it could kill hens, bees and domestic animals, and perhaps cause cancer.

Protests from local leaders and communities could consist of objections which in light of history were in favour of a "horizontal" approach: Poverty, hunger and other diseases should be given priority. But they also

Figure 2: The war that never ends: Children in the Baqaa refugee camp in Jordan after the 1967 Middle East war. (Photo: Dr. Ingegerd Frøyshov 1968)

had a quite specific objection: DDT contained bed-bug eggs, so that bed-bug eradication was requested!

Some similar questions were taken up by Professor Randall Packard, Director of the Institute for History of medicine at Johns Hopkins University. His lecture dealt with social determinants of health in Africa. In Africa also the cultural encounter between the colonial administrators and the native populations led to differences in health, health conditions and health behaviour which have been explained in various ways. Also for Africa, anthropologists have had valid arguments on the necessity of understanding African ways of life in order to implement effective public health measures. As an example was mentioned the structural determinants of AIDS, like the situation for women, labour migration, the relation between social capital and risk of infection, and the cultural meanings of sex and gender.

The discussant was Dr. Hernan Sandoval, President of the Chilean Corporación Chile Ambiente and former Chilean Ambassador to France.

Figure 3: Uruguay – a transit country for immigration to South America where public health measures against infant mortality for a long time did not work. The picture shows the main street in the small city of Colonia del Sacramento, Uruguay. (Photo Øivind Larsen 2006)

He drew attention to political arguments of importance in health campaigns: An example: Was DDT banned because it was *too cheap?*

He also stressed the importance of using a broad view on the consequences of environment for health: His first job in France after having fled Chile and Pinochet for political reasons had been to study the health impacts of the Gabon railway in Africa. At first sight a far fetched connection, at the second indeed not!

And social determinants are also close connected with social justice - a matter for the politicians!

The so-called Western world – a special case?

Dr. Elizabeth Fee from the United States National Library of Medicine pointed to some interesting issues in the history of social determinants and health inequalities in her country, among them that the phrase *health disparity* was the preferred metaphor because of its linguistic and political neutrality. The interest in studies of health determinants had varied. Depression studies experienced a heyday in the 1930's and a research memo-

randum on social aspects of health was published in 1937. But then wartime came and other interests took over, one had to wait for a new generation of researchers.

Professor Bernardino Fantini used malaria and the deserted Italian city of Ninfa as his point of origin, highlighting a series of factors acting when a disease interplays with a population, in this case the Mediterranean.

Northern Europe was covered by Professor Jan Sundin from Sweden. He swept over the centuries with a broad brush, yet in an instructive way, and showed e.g. how the population changes in the wake of the demographic transition led to growth of the group of landless people in the Swedish countryside, which in the larger perspective meant a general social slide downwards. In the period approximately delineated by 1820 and 1860 there was a "male mortality hump" in Sweden. Much of the surplus male mortality of that time could be ascribed to alcohol abuse.

The discussion following the introductory papers in this session dealt with matters like the impact of health on productivity, competition abilities etc., and also on the dependence of internal politics, as proved by the differences between the neighbouring countries of Spain and Portugal.

Professor Virginia Berridge from London School of Hygiene and Tropical medicine in this connection drew up an interesting story from her own country: The so-called Black Report on inequalities in health (1980) was written by a group of researchers who had been commissioned by the labour government, but the report was suppressed at the time of publication by the subsequent Margaret Thatcher regime. Paradoxically, this fact led to an extreme interest just for inequalities in health and the social determinants behind them, provoking attention and research in the field also in other countries!

In discussion, Sir Michael Marmot asked what could be learnt from the Nordic experiences. And should the WHO-commission only relate to national governments? What about other networks, commercial, or politicians who for the time being are out of power? An evidence based politics was wanted: Someone has to learn from history and make the first move! Here contacts with civil groups in society often may yield useful information. They may have other opinions about what evidence matters, but they often know the answers. Always asking for the best evidence may serve as an excuse for doing nothing!

The assessment of global history

In a session chaired by one of the organisers from UCL, Dr. Sanjoy Bhattacharya, Thomson Prentice from WHO presented the Global Health His-

tories initiative. The background of this WHO venture is the understanding that a command of health history helps response to today's challenges, may shape policies, meet needs and create opportunities and contribute to the sharing of knowledge.

Under this umbrella, a history of global health projects is under its way. The history of the WHO itself and its achievements is also to be produced, as well as a series of "public health classics", reprints of important papers which have made a difference in the development. Oral history, including interviews with leading persons will be an important method, as is a series of seminars by international health historians. A comprehensive website, connected to the general WHO-website, and a resource- and research centre will be visible proofs on what is going on.

Race, ethnicity, gender, and class – conflicts and consequences

Is social epidemiology a science? This was one of the provoking questions asked by Professor Stephen Kunitz (New York). His answer obviously was a "yes". With examples from societies with strong internal conflicts, as in Yugoslavia he proved that place and social status are often more important for health, e.g. measured as mortality, than class.

Dr. Kasturi Sen, Research Director at INTRAC (International NGO Training and Research Centre) in Oxford, addressed the social and health consequences of military conflict upon civilian populations by means of examples from very recent history. In general, she stated, clash of civilisations, as accentuated in the modern "war on terror", will lead to an immense impact on health for the groups which are exposed. Chronic conflicts give wide health problems, and as a rule the poor are hurt the most. Herself, she had been engaged in field work in the Middle East since the 1990's, also after the 2006 war in Lebanon. The general experience was that for the civilians, when the conflict ended, the war began! Large scale assaults destroyed cultural memory and identity with long standing effects. She pointed out that there exists only few studies on health consequences of modern war-fare of the Middle East type, especially from the developing world, and of the long-term impact of people being exposed to conflicts and having to rely on coping strategies. For many people the war never ends.

This situation should also be seen in light of the modern global economy with its concentration of wealth. In the wars, often the poor and those with a fragile agricultural economy are those who lose the most, such as recently in Lebanon, where the society also has confessional lines with inherent inequality and rich, trans-national groups living along with them.

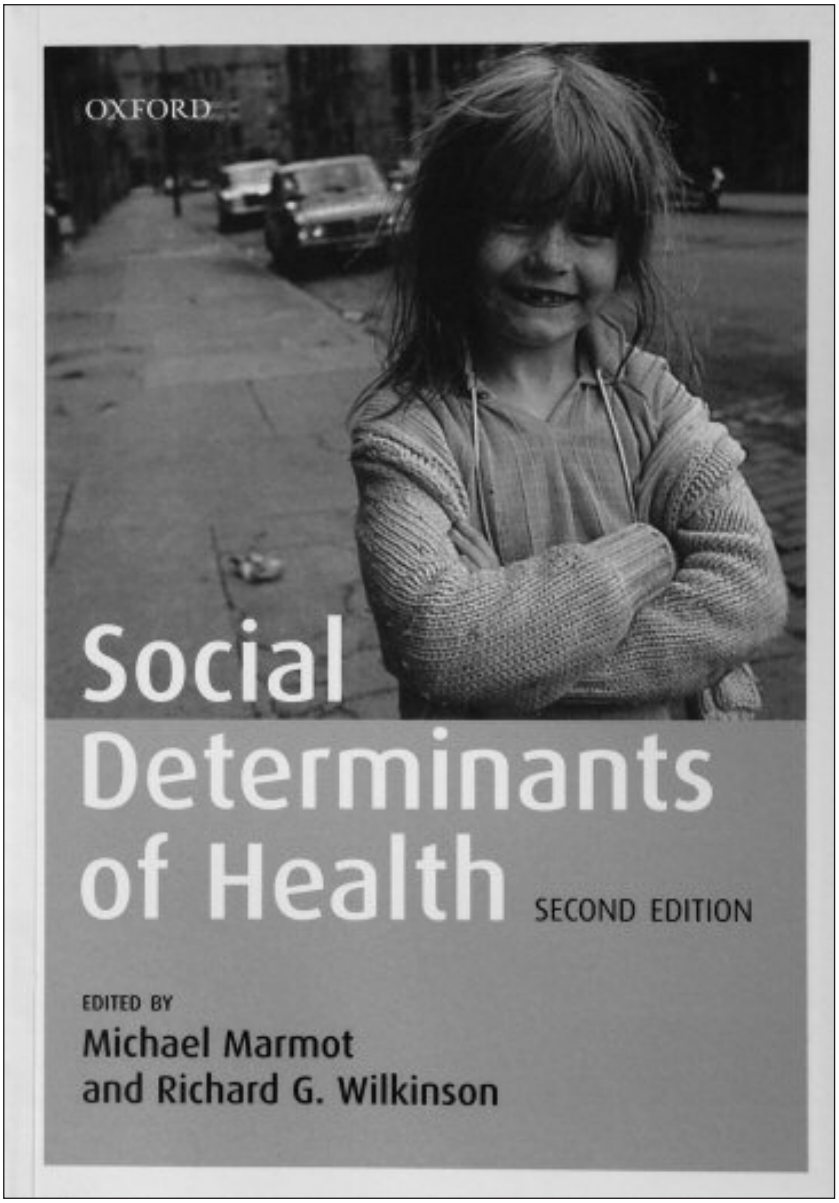

Figure 4: The second edition of a book which is a must for everyone interested in health and society: Marmot M, Wilkinson RG. Social Determinants of Health. Oxford, Oxford University Press, 2006.

Objects for study in suffering civilian populations are among others the psychological and social injuries, the delayed symptoms and the effects of absence of public health policies. Studies made twenty years after the 1980-1981 war in Lebanon e.g. revealed high levels of depression and coping mechanisms, which included a psychological reconstruction of the past, aimed at an understanding of "why". Restoration of social networks obviously is of primary significance for the rehabilitation.

However: As this knowledge is not new: It is scaring to realise that making the most vulnerable parts of a population suffer, gives an aggressor the most long-lasting military benefits and psychological benefits of his destructive activities – although probably not counted as a victory in terms of political reputation and acceptance.

No surprise that the discussions were heated after these presentations!

Do social policies work?

Professor Roderick Lawrence from the University of Geneva made the WHO Healthy Cities Project one of his key points. Here, social, spatial, and temporal dimensions revealed the combined effects of exposure in the urban environment. His lecture was based on his own studies and on broad literature on urban ecology, stressing the necessity for looking at the interplay of various effects, and also at the issue of perception: e.g. the concept of *density* as an objective one, in contrast to the subjective feel of *crowding*.

Dr. Anne-Emanuelle Birn (Toronto) left the audience with interesting open question when presenting her studies from Uruguay for the years 1890-1950. In spite of a series of public health efforts there was a long-time stagnation in the decline of infant mortality. Why?

Realising that health care is politics

Professor Patrice Bourdelais (Paris) went directly to the core of the problems of global public health when pointing to the fact that the needs of the population often seems to be better taken care of in representative democracies than in other types of societies. Looking back at the times of colonisation, he concluded that the first part of the period as a rule led to a deterioration of the general health situation. On the other hand, in the long run, some public health legacies from the colonial periods also could be favourable for the new and free countries. Of course this statement caused discussion and comments.

Professor Imrana Qadeer (Dehli) went through the economic development of modern India from different angles. E. g. for the large parts of the population belonging to the agricultural sector, modern growth was dys-

Figure 5: At the conference a number of "witness reports" was presented. In the foreground "Peptic Ulcer: Rise and Fall". (Photo: Øivind Larsen)

functional and caused problems for living conditions. Also the modernisation of health care in India tended to accentuate health differences. She was worried about politics, she concluded, and pointed out that there were lessons to learn which should be learnt.

Local history and practical work in public health

A general idea behind the whole conference was to extract important knowledge from the work by historians and use it in health planning. In his paper, Dr. Simon Szreter (Cambridge) showed how historical studies of the old British Poor Laws could highlight obvious human right problems of relevance today. Fiona Godlee, a medical doctor, editor of the British Medical Journal and herself with a background in medical history, presented refreshing links to the life and thinking of modern individuals. Margaret Thatcher left Britain with a divided society, Dr. Godlee pointed out. But how to handle this? Setting up guidelines on inequity? Equity as an outcome of intervention? Whom to target? And what about the issue of happiness and health?

The last sessions were mainly methodological and dealt with how to collect relevant historical information, and how to distribute it. The prominent issue was on "eliciting the past from the living". Dr. Tilli Tansey from the Wellcome Trust centre told about the witness seminar method, where key persons from various fields of medical development were invited to tell their stories. Up to now, 27 volumes of this type have been edited and published by Wellcome, but the same method is also used other places, so there are more publications available. Professor Tony Jefferson of Keele University then outlined his "free association, narrative and interview" method, which is presented in more detail in his book, written with Wendy Holway, *Doing Qualitative Research Differently*. This explores how to elicit "hidden" information from biographical narratives.

And professor Laurinda Abreu (Évora) presented the EU-financed Phoenix Thematic Network, which promotes conferences, publications and promising educational programmes.

A general conclusion: The important issue of social determinants of health seems to attract growing attention, not least because of the weight which nowadays is laid on the historical dimension. However, the crucial question is to what extent the increasing amount of knowledge can be converted into practical work.

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Thanks are due to Professor Anne Hardy, University College London, for reading and commenting on this manuscript.

Michael

1. *Michael* is a publication series of The Norwegian Medical Society (Det norske medicinske Selskab).

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Postal address:
Tidsskriftet *Michael*
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Annual subscription rate
NOK 500 (2021)

ISSN 1893-9651

Retur: Tidsskriftet *Michael*, Boks 1152 Sentrum, N-0107 OSLO

www.dnms.no