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A Preference for Doing Nothing or a Misplaced Focus on Men?

Problematic Starting Points for Early Twentieth-Century Public Health Reform in Cornwall

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Introduction

Historically there have been very few published studies on health in Cornwall. This dearth of secondary literature applies equally to assessments of the health of the population and to any evaluation of services provided by the statutory or voluntary sectors. The few authors who have addressed these important questions have been quick to draw attention to the limited primary sources addressing Cornish health topics.[1] This unfortunate situation may usefully be contrasted with the voluminous and readily accessible material for comparable areas such as Devon, Somerset, and Dorset. Even routine Cornish paperwork such as the Annual Reports of the Medical Officer of Health (MOH) are difficult to read locally, although London libraries have incomplete sets available.[2]

This lack of direct knowledge of Cornish health problems and health provisions has led to speculation about the alleged 'backwardness' of Cornwall rather than full discussion of any distinctive patterns in the demand for, as well as supply of, health care. Sheaff has started to correct this one-sided view of the problem,[3] but work in the field is still under-developed compared to extensive literature that has, for example, identified unique Cornish work cultures, community practices and migration patterns.[4] These factors all

undoubtedly had an impact on health, but full analysis of their respective influences is beyond the scope of this article. Instead, we simply suggest that in Cornwall certain long-standing concerns and traditions may have served to prioritize male health at a time when central government was turning its attention to the welfare of women and children.[5]

It was Deborah Dwork who first suggested that war is good for babies and other young children.[6] She demonstrated that specialist services were developed in response to the social, economic and political problems that were identified retrospectively after the Boer war and re-emphasized during the First World War. These services, formalized and encouraged by the 1918 Maternity and Child Welfare Act, became a major public health project for the new Ministry of Health after 1919. For some commentators, such as Jane Lewis, this was an unhelpful direction for the public health services to take,[7] but they certainly provided new criteria against which central government officials were increasingly keen to measure local performance. Cornwall, as a late and reluctant promoter of maternity and infant welfare services, looked increasingly weak in top–down assessments of health care, and this may have distorted views of the quality and quantity of inter-war provision.

Historians exploring the origins of the welfare state, and especially the campaign for a National Health Service,[8] have identified the interwar period as an important moment; at least in the negative sense of revealing the inadequacy of local arrangements and the need for fundamental reforms.[9] The years between 1919 and 1939 thus emerge as a period of conflict; where major debates about the powers and duties of the local and national state were conducted inside and outside of government and given particular urgency by the crisis created by the great depression.[10] The 1929 Local Government Act and the transfer of many Poor Law functions to local councils emerged as a defining moment in British welfare policy. Such a significant realignment of services also encouraged a new interest in the performance of the responsible local authorities, and section 104 of the Act empowered the Ministry of Health to conduct detailed public health surveys of all the county and county borough councils in England and Wales. These were duly undertaken by a team of inspectors who wrote a series of survey and re-survey reports in the 1930s.

The voluminous paperwork created represents a potentially useful source for uncovering what was going on in particular regions and some clues as to why certain developments were being encouraged or discouraged. For a territory like Cornwall, where other sources are limited, the survey report offers potentially unique insights into these questions. The Cornish services explored in this article do not provide a comprehensive overview of what was on offer, but the detail of provision helps to fill in some important gaps in existing knowledge and the critical edge provided by the Ministry inspection

draws the case study into wider debates about health and healthcare at this time. Analysis falls into four parts. First there is an attempt to assess the value of the survey as a source; since it has its limitations. Consideration is then given to the Cornish context outlined in the survey document, and this is followed by discussion about the services that featured in the report. In the final section the results of the survey are compared to other accounts of health and health services in Cornwall and attention is given to factors that the inspectors appear to have either overlooked or omitted when framing their comments.

The scope and limitations of the survey

The public health surveys conducted under section 104 of the 1929 Local Government Act served a variety of purposes for contemporary actors. This perhaps explains the cautious use that later historians have made of them. However, the surveys represent a potentially useful source of information, as their content can be as interesting and illuminating as attempts to uncover the motivation for compiling them, and the hidden central government agendas they might reveal. Levene, Powell and Stewart note the need for care with the surveys, but their work on hospital provision develops an interesting comparative analysis of services in different areas based on the detailed information contained in the reports.[11] This approach works well because the statistical evidence presented in the surveys was checked and rechecked by several different people against local knowledge, statistical information and reports periodically returned to the Ministry of Health and the results of previous central government inspections. Whatever bias there may in accompanying commentary, the statistics themselves may be taken to be fairly robust. If a survey report says there was a fifty-bed local voluntary hospital with an occupancy rate of eighty percent on the date of inspection this can be accepted as correct, and any breakdown of patients by age, sex or condition should also be understood to be accurate. This is important for an area such as Cornwall, where such information may not otherwise be readily available due to the paucity of surviving local sources.

One of the agendas that lay behind the survey exercise was an attempt to assess local services against national criteria determined by the Ministry of Health. The comparative approach adopted, with councils explicitly assessed against similar local authorities as well as national averages, was apparently designed to reveal differences and encourage standardization with preferred Ministry of Health schemes.[12] Local actors appear to have found the inspection regime intrusive, but in most cases not without value. The survey exercise provided a useful opportunity to make a detailed local assessment of

what was wanted and required in terms of future public health services. This enabled interested actors to make new demands on the Ministry and/or gain the support of Ministry of Health officials in local battles over the future direction of, and funding for, different services.[13]

The modern mixed economy of care in health is closely associated with ideas about the value of local autonomy and the importance of imposing national targets and benchmarks to raise standards across the board.[14] Supporters of this approach point to the benefits of sharing best practice and identifying and remedying weaknesses, while detractors oppose the burden of inspection and point to the distorting effects of artificial targets. It was ever thus, but inspection regimes which generate data for national league tables provide a valuable historical source, despite their well known limitations. Some of the survey data has certainly been put to good use, with Peretz using the Oxford and Oxfordshire data to develop a comparative analysis of infant welfare services. The data presented are supplemented by quotations from the accompanying commentary to highlight the limitations of what was offered; Peretz sharing the Ministry view that such prosperous areas could and should have been doing more to help poor women and their children.[15]

Comparative analysis at a regional level along the lines developed by Peretz is still quite rare in historical assessments of health services. While local variations in the quality and quantity of provision are a recurrent theme in any study of health care, and have special resonance in work that looks at the emergence of the National Health Service [NHS], the way the historiography is organized can lead to somewhat unhelpful generalizations. Thus a particular council may be identified as 'progressive', or not, or it is acknowledged that across the country some groups (e.g. children) or services (such as acute care) received more resources than what became known in the NHS era as the Cinderella services (for the elderly, chronic sick and disabled and the mentally ill). These conclusions are important, but there are other points that may be illuminating. Thus a 'progressive' council may have gained such a reputation for significant innovation in a limited number of fields, and it is helpful to understand what was being neglected and why.[16] Likewise an apparently 'backward' area may have offered some services that met or even exceeded national standards, or simply imaginatively coped with unusual circumstances in a way that other disadvantaged regions could benefit from adopting even if the level of service achieved was only average.

The Cornish context

The surveying team from the Ministry of Health explicitly identified Cornwall as a 'backward' area, and one that faced unusual problems. Contemporary

commentators in the 1930s were heavily influenced by this view even before beginning their investigations. The Ministry of Health had long been frustrated by the apparent determination of Cornwall County Council to do as little as possible in the field of public health. When Dr Allan C. Parsons comprehensively surveyed the administrative county in 1931 he was angered that progress had been even slower than previously suspected.[17] His criticism was particularly damning as it drew on his own comparative assessments of public health services in neighbouring counties, such as Devon and Somerset, which faced problems not totally dissimilar to those in Cornwall.[18]

The inspection team led by Parsons was, however, prepared to consider Cornwall as a special case suffering under unusual disadvantages. Adverse factors identified in the survey report included remoteness from London and geographical features that 'unhelpfully' dispersed the population and made transport and communications difficult.[19] This was, it was considered, a problem compounded by the complexity of local administration in a county structure that had no towns of county borough status but maintained twelve non-county boroughs, sixteen urban districts, fourteen rural districts and 227 civil parishes.[20] Population decline (from 328,098 in 1911 to 317,951 in 1931) was linked in the report to major difficulties experienced by all the major local industries (mining, agriculture and fishing) and identified as a problem in its own right.[21] Although the number of people receiving indoor and outdoor relief in 1930 was not viewed as excessive, unemployment was above average compared to rural parts of England and Cornwall as a whole was regarded as 'poor'.[22] This limited the amount that could be raised by the rates, which inhibited any public health schemes that the county council might seek to instigate.

The survey report makes it clear, however, that Parsons and his team were not very impressed by the Cornwall County Council, or its public health record. Although economic difficulties were understood to restrain progress, Parsons also identified a worrying preference for other forms of public expenditure. Highways and schools accounted for unusually large proportions of the available budget and council borrowings.[23] Parsons thought it doubtful 'whether the health department gets its fair share', and used the low salary offered to the Cornwall Medical Officer of Health [MOH] to support this conclusion.[24] He returned to this theme later in the report, arguing that the low salary of the MOH reduced his status among the council's senior officers and restricted his ability to represent his department's interests.[25] This was a problem made worse by the lack of prestige attached to service on the council's public health and housing committee.

The main criticism of the health department, and by implication the responsible committee, fell into two main areas. First, there was evidence that Cornish vital statistics were deteriorating as other areas of Britain made

greater inroads into key death rates. Cornwall had a lower than average birth rate, and the crude death rate had showed no decline over the 1920s. Maternal mortality rates and deaths from tuberculosis, cancer and heart disease were consistently above the average for English counties.[26] Parsons found no evidence of official concern in Cornwall about this; instead it appeared that other indicators (lower than average infant mortality and deaths from infectious disease other than enteric fever) were encouraging complacency. There was also recourse to an argument that insisted that population trends (a rapid ageing of the population as young adults left in search of work) were to blame. Parsons expressed some sympathy with this view, noting 'to some extent ... Cornwall is a county for the retirement of elderly people', but drew a direct correlation between the high maternal mortality rate and the unsatisfactory state of Cornish maternity and child welfare services, and linked excessive deaths from enteric fever to inadequate sanitation .[27]

Secondly, the poor state of local services was a consistent theme in Parsons' report. He blamed a serious lack of ambition among the officials and councillors who did not seem to grasp the importance of public health improvement or appreciate the need for urgent reform. The public health and housing committee was tasked with a number of duties under various pieces of legislation and maintained three sub-committees to deal with blind persons, maternity and child welfare and tuberculosis.[28] Parsons thought that this committee took a minimalist approach to its work, inappropriately delegating responsibilities to the other local authorities in Cornwall or ignoring them altogether.[29] The committee tended not to attract the more ambitious councillors, and had to share responsibilities for health services with other (more powerful) committees.[30]

This fragmentation of responsibilities for medical and health services (shared and split with the education, public assistance, mental hospital and mental deficiency committees) could have been less damaging if the officials in the health department had been able to adopt an effective coordinating role. Parsons was, however, unimpressed by the quantity and quality of the available personnel and their performance. The department was badly understaffed, even compared to neighbouring rural counties not known for lavish public health provision, but for Parsons this was made more serious by the way the department was organized which reduced flexibility to a minimum.[31] This made pre-war staffing levels even less effective in the interwar period as the school medical work was bolstered at the expense of other services.

Another major problem was the poor qualifications of the medical staff employed, which Parsons linked to the low salary policy in Cornwall. The whole-time medical staff of seven included four school medical officers, two of them female, none of whom had public health qualifications. They did the

school medical inspections but this left important areas of work uncovered as, apart from Dr Clarke the county MOH whose job was largely administrative, the other staff concentrated exclusively on tuberculosis. Part-time medical officers covered venereal disease and orthopaedics, to a degree, but there was no special provision for routine maternity and child welfare work or mental health.

These tasks were, in a limited way, delegated to a team of health visitors who conducted domiciliary visiting (for the school, maternity and child welfare, and tuberculosis services and under the Children Act), and did a certain amount of clinic work under the tuberculosis scheme. With just eight full-time and two part-time health visitors the service they could offer a population of more than 300,000 was obviously limited. Apart from a separate school dental department (employing two dentists and two dental nurses) there was just an orthopaedic sister. Parsons noted, with more than a hint of irritation, that there were no 'municipal nurses and no sanitary inspectors'.[32] The clerical staff of six clerks also seemed inadequate to Parsons, especially when he noted in other parts of his report that some of the clerks and even caretakers undertook clinical duties to keep essential services going. Parsons made a strong case for appointing more staff, and then re-organizing the staffing system. He used Dorset as a possible model that made economic use of limited resources in a predominantly rural area.[33] The point was to get staff out of the office and into the field where they could achieve more themselves and also encourage other actors in the statutory and voluntary sectors to be more visible and dynamic.

Parsons was concerned that a 'spirit of defeatism' infected the health department in Cornwall.[34] Key officials seemed ill at ease and disinclined to put forward any schemes that cost money. One suggested that the only way forward was to combine with Devon to develop public health provision. Parsons was infuriated, not least because of his own reservations about the state of public health administration in Devon, and the detailed remarks he makes about different services he inspected do reflect his obvious frustration.[35] Yet while Parsons found much that concerned him there was also evidence of some good practice, or at least better-than-expected services being offered in near-impossible circumstances. Specialist provision for women and children in Cornwall was undeniably weak but in other areas of provision the picture was not universally so gloomy. This is an important point to consider today, when it is noteworthy that ongoing difficulties with the provision of health care in Cornwall continue to be blamed on a shortage of resources and a lack of understanding of the special needs of Cornwall within a centralized and relatively monolithic NHS.[36] The detailed picture that emerges from the case studies below is that in the past local control imparted strengths and weaknesses. Under this model there was potential for innovation and flexible working but localism also created its own difficulties in terms of organization and finance.

The services

The first service dealt with in the voluminous Cornwall survey report was mental welfare.[37] Parsons noted that mental health and mental deficiency were only of limited concern to his work, and further made it plain that as a non-expert in these subjects he was reliant on reports from the Board of Control and offering something of a layman's opinion. This is interesting, because although there were concerns about some aspects of provision Parsons also found much that was praiseworthy. The 'county asylum' at Bodmin appeared to be running smoothly and patients detained at various public assistance institutions under the Lunacy Act appeared to be housed appropriately.

The council had no dedicated accommodation for mental deficiency cases and a recent plan to purchase a mansion for this purpose had come to nothing. While Parsons identified a need to provide more accommodation he was impressed by the quality of care offered at local workhouses, which were increasingly being used as specialist centres in Cornwall. Parsons recorded; 'I thought that the circumstances of the mental defectives in the institutions at Bodmin, St Columb and Falmouth were very satisfactory and the quarters for imbeciles at St Austell were very good'.[38]

The survey report advocated protecting and expanding these services, making the case that they were effectively meeting client needs: 'I was impressed, too, not only by the cheerfulness of the men [patients] I saw at work but by their keenness and application. There seems to be a good tradition behind this side of the work at the Falmouth institution and as far as I could judge the accommodation was suitable.'[39]

At the Bodmin institution there were also positive signs: 'For the men there is plenty of scope for exercise and occupation in the garden and in the care of pigs and poultry; the women are healthily and usefully employed in household duties and laundry work; their yard is not particularly attractive but the adjoining children's yard which is asphalted is generally available.'[40] The conclusion appeared to be that, with limited further investment, these facilities could provide the core of a very effective service that would negate the need for costly specialist provision. This was good for county council finances, but also good for patients involved, as the alternative scheme preferred by the Board of Control was for Cornwall to invest in the Starcross asylum in Devon – which would require Cornish patients to be sent a long distance from their families and communities.[41]

The idea that ingenuity and goodwill could overcome distinctly Cornish problems and actually meet the real (rather than assumed) needs of the people of Cornwall is a definite theme in Parsons' analysis. The tuberculosis scheme offers a good example of his thinking on these points. The scheme shared the common Cornish problem of being severely understaffed, with just one clinical tuberculosis officer, but Parsons thought Dr Day seemed competent and committed.[42] He was dealing with a large case load but was getting appropriate referrals from other medical practitioners and was running four dispensaries and a clinic (at Tuckingmill, Truro, Penzance, St Austell and Liskeard) successfully.[43] Dr Day was imaginatively using domiciliary visits as an alternative to dispensaries in sparsely populated areas and was credited with organizing the health visitors into a particularly effective team of tuberculosis visitors.

Community care for tuberculosis patients, and suspected cases, was assessed by Parsons to be generally good and improving, with a tentative correlation drawn to declining numbers of diagnoses and deaths. Institutional care under the tuberculosis scheme was also viewed as surprisingly good, although meeting Cornish needs and circumstances rather than an ideal model. In an area where the council maintained minimal institutional provision the Tehidy sanatorium was somewhat unusual. Its origins lay in voluntary sector effort, being the gift of the Cornish War Memorial Committee, but it was well managed by the council.[44] Parsons thought the resident medical officer, Dr Chown, had admirable personal qualities as well as professional qualifications, and his own prior history as a tuberculosis sufferer encouraged a good relationship with patients.

The Tehidy institution had originally been planned as a proper sanatorium but to meet local needs had been adapted to also serve as an observation centre, a treatment facility for advanced cases and what might be termed a hospice for terminal cases. Parsons feared this mixing might depress patients, reporting that while Chown thought patients were philosophical about the inevitable deaths, an un-named health visitor believed the work was hindered by a perception that 'to go to Tehidy was to die'.[45] Nonetheless, Parsons was impressed by the facilities on offer and the support the institution enjoyed from the local medical community. Parsons also thought provision was generous; certainly Tehidy provided more beds than the Astor scale suggested Cornwall needed.[46] The institution also supported other schemes by doing all the dispensary x-rays (with the help of a clerk) and offering artificial light treatment to patients suffering from a variety of illnesses. There were aspects of the tuberculosis scheme that Parsons thought would benefit from development but generally things were 'sufficient for the present'.[47]

One point that Parsons did find remarkable was the lack of voluntary after-care committees in Cornwall. He mentioned to staff that Somerset had

a comprehensive scheme involving twenty such groups but there seemed no enthusiasm for such work in Cornwall, amongst the officials or the public. Dr Clarke, the MOH, was reported to be 'of opinion that such voluntary care associations do not flourish on Cornish soil where any movement associated with the collecting of money is ill-regarded. He is inclined to think that they are not really necessary.'[48]

Local factors also featured strongly in Parsons' assessment of the scheme for venereal disease, although this service combined a county council clinic with recourse to the larger in and out patient facilities available to Cornish patients in Plymouth. The clinics at the South Devon and East Cornwall Hospital were staffed by the Plymouth health department and the costs were shared with Cornwall and Devon. The separate Cornwall clinic was somewhat unusual, and so Parsons described it in some detail.[49] The clinic was based in an adapted private house at Tuckingmill that also served as a tuberculosis dispensary. Rooms in the house were also allocated to in-patient care for patients suffering from venereal disease and certain maternity cases.

The Ministry of Health had approved the arrangements in 1928 and 1929 but Parsons was keen to see how they operated in practice. He praised the location of the property, which was sufficiently private to encourage use but was also easily accessible from the most populous parts of Cornwall. Parsons was concerned that the lease was due to expire and made a strong case for extending it. Inside the house, however, Parsons found less to be pleased about. Staffing the clinic was difficult, as the local health visitor refused to live in. She had officially complained about the accommodation but may have been unwilling to take responsibility for the wards as the resident nurse. Parsons found a rather unsatisfactory arrangement where the county VD officer attended some clinic sessions but intermediate out-patient treatment was offered to men by the caretaker and to women by the health visitor. The wards were not really used for treatment but simply accommodated patients who were unable to attend as outpatients. This made Parsons wonder what would happen if the maternity beds were in use. He noted that so far no such cases had been admitted, and the health visitor explained that she thought no woman would consent to being treated in a known VD centre in any circumstances. Parsons tended to agree, but dwelt on the benefits of a unified centre where some good work was being done despite necessary economies that gave the equipment a 'Heath Robinson' appearance.[50] Parsons praised the work of Dr Rivers, the part-time medical officer and local GP, noting the training he had given to the clinic staff and the good liaison work done with other statutory and voluntary sector organizations.

The schemes for venereal disease and tuberculosis were not without problems but they were fairly long established and were attracting a growing number of patients. The Cornish orthopaedic scheme was, however, relatively

new and Parsons was keen to investigate its key features.[51] In this case, unlike the VD service, the Royal Cornwall Infirmary was central to the scheme, though a number of other clinics also operated alongside arrangements for in-patient care and domiciliary visiting. Patients were referred from the maternity and child welfare, school and other services, though oddly the tuberculosis scheme was organized separately and Parsons thought this tended to reduce the effectiveness of the orthopaedic work. This was also hampered by transport difficulties that made it difficult for patients in some parts of Cornwall to attend clinics and a general shortage of treatment facilities. Parsons, who was keen to avoid wasteful duplication of effort, tied the future of the Cornish scheme to the development of a new orthopaedic hospital in Plymouth but despite his critical remarks it seems that there was quite a bit of enthusiasm for the work, including voluntary sector support, and the scheme had developed significantly during its short period of operation.

Following quite lengthy discussions of the different services that were offered by Cornwall, Parsons turned his attention to the obvious gaps in provision. While the inspection team had found much to commend in the foregoing analysis, and certainly did not find the limitations of the Cornish schemes unique, there is a sense that it could not quite believe that Cornwall County Council was neglecting certain key areas. Parsons noted that Cornwall completed significantly lower than average amounts of sampling work, with the implication that the population was left dangerously exposed to the sale of unfit and/or adulterated food supplies and contaminated milk. Since these problems went largely un-investigated it was impossible to even begin to gauge the extent of the problem in Cornwall; a situation made more problematic by a lack of laboratory facilities and reliance on a London-based expert for analysis.[52]

Health topics that were attracting national attention, and even seemed to affect the Cornish population disproportionately, received virtually no attention from the county council. There was no particular effort to educate the local population about cancer prevention despite above average death rates and a series of Ministry of Health circulars on the subject.[53] Local voluntary hospitals were not averse to offering cancer treatments but without any clear leadership from the council were waiting on developments in Devon (including Exeter and Plymouth), where cancer services were recognized as a priority. This reliance on other centres certainly reduced the infrastructure for cancer care in Cornwall. Parsons acknowledged that this was a threat to Cornish pride but considered that local patients did not necessarily suffer as both the health and public assistance committees had well-tried arrangements to send Cornish cases to regional and even national cancer facilities.

One area that Parsons was keen to develop was health propaganda. He was very surprised that the health department made no special effort in this regard. In Somerset a vigorous outreach campaign, led by a full-time woman health propaganda officer, was understood to be usefully filling in the inevitable gaps in a scattered rural service. Yet in Cornwall even the clinics were devoid of the usual posters and leaflets routinely displayed elsewhere. Parsons credited individual health visitors with developing a role 'as missionaries in the cause of better health' but thought instruction in the clinics could be established on a more systematic basis and extended to wider health initiatives.[54]

For Parsons, a particularly disappointing aspect of the Cornwall County Council's work was the limited response made to the opportunities presented by the 1929 Local Government Act. A few tasks, such as infant life protection work, had been allocated to the health visitors but there was no plan to make immediate or comprehensive changes. The only declaration made by the council on the provision of relief other than by means of the Poor Law, expressed the hope of doing something 'as soon as circumstances permit'.[55] This was a very conservative response, as other local authorities not only committed to definite dates but made considerable progress towards achieving them. Cornwall had reorganized its twelve Poor Law unions into five guardian committee areas but despite unusually cordial relations between the MOH and the public assistance committee, virtually nothing had been done about transferring poor law medical facilities to the control of the health committee.

The County Council had inherited 13 workhouses and 11 children's homes from the guardians.[56] Three of the former were made available to the mental deficiency committee but no other plans had materialized. Parsons thought the 512 available sick beds were probably more than was required (216 being empty at the time of inspection) but the scattered population made it difficult to concentrate provision in fewer centres and none of the institutions approximated 'a thoroughly modern hospital'.[57] Parsons thought there was potential to develop the facilities at St Austell, which uniquely had an operating theatre, albeit an unsatisfactory one, and Liskeard and Redruth where maternity provision was rated as 'fair'.[58]

The situation was perhaps not as bad as Parsons suggests. In fact, he himself noted that the beds in the public assistance infirmaries were particularly suitable for the elderly and chronic patients who at the time of the survey slept in them at night but vacated them during the day. What the county council lacked, however, and was not going to acquire from the former workhouses, was comprehensive provision for its maternity cases, surgical patients and cases of infectious disease. Two possibilities existed. Cornwall would either have to develop its own hospital facilities or enter into negotiations with local voluntary hospitals to see what they could provide and how they might best co-ordinate with council services. Parsons was concerned

to find that neither option was being properly considered let alone taken up, although pre-existing schemes with the Royal Cornwall Infirmary and the West Cornwall Miners' and Women's Hospital were continuing.[59]

On the other hand, arrangements with the County Nursing Association were working well with all but fifteen parishes covered by an affiliated or unaffiliated district nursing association.[60] The county council made grants totalling £2,794 in 1929 to support the work, with dedicated funds made available for school nursing as well as health visits. The council also made a training budget available for midwives. This concern with midwifery in Cornwall was in marked contrast to the general neglect of infant welfare. Parsons noted that the council made no grants to any of the eighteen voluntary sector clinics and as a result the county medical officer 'exercises no supervision over ... [their] organisation or work'.[61] This was part of a wider and worrying trend that Parsons identified operating in Cornwall: 'There is a good deal of dependence in Cornwall upon voluntary assistance in health work, but there is not always as much coordination and cooperation on the part of the council as one might expect. The virtual independence of the voluntary committees conducting infant welfare centres may be noted as an example'.[62]

Parsons returned to these themes in his concluding remarks and attributed the problem, and other deficiencies that he had discussed, to the inadequate staffing arrangements he had already identified, a shortcoming that exacerbated the unique disadvantages Cornwall was understood to suffer from. He further argued:

> Essentially, I think, the poor progress, for which Cornwall has long been notorious in this department [of the Ministry of Health], is due not so much to the natural circumstances of the county but in great measure to human causes. Chief among these causes is the fact that in those responsible for carrying out local government, as well as those they represent, the public health conscience is undeveloped.[63]

Discussion

In the background to his survey Parsons rehearses some familiar arguments that help explain why the Ministry expected to find problems in Cornwall. He mentioned the 'adverse' geographical features that dispersed the population, making it impossible to provide centralized services. It was generally accepted in public health circles that rural provision would always be more expensive and less comprehensive, simply on the grounds of distance and population

density.[64] Yet Parsons was quick to state that other predominantly rural counties still managed to significantly outperform Cornwall in terms of the quantity and quality of services provided.

This led Parsons to develop an economic argument. He drew particular attention to significant problems in all the major industries, noting the ongoing decline of mining, and short-term difficulties in both agriculture and fishing. Cornwall was experiencing particularly severe social and economic problems in the 1930s but had limited resources to address them. Yet this difficulty was itself understood to be symptomatic of an historical resistance to investing in services, even when economic conditions were better. Parsons concluded that where agricultural interests dominated the local political landscape, as they did in Cornwall, there would always be a reluctance to spend money and a lack of appreciation of the long term health and wealth benefits derived from investment in public services.

This was also a factor in Devon, as Parsons had clearly noted in his Devonshire Survey, but there were other factors that applied to an unusual extent in Cornwall.[65] The problems of migration were emphasized in the Cornish case, with Parsons noting the exodus of both skilled miners and young people. These phenomena were linked in the survey to economic dislocations but were also correlated with the 'isolation' of Cornwall and the apparent desire of people to move away to be closer to the centre of affairs. Distance from London was singled out by Parsons as a factor explaining both a local lack of interest in new developments in public health and an inability to attract the services of the more ambitious public health officials.

The emphasis placed on the damaging lack of leadership offered by key officials and councillors is explained by the orientation of the Ministry of Health inspectors and the political and professional agendas that underpinned the whole survey exercise. What Parsons may have missed in his top-down analysis of Cornwall's public health problems were the alternative traditions of independence and self-help, strongly embedded in local work cultures, that Sheaff, among others, has argued gave rise to distinctive patterns of demand for, as well as supply of, Cornish health services.

While Parsons was critical of the standards achieved overall, the lack of imagination shown in grappling with problems encountered, a tendency to evade responsibility, and a general lack of enthusiasm (on the part of service-users as well as service-providers) for the type of public health work that was being institutionalized elsewhere, he nonetheless found some beacons of excellence and some areas of special concern. The main weaknesses were found in the field of maternity and child welfare services, where a qualitative assessment of apparent shortcomings was backed by a comparative analysis of statistics that suggested that Cornwall should have been doing better. There were four areas where Parsons identified much better performance.

One of these, mental welfare, was somewhat anomalous and at the periphery of Parsons' concerns but the other three deserve further consideration. The services that Parsons identified as having the most potential, as well as achieving the highest level of current performance were the schemes addressing tuberculosis, venereal disease and orthopaedics.

In the survey report Parsons drew a close correlation between the success of the first three schemes and the personal commitment and professional expertise of their responsible medical officers. This was in marked contrast to his analysis of the failures of the infant welfare and other schemes which were attributed to weaknesses in organization and management; problems blamed on a lack of local interest as much as a lack of local resources. The different schemes were discussed in more detail above, but while we might agree with Parsons that some of the successes were due to individual officers doing excellent work in challenging circumstances, and some of the failures began and ended in the woefully mismanaged health department, there are other factors to consider.

What Parsons, who was tasked with examining responses to the 1929 Local Government Act, would have missed was the historical importance of occupational rather than public health in developing Cornish services. An area dominated by mining industries needed its health services to be able to respond to the distinctive medical problems faced by miners.[66] The emergence of support for tuberculosis and orthopaedic schemes probably went beyond the personal interventions of the medical officers singled out for praise by Parsons to a long-standing requirement to make some provision for chest conditions and the repair of bone and joint injuries. In a similar way the migration, and return, of the male miners provided an obvious risk of the importation of infectious disease. The perceived risks of imported infection within distinct migrating communities (sailors as well as miners) provide a better context for understanding the commitment made to developing venereal disease surveillance and treatment services.

The vital though often over-looked connection to work, and also work cultures, also helps to explain other policy developments and the identification of specific health problems as urgent priorities. Although the Ministry of Health was enamoured with a theory of 'backwardness', a preoccupation that helps to explain the unenthusiastic reception its preferred models of public health reform received in the 1930s, a dialogue between local elites and other parts of Whitehall had previously served to advance health agendas and make Cornwall a national focus of concern and innovation. To take just one unusual example, the campaign to control debilitating hookworm infection amongst the miners in the late nineteenth and early twentieth centuries drew on, and served to re-enforce, many of the late-Victorian and Edwardian pre-occupations with national efficiency and racial deterioration, concerns that

other historians have placed at the centre of movements to improve maternity and child welfare.[67] In Cornwall these services for women and children were noticeably under-developed, in both the statutory and voluntary sectors. It may be argued that the concern with underground labour had led to a situation where the attention and interests of health reformers were fixed on men and not women or children.[68] Even at the mines, their gendered work-place health concerns were traditionally marginalized, and problematically misrepresented in the few sources that examine the health of the Cornish bal maidens.[69] The emphasis on work and working conditions arguably had the further damaging effect of linking the health of the community to the state of its main industry, which allowed the terminal decline of the latter to overshadow attempts to promote the former. A situation further complicated by the fact the institutional memory of the sustained effort to promote mine, and thereby community and public, health was located within the Home Office through the records of the Mines Inspectorate, and not within the Ministry of Health.

Conclusion

Many of the above points remain speculative as available sources do not allow for their full evaluation. However, they provide a counterpoint to the sometimes unduly critical analysis of personal failings and local difficulties that can be found in the 1931 Cornish public health survey. None of the surveys (and each county council and county borough council in England was surveyed) was written from an entirely objective perspective, and collectively they say as much about the pre-occupations of Ministry of Health officials as they do about the quality of local health services. Yet the Cornish survey is an important one, not least because it offers a uniquely detailed external assessment and critique of services that are not easy to study because of the limited range of primary and secondary sources available.[70] Significantly, some of the themes identified and comments made by Parsons and discussed in this article also continue to have resonance with current debates about the future of health care in Cornwall.

Notes and references

1. See for example R. Sheaff, 'A Century of Centralization: Cornish Health and Healthcare', in P. Payton (ed.), *Cornish Studies: Four* (Exeter,1996) pp. 128–46.
2. The Wellcome Library catalogue lists available reports and gives a brief background to the evolution of public health authorities in the county. The series of County

Medical Officer of Health reports held in the Cornwall County Records Office begins in 1926.

3. Sheaff, 'A Century of Centralization'.
4. For example see G. Burke, 'The Cornish Diaspora of the Nineteenth Century', in S. Marks and P. Richardson (eds), *International Labour Migration: Historical Perspectives* (London, 1984), pp. 57–73; J. Rule, 'A Configuration of Quietism: Attitudes Towards Trade Unionism and Chartism Amongst Cornish Miners', *Tijdschrift Voor Sociale Geschiedenis*, xviii, 2/3 (1992), pp. 248–62; J. Rule, 'A Risky Business, Death, Injury and Religion in Cornish Mining 1780–1870', in B. Knapp, V. Pigott and E. Herbert (eds), *Social Approaches to an Industrial Past, The Archaeology and Anthropology of Mining* (London 1998), pp. 155–73; C. Mills, A Hazardous Bargain: Occupational Risk in Cornish Mining 1875–1914', *Labour History Review*, 70, 1 (2005), pp. 53–71, R. Burt, 'Industrial Relations in the British Non-ferrous Mining Industry in the Nineteenth Century', *Labour History Review*, 70, 1 (2006), pp. 57–79; S. Swartz, 'Bridging "The Great Divide": The Evolution and Impact of Cornish Translocation in Britain and the USA', *Journal of American Ethnic History*, 25 (2006) and S. Schwartz and B. Deacon, 'Cornish Identities and migration: A Multi Scalar Approach', *Global Networks: A Journal of Transnational Affairs*, 7, 3 (2007), pp. 289–306.
5. Recent work by Lara Marks confirms the centrality of maternity and child welfare services in the development of municipal medicine and state welfare. L. Marks, *Metropolitan Maternity: Maternal and Infant Welfare Services in Early Twentieth Century London* (Amsterdam, 1996). In a comparative study of urban environments Marjaana Niemi argues tuberculosis services could serve similar agendas, that embraced patient care but also extended to policing the community and reinforcing social norms relating to work, gender roles and family life. M. Niemi, *Public Health and Municipal Policy Making: Britain and Sweden, 1900–1940* (Aldershot, 2007), pp. 1–24.
6. D. Dwork, *War is Good for Babies and Other Young Children: A History of the Infant and Child Welfare Movement in England 1898–1918* (London, 1987).
7. J. Lewis, *What Price Community Medicine? The Philosophy, Practice and Politics of Public Health Since 1919* (Brighton, 1986).
8. B. Harris, *The Origins of the British Welfare State: Social Welfare in England and Wales, 1800–1945* (Basingstoke, 2004).
9. C. Webster, *The Health Services Since the War. Volume 1. Problems of Health Care. The National Health Service before 1957* (London, 1988).
10. This point has been explored with relation to health policies, but a new dimension to the debate is added by A. Digby, 'Changing Welfare Cultures in Region and State', *Twentieth-Century British History*, 17, 3 (2006), pp. 297–322.
11. A. Levene, M. Powell and J. Stewart, 'The Development of Municipal General Hospitals in English County Boroughs in the 1930s', *Medical History*, 50, 1 (2006), pp. 2–28, pp. 5–6.
12. This agenda could serve to accelerate or retard the adoption of particular schemes. Niemi sees central government opposition to BCG vaccinations as a major reason why they were not adopted by progressive local authorities in Britain. Niemi, *Public Health*, p. 145.
13. Ministry of Health inspectors explicitly used the survey report for Halifax to help the MOH there resolve a long-standing dispute about the allocation of duties between the health and education departments and in the West Riding of Yorkshire there was an attempt to use the report to bolster the position of a newly appointed MOH who was struggling to assert his preferred model of institutional care. National Archives (hereafter NA), MH 66/1071, paragraphs 91–104 and 527–41; NA, MH 66/289 West Riding of Yorkshire Public Health Survey, Dr C.J. Donelan, 1933, paragraphs 794–8.
14. Saving Lives: Our Healthier Nation Department of Health, British Parliamentary Papers, July 1999, (Cm 4386).
15. E. Peretz, 'Infant Welfare in Inter-War Oxford', *International History of Nursing Journal*, 1 (1995–96), pp. 5–18.
16. International comparisons are also illuminating, See Niemi, *Public Health* for detailed comparative study of Birmingham and Gothenburg.
17. NA, MH66/30, Administrative County of Cornwall, Report on a Survey of Health Services (hereafter Cornwall Survey) by A.C. Parsons. (Survey conducted 25 September to 15 October 1931).
18. See for example Cornwall Survey, p. 13.
19. Cornwall Survey, p. 2.
20. Cornwall Survey, p. 4.
21. Cornwall Survey, p. 2 and p. 6.
22. Cornwall Survey, pp. 3–4 and p. 6.
23. Cornwall Survey, p. 6 and pp. 90–1.
24. Cornwall Survey, pp. 6–7.
25. Cornwall Survey, pp. 13–16.
26. Cornwall Survey, p. 8.
27. Cornwall Survey, p. 9.
28. Cornwall Survey, p. 10.
29. Parsons found it odd the public health and housing committee did nothing under the Housing (Rural Workers) Act, 1926 and was not swayed by their arguments for this inactivity. Cornwall Survey, p. 22.
30. This was by no means unique to Cornwall and has been used by many authors to explain how service on the less popular committees like health allowed elected and co-opted women to gain footholds in local government.
31. Cornwall Survey, pp. 13–14.
32. Cornwall Survey, p. 12.
33. Cornwall Survey, pp. 15–16.
34. Cornwall Survey, pp. 16–17.
35. NA, MH 66/58, Administrative County of Devon, Survey Report (hereafter Devon Survey) by Allan C Parsons, January–February 1931, p. 1 and pp. 73–4.
36. Sheaff, 'A Century of Centralization', pp. 135–40.
37. Cornwall Survey, pp. 18–22.
38. Cornwall Survey, pp. 19–20.
39. Cornwall Survey, pp. 20–1.
40. Cornwall Survey, p. 21.
41. For discussion re this policy and its impact on other councils in the region see G. Chester and P. Dale, 'Institutional Care for the Mentally Defective, 1914–1948: Diversity as a Response to Individual Needs and an Indication of Lack of Policy Coherence', *Medical History*, 51, 1 (2007), pp. 59–78, pp. 60–1.
42. This did not however mean his expertise was fully appreciated by other medical

practitioners. Cornwall Survey, p. 27. Niemi, *Public Health*, pp. 140–2, discusses the lack of prestige attaching to tuberculosis officers and the problems this created.

43. Cornwall Survey, pp. 27–8.
44. Cornwall Survey, pp. 32–3.
45. Cornwall Survey, p. 33.
46. Cornwall Survey, p. 34.
47. Cornwall Survey, p. 36.
48. Cornwall Survey, p. 36.
49. Cornwall Survey, pp. 39–42.
50. Cornwall Survey, pp. 40–1.
51. Cornwall Survey, pp. 47–8.
52. Cornwall Survey, pp. 51–4.
53. Cornwall Survey, p. 58.
54. Cornwall Survey, p. 60.
55. Cornwall Survey, p. 61.
56. Cornwall Survey, pp. 62–3.
57. Cornwall Survey, pp. 63–4 and pp. 68–9.
58. Cornwall Survey, pp. 70–2.
59. Cornwall Survey, p. 86.
60. Cornwall Survey, p. 84.
61. Cornwall Survey, p. 85.
62. Cornwall Survey, p. 89.
63. Cornwall Survey, p. 89.
64. Peretz, 'Infant Welfare in Inter-War Oxford', pp. 14–15, shows higher costs involved with doing less in Oxfordshire than Oxford.
65. Devon Survey, p. 7.
66. This concern had been a factor behind nineteenth-century research, often carried out under the auspices of the Royal Cornish Polytechnic Society and the Royal Institute of Cornwall, which drew a clear distinction between the health of miners (or mining areas) and the rest of the population in Cornwall. An early example of this is R. Blee, 'An Inquiry into the comparative Longevity of Mining and other Districts of the County of Cornwall', *Annual Report of the Royal Cornwall Polytechnic Society*, 1838, pp. 68–80. A focus on mining also provided a national forum to discuss the health of underground workers and others. In 1914 Telfur Thomas argued women and non-mining men in the county were relatively free from tubercular disease. Testimony of J. Telfur Thomas, MOH for Camborne, *Second Report of the Royal Commission on Metalliferous Mines and Quarries*, British Parliamentary Papers, 1914, Evidence and Appendices, Vol. II, Cd. 7477 (15,997), p. 185.
67. C. Mills, 'The Emergence of Statutory Hygiene Precautions in the British Mining Industries 1890–1914', *Historical Journal*, 51, 1 (forthcoming 2008), pp. 1–24; A. Davin, 'Imperialism and Motherhood', *History Workshop Journal*, 5 (1978), pp. 9–65.
68. Efforts to redress this imbalance have tended to concentrate on women at work. Burke, G., 'The Decline of the Independent Bâl Maiden: The Impact of Change in the Cornish Mining Industry', in A.V. John (ed.), *Unequal Opportunities: Women's Employment in England 1800–1918* (Oxford, Basil Blackwell, 1986), pp. 179–206, and S. Schwartz, 'In Defence of Customary Rights: Labouring Women's Experience of Industrialisation in Cornwall c.1750–1870', *Cornish Studies*, 7 (1999), pp. 8–31, and S.P. Schwartz, '"No Place for a Women": Gender at work in Cornwall's Metalliferous Mining Industry', in P. Payton (ed.), *Cornish Studies: Eight* (Exeter, 2000), pp. 68–96.
69. For example Mayers, *Bâl Maidens*, pp. 131–51, extrapolates an 1842 survey to represent health concerns across the entire nineteenth century.
70. The main report runs to 95 pages and is accompanied by several lengthy appendices and special reports.