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The Highlands and Islands Medical Service Precursor of a State Funded Medical Care System ?

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Summary

The Highlands and Islands of Scotland cover a large area of the country and are sparsely populated. A series of man-made and natural disasters ensured that, early in the nineteenth century, they were also poverty stricken. It was gradually recognised that the degree of social deprivation was too severe for self-help and could only be alleviated from outside the area. This paper traces the use of State funds to support a medical service, from the first payments under the new Poor Law until the outbreak of war in 1939.

Improvement was at first very slow but a turning point came with the establishment in 1913 of the Highlands and Islands Medical Service Committee. The committee was given a free hand to expand or retain its annual grant as it saw fit; the way in which the money was used to develop first a comprehensive primary care service and then the nucleus of an integrated hospital service is revealed in the annual reports. The success of this local scheme may have made easier the later introduction of a national health service.

Résumé

Les Highlands et les Iles écossaises occupent une grande étendue du pays et ces zones sont très faiblement peuplées. Une suite de désastres naturels et de calamités engendrées par l'homme a contribué au fait qu'au début du 19e siècle, la région était dans la misère. Peu à peu on a constaté que le degré de privation sociale était trop important pour les efforts personnels des habitants et que cette situation ne pouvait être allégée que par des efforts extérieurs. Cet article retrace l'utilisation des fonds de l'état pour l'instauration et l'entretien d'un service médical depuis les premiers versements aux termes des lois sur l'assistance publique jusqu'au moment ou éclata la guerre en 1939.

Au début, l'amélioration fut très lente, mais la situa tion fut améliorée par l'établissement en 1913 du comité de service médical des Highlands et des Iles. Le comité avait le pouvoir d'augmenter ou de diminuer sa subvention annuelle selon son propre jugement. Dans les rapports de gestion, on peut examiner l'histoire de l'utilisation de cet argent. En premier lieu, il a servi à développer un service compréhensif de premier soins et ensuite le début d'un service d'hospitalisation intégré. Le succès de ce projet régional a peut-être facilité l'introduction de la sécurité sociale plus tard.

Although England, with an area of 50,000 square miles, is considerably largerthan Scotland (30,000), in physical extent, especially if one includes the outlying island groups, it is the lesser. There are also profound differences in population density. These are indicated on the map; England at about the turn of the century had approximately 700 inhabitants per square mile. The comparable figure for the whole of Scotland is 150. The population of the Highlands and Islands which, for the purpose of this paper, comprise the counties of Sutherland,

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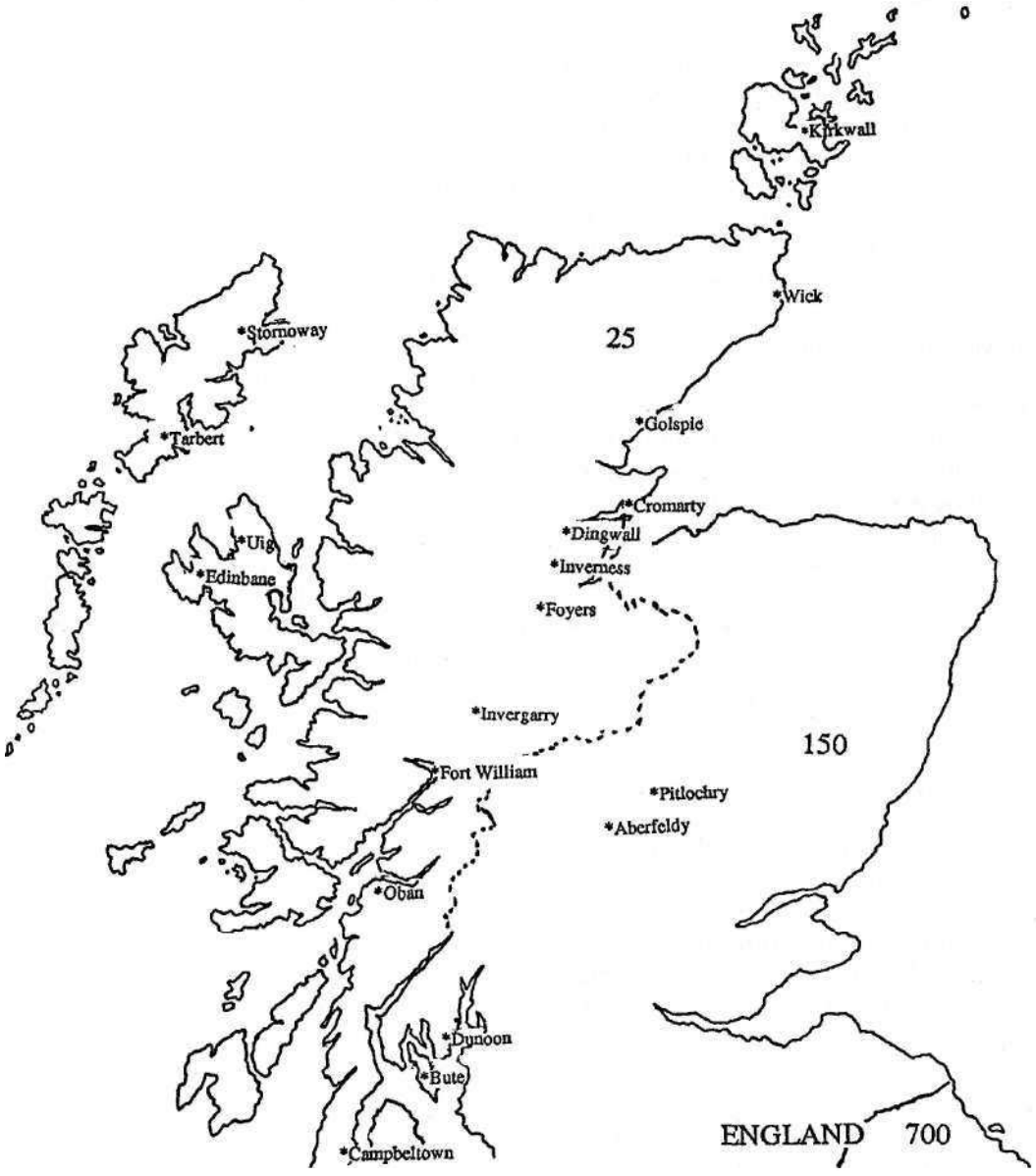
HOSPITALS IN HIGHLANDS AND ISLANDS IN 1912
(with population densities per square mile)



Caithness, Ross and Cromarty and Inverness with parts of Argyle and Perthshire (i.e. the land to the left of the dotted line on the map) has dropped steadily over the last century and a half, but in 1900 was about 350,000 giving a density of less than 25 per square mile - indeed the Registrar General who counted heads per acre to the nearest whole head, could not accept that the Highlands were populated at all !

It is now exactly 150 years since the passing of the Poor Law (Scotland) Amendment Act 1845 and this measure constitutes the first meaningful Government involvement in the provision of medical care. There were important differences between this Scottish and the comparable English Act of 1834. Firstly the *able bodied* Scot had no legal entitlement to poor relief; more importantly the provision of outdoor relief (outwith the poorhouses) was given far more prominence - indeed it was actively discouraged in England. Parochial Councils were compelled to provide medical attendance to the immates of poorhouses where these existed but they were also enabled to subscribe to local hospitals and enjoined to provide "medicines, medical attendance, nutritious diet, cordials and clothing for such poor in such manner and to such extent as may seem equitable and expedient". Interestingly enough no definition was given of "the poor".

It will be shown that the somewhat permissive phraseology of the 1845 Act was used to provide at least a rudimentary medical presence in the more remote parishes of the Highlands; meanwhile it is worth noting the inception in 1848 of the Medical Relief Grant. This was an additional sum of £ 10,000 provided centrally and distributed annually to participating parishes, which had to match the grant from their own resources. It was given on a per capita basis of up to two pence per parishoner but on a sliding scale based on population density - probably the first occasion on which the special medical needs of the remoter areas were formally recognised.

Consideration of medical care cannot be divorced from that of the prevailing economic conditions. Thus one should note that by 1845 the profitable and labour-intensive kelping industry had been all but extinguished ; there was a harvest failure in 1836 whilst in 1847 the same potato blight which decimated Ireland brought famine conditions to the Highlands. Throughout the period and for the next thirty years there continued the devastation of the Clearances. The enforced emigration of a substantial proportion of the able bodied demonstrably skewed the age profile of the population which in any case declined by about 25 % in the period under review.

Attention was drawn to the parlous state of the medical services in the Northern counties in 1852 by the Royal College of Physicians of Edinburgh. They published a survey (1) based on a questionnaire addressed to parish ministers, doctors and others; replies were received from 155 (out of 170) parishes. Of these, 62 were deemed to be adequately supplied with doctors, 52 partially and 41 (i.e. population of 34,366) not at all. The replies to the questionnaire (which are still in the possession of the College) are extensively quoted by Collacott (2) in a wide ranging survey of Highland medical history. The ministerforWalls (Shetland), for example, wrote:

"There is a kind of despair, or rather apathy among the people as if the hopeless condition in which they are left in regard to competent medical aid were necessarily their lot'.

The medical comments were from a different viewpoint:

"The special hardship incident to my situation is the poverty of the people and the many applications for medical relief which, although unremunerated, cannot in many cases be refused".

"Owing to the miserable and inadequate remuneration I cannot afford after supporting a wife and ten of a family, even to insure my life or make any provision for myself or them.

As my family increased I was obliged to give up a medical periodical I can scarcely afford to give my family the common rudiments of education".

The forthright conclusion of the committee was that no improvement in the social state of the people would be brought about within the present generation as would enable them to provide medical aid for themselves; if relief were to be given "it must be from without". Both the requirement for external (State) funding and the need to extend relief to some not covered by the Poor Law provisions were clearly demonstrated but the report was ahead of its time and appears to have elicited little comment and no action.

It is hardly surprising that any improvement in medical provision was modest. In 1851 the *Medical*D/recfory lists 73 names of practitioners with addresses in the Highlands and Islands; by 1883 there are 103 - but there are 121 parishes paying to their doctors sums which vary from £2 to £172 annually. The average sum paid in Sutherland for example was about £60 yet, as we shall see, this constituted a major part of the doctor's income. Hospital provision was similarly scanty - the Belford Hospital in Fort William was founded in 1865 and there were already hospitals in Orkney (1836) and Inverness (1800) but most of the small highland hospitals were built towards the end of the century.

There were many reasons for the growth in the 1880's of political awareness in Westminster of the plight of the northern counties; the Royal Commission which resulted did not mince words and reported "a state of misery, of wrong doing and of patient long suffering without parallel in the history of our country". (3) The Crofter's Holding Act of 1886 which followed and which in effect gave the crofter a permanent lease of his land has been called the Magna Carta of the Highlands and proved to be the measure which provided the social stability upon which a framework of medical care could be built.

The last quarter of the century which saw the building of a number of small hospitals (Dingwall 1873, Stornoway 1896, Lerwick 1900) was also enlivened by the reports of the County Medical Officers of Health. These reports suffered from the disadvantage that the morbidity and mortality of the Highlands was perforce compared with that of the more crowded and industrialised south and, of course, at a time when direct personal medical attention did little to affect the figures; thus the MOH for Ross and Cromarty stated "much has been said as to the filthy and squalid state of many of the houses of our highland fishing and crofting population. No doubt aesthetically such accusations are well founded but when brought to the test of hard statistics the fact remains that in such habitations there exist more than usually healthy men and women". With that he quoted an annual death rate of 13.9 per 1000 against that for England and Wales of 14.5. Reliance therefore tended to be placed on anecdotal evidence, reserving as the main statistical weapon the percentage of uncertified deaths. This figure which in many cases was over 50 % (80 % in Loch Broom as late as 1908) was used to suggest that no medical attendance was available (or utilised) during the final illness. Whatever the true signifiance of these figures they at least presented a contrast to those for mainland Scotland which hovered around the 2 % mark.

A major survey into the application of Poor Law Medical Relief in Scotland was carried out in 1904. (4) By this time the treasury grant of £10,000 had doubled to £ 20,000 but this extra amount was used in the main to provide nursing care in the larger poorhouses; by this time also the percentage of participating parishes had risen from 50 % to over 90 % so the amount available to the smaller parishes had actually diminished. The report, although comprehensive could do little more than point out the special circumstances of the Highlands and Islands.

The same point was made in the report of the Royal Commission which in 1909 considered the workings of the Poor Law as a whole. (5) It found space to state that medical attendance in many of the smaller (northern) parishes was "deplorably insufficient". Many of these parishes were unable to maintain a doctor at all, in the small island parishes medical officers were constantly changing; the jobs seemed to attract those without sufficient capital to purchase a practice further south and one can gain the impression that there was a high proportion of women doctors, some of whom were said to come for the summer but to migrate south during the highland winter. Be that as it may, the job of the highland doctor was no sinecure - the report quotes one area of Lewis where from Europie in Ness to Mealshader in Uig there is a single road of 72 miles linking 40 villages with a total population of 13,000 and served by two doctors who do their rounds in a gig or on foot. Many of the houses were said to be more worthy of a kaffir kraal than a section of Great Britain.

With constant repetition, the message that the Highlands and Islands were different finally got through in 1912 when the Asquith Government set up a commission under the chairmanship of Sir John Dewar specificaly to report on the Medical Services of the Highlands and Islands. The Dewar report (6) with its associated minutes of evidence (7) was not only of profound importance to the health care of the north, it gives also a fascinating and comprehensive picture of the state of medical practice at the turn of the century. Admittedly there is an element of special pleading - many of those being interviewed stood to gain and it did their case no harm to emphasise the more arduous or bizarre aspects to their jobs, but this serves merely to add spice to the document.

The committee conducted interviews throughout the area with witnesses who had previously been circulated with questionnaires. Such was the interest in the enquiry that 87 of 102 doctors responded. Detailed evidence was taken as to the sources of income of the practitioners and it is quite clear that the payments by parish councils for the care of paupers formed the biggest single contribution. It is equally clear that these payments bore little relationship to the number of paupers on the roll - one payment as large as £12 per pauper per year was reported and this compared with a figure of a few shillings down south. The payment was therefore set in order to attract a doctor into the parish and was perhaps a tacit recognition that there were large numbers of crofters and their dependants on the borderline of pauperdom, many of whom could not or would not pay the doctor's fee. Many doctors claimed 30 % of bad debts, Dr Mackay of Lochcarron reckoned that in his practice the figure was nearer to 75 %.

The fee for a visit was not large - a sum of half a crown (12.5 p) could be afforded by many, but the doctor was constrained to charge mileage at a rate of about a shilling (5p) a mile; when many homes were ten or more miles from the surgery, this could add up. Dr Mackenzie of Badenoch said his furthest patient was twenty miles away, nine miles of the journey being by footpath. Whilst the doctor who served Rhenigadale in North Harris pointed out that the path there was so narrow that one had to walk sideways - on the north side there is a sheer drop to the sea. The mileage charge could, of course, be shared between several patients or levied on the one patient who could pay. There is a rathertouching anecdote of a practitioner who went to visit the local landowner but who found himself giving ten or more free consultations at the roadside as well.

Then as now a major concern of the profession was the possibility of being subjected to frivolous calls if there were any form of capitation payment and most insisted that there should be some deterrent charge at the time of consultation. One man with experience of the club system was asked :

"How did you assume it was a trivial call ?
"I didn't assume anything, I simply went to calls in rotation.
"What did you say when you arrived ?
" I did not say anything, I thought a lot".

Any form of complacency met with a savage response from the committee who seemed to have a clear idea of what they wanted witnesses to say; thus Mr Donald Smith Inspector of Poor forthe parishes of Lochs and Barvas was pilloried:

"The general effect of this paper you have put in would be to suggest there is no medical problem whatever in Lewis. You say that people are invariably able to pay the doctor's fee and that the district was never so well supplied with doctors and nurses...
"Does that really represent your mind ? ...
"Should this committee report that there is no medical question requiring to be solved ?
" If that is not your view, what is it ?
"Is it not a fact that a year or two ago your rates were in such a condition that you were not able to pay either the paupers or the medical officer ?
"You are quite likely to be again in the same position of having no money eitherto let your doctor live or to provide food for your paupers ?
"So there is some room for improvement in your medical services!

His answers were monosyllabic.

Any lack of awareness amongst the doctors themselves was similarly exposed. Dr Victor Ross of Garynahine had 4462 patients, the furthest 30 miles from his home and several hundred on the island of Bernera where there was no wheeled traffic at all. He was asked whether he had more work in the parish than he had time to do and replied that he had had only two messages in a fortnight. He was never hard worked save for three months of the year - forthe other nine months there was just enough to keep him going. He was obviously a therapeutic nihilist:

"Wouldyou be glad to have some more work to do ? Yes.
"There is material for work if the conditions were favourable ? Yes, you could make a great amount of work.
"And useful work ? I don't say it is useful, you could make it".

There were not many calls for additional doctors despite what seems to us to be a heavy case load; some doctors' houses were inconveniently sited on the edge of a practice and the need for cars was obvious but the loudest call was for additional trained nurses. The few that were in post were very highly regarded both by the doctors and by the populace. Many appeared to be working with only the lightest of medical direction. Much of the midwifery was performed by local women who had undergone only a few months training but many of the deliveries were conducted by village wives whose efforts did not receive the same approval from the doctors. DrTolmie of South Harris did not mince matters :

"Are there two maternity nurses in your district ?... Yes. I don't know the qualifications of the one in the middle of the island. I asked her and she said she did not know what the Highlands and Islands Committee had to do with her qualifications. The other is an old crofter's wife and goodness knows how she came to be a nurse; she cannot read and she cannot write. She is great on that ointment called Zam-buk. When speaking of Iodoform she says lofferdum..."
"Is there a house in Harris with people under the same roof as the cattle ? Yes, I was going to a house where somebody was sick and I was met by a calf... It was a calf that answered the door."
"Is this still going on ? No, there was a party staying with this woman and they had a row and she pulled the house down."

The Dewar Report was followed commendably quickly by the Highlands and Islands (Medi-

cal Service) Grant Act 1913 which set up a fund of £42,000 "forthe purpose of improving medical services including nursing". The disbursements from this fund are detailed in the annual reports of the Scottish Board of Health. Little happened during the first World War and by 1922 the balance of the fund stood at £173,000; there had been no capital expenditure but some £44,000 had been paid out for doctors' travel expenses, £2,000 on accommodation and smaller sums on sickness and holiday relief. (8)

By 1923/4 it was believed that the situation as regards general practitioner services had been largely remedied. Not only was there provision for a doctor's attendance in the most inaccessible mainland districts and remotest islands, but fees were so reduced that no person who required medical advice or treatment need hesitate on financial grounds. Furthermore there were being attracted into the Highlands and Islands practitioners of a very satisfactory class, mostly young men equipped with up to date medical teaching. A ceiling was now placed on doctor's mileage payments but the continued rise in other expenditure meant that the fund overspent by £12,000 in this year. The balance was now £130,000. (9)

The following year a decision was made to improve the hospital services. Ideas about hospital provision had changed since 1913 - then the call was for a two or four bed hospital in every parish, the need for which was illustrated by Dr Mackenzie of Uist who had had to operate in a hut on a case of strangulated hernia where a clerk gave chloroform and light was obtained from a tallow candle held by a neighbouring crofter who fainted during the proceedings. Now there was a tendency towards centralisation and specialisation. The map indicates by dots the hospitals which were in place in 1912. A surprising number of these survive and one of the more far sighted decisions of the board was to set up specialist services in the more isolated hospitals. By 1924/5 there were general surgeons attached to hospitals in Lerwick, Kirkwall and Lewis. Wick was shortly to follow. Modern operating theatres were built and at the same time steps were taken to provide centralised laboratory services at Inverness. An ENT surgeon was installed here and he was given pastoral oversight of the region.

One hospital will serve as an example of the impact of these changes; the Lewis Hospital in Stornoway was built in 1896. It had 12 beds originally but was enlarged to 20 beds in 1915. A general surgeon was appointed in 1924, his basic salary paid by the fund and the table shows the dramatic effect this appointment had on the work of the hospital. The numbers of outpatients, of admissions and of operations all rise precipitately whilst the mortality rate stays constant or, if anything, declines. The fund was also used to build a theatre, Xray room outpatient suite and laboratory together with a boiler house and nurses accommodation. (10)

	1899	1915	1923	1929
Admissions	77	56	183	596
Outpatients	2	0	7	1690
Operations	26	?	60	551
Deaths	5	5	11	23

Activity data from Lewis Hospital, Stornoway

Successive annual reports reveal the continued development of the hospital service and a continued decline in the financial position of the fund. In 1929, by which time the Board of Health had become the Department of Health for Scotland, the Highlands and Islands Additional Grant Act was passed. Little was to come from this new source until the existing surplus was exhausted, but it did enable some expansion to be continued despite the world financial crisis. In 1931 a surgeon was employed at Caithness. It is interesting that his salary was paid in part by the County Council and also that he was nominated by the Professor of Surgery at Aberdeen; (11) he had a limited tour of duty and his "prospects in relation to the University and Infirmary were not to be diminished." By the mid 1930s there is mention of an air ambulance service (the first in Argyll in 1933). Money continued to be spent on hospital extensions and in 1935, (in Shetland) on wireless communication. The balance that year from a total grant of £80,000 was £3-15-3 (£3.76) !

This survey did not extend beyond 1939 in which year there were surgeons at Wick, Thurso, Fort William, Lerwick, Kirkwall, Stornoway and Golspie, an anaesthetist at Fort William and developing specialist services at the base hospital in Inverness. It is, however, more appropriate to close with a comment from the report of the Cathcart committee which studied the working of the Scottish health service as a whole. (12) After mentioning the interdependence of a hospital service and a transport system (a problem which is still with us today) this remarkably upbeat report concludes :

"On the evidence before us the Fund has brought great benefits to the people of the Highlands and Islands, is administered in an atmosphere of sympathy and understanding between the central department and the doctors and nurses and other parties and to the satisfaction of all concerned... Our study of the service was primarily directed to the peculiar conditions of the Highlands and Islands but we found that it had a wider bearing and we suggest that further study may provide valuable pointers for consideration of the larger issue of the future of medical services in Scotland as a whole".

Herein, I believe, lies the justification for my subtitle.

References

1. *"Statement regarding the existing deficiency of medical practitioners in the Highlands and Islands".* Issued as pamphlet by the Royal College of Physicians of Edinburgh 1852.
2. Collacott R.A. 1982, *"A study of the Development of General Practice in the Scottish Islands",* University of Leicester Ph. D. Thesis.
3. *"Report on the ...Condition of crofters and Cottars in the Highlands and Islands",* Royal Commission Report 1883.
4. *"Report of Committee on Poor Law Medical Relief (Scotland)"* 1904. Minutes of evidence Cmd 2022.
5. *"Report of Royal Commission on Poor Law Relief of Distress (Scotland)'^* 909 Cmd 4922.
6. *"Report of Highlands and Islands Medical Service Committee"* 1912 Cmd 6559.
7. *ditto* Minutes of Evidence 1913 Cmd 6920.
8. *3rd Annual Report of the Scottish Board of Health 1921/2 Cmd* 1697
9. *5th Annual Report of the Scottish Board of Health 1923/4* Cmd 2156
10. Crosfill M.L. 1973 "The Lewis Hospital Stornoway" *Medical History* XVII, p.49-60.
11. *3rd Annual Report of Department of Health for Scotland W2.M2* Cmd 4080
12. *Scottish Health Services Report* ("Cathcart Report") 1935/6 Cmd 5204

Biography

Theauthor, who is now retired, worked for eight years as general surgeon at the Lewis Hospital in Stornoway. 1ste of Lewis