New Poor Law Medical Care in the Local Health Economy

Alistair Ritch

Abstract

The Poor Law Amendment Act (1834) failed to address sickness as a major reason for the increasing levels of pauperism and yet has been credited with setting the scene for the development of the National Health Service in 1948. This investigation analysing the poor law medical services of Birmingham and Wolverhampton demonstrates that the influence of the New Poor Law in their development was significant in the latter, but had little immediate effect in the former. However, in both towns the medical service played a crucial part in the control of infectious disease, particularly at times of local outbreaks or national epidemics. This role within the local community involved close collaboration with the relevant sanitary authority, in some cases with the provision of joint isolation facilities and policies. Overall, the poor law medical services in both locations were important elements in the lives of the poor even in the early days after the Act and comprised significant components of the medical landscape of each town. Although the medicalization of English workhouses was not a late nineteenth century phenomenon, they became the single most important institutional setting for the provision of medical care by the early twentieth century.

Introduction

This article will illustrate how the New Poor Law medical service served health care within the local populations of Birmingham and Wolverhampton. It will draw out the impact of medical care on sick paupers themselves and will conclude that the poor law medical service was an important element in the lives of the poor throughout the remainder of the long nineteenth century. The concept of 'the economy of makeshifts' encompasses the range of strategies that the poor adopted to ensure material survival by accessing disparate sources of income.[1] Similar strategies were employed in times of sickness to access the local mixed economy of health care comprising private, voluntary funded and public provision. This study of the poor law medical services in Birmingham and Wolverhampton will demonstrate that they were a central component of the medical landscape of both towns. This was particularly important in controlling the spread of infection within the local community through the provision of isolation facilities within workhouse infirmaries, a role that has not previously been appreciated. Thus they were serving the whole community, not just those members who were destitute. Towards the end of the nineteenth century,

1 S. King and A. Tomkins, 'Introduction', in S. King and A. Tomkins (eds), *The Poor in England 1700–1850: an Economy of Makeshifts*, (Manchester, 2003), pp. 1–38 (here at p. 1).

workhouse infirmaries became the predominant element of institutional medical care for the poor, providing 'important institutional diagnostic spaces'.[2]

Recent historiography of the nineteenth century Poor Law has been accused of having a rural bias, but rural workhouses could contain few inmates who were sick.[3] In the area of medical relief, there has been a concentration on the institutional facilities in London, but the capital's medical welfare system has been described as so dissimilar to other major English cities as to be 'something of an oddity'.[4] Workhouses of the large provincial cities have been relatively neglected, particularly those with rapidly expanding populations in the early nineteenth century as a result of industrialisation, such as Birmingham and Wolverhampton.[5] Birmingham is an example of a very populous, heavily industrialised town where medical provision mirrored London's, while Wolverhampton is similar to many medium-sized, commercial urban towns. A study of these two populations adds a significant piece to the jigsaw of disparate medical services that developed after the New Poor Law in England.

Medical policy

The 1834 Report of the Royal Commission on the Poor Laws was principally concerned with 'the increase in the number of the able-bodied paupers', which the Commissioners considered to be 'the principal evil of the system' of poor law relief. Thus, the report's first recommendation stated that all relief to able-bodied persons and their families, other than in well-regulated workhouses, should cease. However, this did not apply 'as to medical attendance' and medical treatment of the sick poor by parishes under the Old Poor Law by contract with a surgeon was considered 'adequately supplied, and economically'.[6] The only other reference in the report to sick paupers was the recognition that appropriate rooms would be required for them within workhouses. Sick wards were included in the plans of the model workhouses in the first annual report of the Poor Law Commissioners in 1835, one type involving an infirmary building separated from the main workhouse. When the Commissioners established a formal classification system for workhouses in 1842 with

2 G. Mooney, 'Diagnostic spaces: workhouse, hospital, and home in mid-Victorian London', *Social Science History*, 33 (2009), pp. 357–90 (here at p. 358).

3 M.E. Rose (ed.), *The Poor and the City: the English Poor Law in its Urban Context, 1834–1914* (Leicester, 1985), p. 4; S. Wildman, ' " He's only a pauper whom nobody owns": caring for the sick in the Warwickshire poor law unions, 1934–1914' (occasional paper of The Dugdale Society in association with the Shakespeare Birthplace Trust), (Stratford-upon-Avon, 2016), pp. 18–19.

4 S. King, *Poverty and Welfare in England 1700–1850* (Manchester, 2000), p. 13.

5 Recent local studies covering New Poor Law medical services in urban areas include: A. Negrine, 'Medicine and poverty: a study of the poor law medical services of the Leicester Union 1876–1914', (unpublished PhD thesis, University of Leicester, 2008); E.C. Bosworth, 'Public healthcare in Nottingham 1750–1911', (unpublished PhD thesis, University of Nottingham, 1998); G.A. Butler, 'Disease, medicine and the urban poor in Newcastle-upon-Tyne, *c.* 1750–1850', (unpublished PhD thesis, University of Newcastle, 2012).

6 House of Commons, *Report from His Majesty's Commissioners for Inquiring into the Administration and Practical Operation of the Poor Laws*, British Parliamentary Papers (hereafter BPP), 1834 XXVII [C. 44], pp. 25, 146, 170, 176.

seven classes of inmate and complete segregation of each class within the institution, they allowed guardians to provide facilities outwith the system for 'persons labouring under any disease of body or mind'.[7] However, such provision was intended for inmates who became sick and the Commissioners never envisaged that acute illness would be a reason for admission. Furthermore, the Poor Law Commission, set up as the central authority to administer the new system of relief, never produced a definitive medical policy in the early years after the New Poor Law. The expansion of medical relief from the late 1830s was a spontaneous development influenced by administrative orders of the Commissioners rather than by the central authority itself.[8] The first legally binding policy was not issued until 1842 as the General Medical Order, although it dealt only with the conditions of employment of medical officers. Nevertheless, in Samantha A. Shave's opinion, it gave official recognition that medical relief to the poor was a state responsibility.[9]

The Commissioners' failure to recognise that sickness could give rise to the need for relief was a major oversight since medical relief became an increasingly frequent reason for admission to the workhouse. It is obvious today that sickness can cause poverty and destitution by restricting earning power, but we also know now that the relationship between poverty and sickness is more complex and that the poor are likely to suffer more ill health.[10] The proportion of sick inmates within the workhouse population increased from 10 per cent in 1847 to 30 per cent in 1867 and most likely remained around this proportion into the early twentieth century, as 32 per cent of inmates of poor law institutions in 1915 were accommodated in sick wards or separate infirmaries.[11] Poor law institutions provided eight per cent of the country's hospital beds by 1861; so it is not surprising that, ten years later, workhouses could be described as the first public hospitals and those in the larger towns as infirmaries for the sick.[12] Moreover, there were contributory reasons for the increase in sick inmates. Unions' medical officers began to realise the benefits of institutional medical care over care at home, often due to the poor condition of paupers' homes. The popularity of hospitals for medical treatment grew among the poor, but the strict exclusion policies of voluntary hospitals, rejecting those with infectious, chronic or terminal disease as well as excluding older patients and children, meant there was little choice other than the workhouse infirmary. This trend was enhanced

7 House of Commons, *Articles of General Workhouse Rules issued by Poow Law Commissioners, February 1842*, BPP, 1844 XL [C. 45], p. 1.

8 M.W. Flinn, 'Medical services under the New Poor Law', in D. Fraser (ed.), *The New Poor Law in the Nineteenth Century*, (London, 1976), pp. 45–66 (here at pp. 48–9).

9 S.A. Shave, *Pauper Policies: Poor Law Practice in England, 1780–1850* (Manchester, 2017), pp. 26, 214.

10 A. Tomkins, ' "Labouring on a bed of sickness": the material and rhetorical deployment of ill-health in male pauper letters', in A. Gestrich, E. Hurren and S. King (eds), *Poverty and Sickness in Modern Europe* (London, 2012), pp. 51–68 (here at p. 52).

11 R.G. Hodgkinson, *The Origins of the National Health Service: the Medical Services of the New Poor Law 1834–71*, (London, 1967), pp. 147, 467; M.A. Crowther, *The Workhouse System, 1834–1929: the History of an English Social Institution* (London, 1981), p. 89.

12 D. Fraser, *Evolution of the British Welfare State* (Basingstoke, 2003), p. 100; Hodgkinson, *Origins of the National Health Service,* p. 451.

when the Poor Law Board reversed the policy of less eligibility in relation to the sick in the late 1860s and its President declared the deterrent principle to be no longer appropriate.

A significant step in the development of the poor law medical service was the passage of the Metropolitan Poor Act in 1867, as it started the movement toward infirmaries that were geographically separated from workhouses and promoted designated institutions for the isolation of those with infectious diseases. A common fund pooling the poor law levies in London was established and all parishes and unions were combined into one Metropolitan Asylum District under the control of one board, resulting in a centralised hospital system. In the following year, the principles of the act were extended to the whole country, although separate infirmaries were usually limited to the larger cities. The Act represented an explicit acknowledgement by the state of its responsibilities for the destitute sick.[13] It established a clear policy that transformed the medical activities of the poor law authorities into an extensive working-class health service.[14] The trend toward medicalization has led to a claim that the medical service was the great success of the New Poor Law, on the basis that it improved and widened the range of medical facilities.[15] However, the state of affairs by the time of the Local Government Act in 1929 was a 'patchwork of local provision and uneven services in medical care for the poor'.[16] The municipal structure of medical services that developed from poor law facilities after the Act was initially the preferred model for the future of health care. However, the experience of the Emergency Medical Service set up prior to World War II may have influenced the decision to go for centralised control. The emergency service had co-ordinated all hospitals and dictated the role each should play during wartime and its success led to calls for its conversion into a national hospital service after the war had ended.[17] Hence Ruth Hodgkinson's assertion that the National Health Service has its direct roots in the medical services of the New Poor Law.[18]

Medical activity

Wolverhampton Union was formed in 1836 by combining the townships of Wolverhampton, Bilston, Willenhall and Wednesfield. The Union Workhouse for between 400 and 500 inmates was erected three years later to replace around 250 places in three smaller institutions and to serve a population recorded in 1841 as 68,426. Although the new workhouse did not have a separate infirmary, it did have infirmary wards and 'infectious wards'. In 1842, the former could hold 28 men and 25 women and the latter 6 of each sex,

13 G.M. Ayers, *England's First State Hospitals and the Metropolitan Asylums Board* (London, 1971), pp. 17 and 28.
14 J.E. O'Neill, 'Finding a policy for the sick poor', *Victorian Studies*, 7 (1964), pp. 265–84 (here at p. 269).
15 S. Fowler, *Workhouse: the People, the Places*, *the Life Behind Doors* (Richmond, 2007), p. 150.
16 A. Levene, 'Between less eligibility and the NHS: the changing place of poor law hospitals in England and Wales, 1929–39', *Twentieth Century British History*, 20 (2009), pp. 322–45 (here at p. 323).
17 J.E. Pater, *The Making of the National Health Service* (London, 1981), p. 21; C. Webster, *The National Health Service: a Political History* (Oxford, 1998), pp. 6–7.
18 Hodgkinson, *Origins of the National Health Service,* pp. 64 and 696.

accounting for 23 per cent of total beds.[19] Five part-time medical officers were appointed to provide medical care throughout the Union and within the workhouse. The first voluntary hospital, South Staffordshire General Hospital, was not erected until 1849 with around 80 beds. No information is available relating to the medical care of paupers prior to the New Poor Law, but details of medical work within the Union are evident from the early 1840s. In July 1841, Anne, the wife of John Walford, was suffering from a disorder of her liver and bowels that was likely to last for six or seven weeks and resulted in her being 'unable to follow any employ'. Both her sons required constant attention: John, aged two years, was 'labouring under water on the brain', and George, seven weeks old, also had a bowel disorder. Charles Hodgkins, one of the Union's medical officers, issued an order for them to be able to receive four pounds of mutton and four loaves of bread per week for two weeks and planned to admit Anne after that to the Union Workhouse. However, at the end of the two weeks, her condition had deteriorated to such an extent that Hodgkins regarded her recovery as very doubtful and removal to the workhouse as not prudent. The rations were continued for a further four weeks. Whether she recovered or not, we shall never know, but Hodgkins clearly saw the workhouse as an appropriate place for the treatment of a sick pauper.

From that time the number of sick inmates in the workhouse began to increase, from 336 in the year 1841–1842 to 823 in the middle of the decade, an increase of 145 per cent. The total number of inmates over that time remained much the same, so that the proportion of those who were sick increased from 17 per cent to 37 per cent (Table 1). Among those admitted were Thomas Haney with a bowel disorder, William Watts and John Wittle with fever, James Kempton, aged 13 years, suffering from typhus, Elizabeth Davies and Ann Smallwood with lung disease, Samuel Highland who had fractured his leg, three middle-aged women with debility and two men run over by vehicles.[20] A similar increase took place in the proportion of paupers who were sick among those in receipt of outdoor relief (Table 1). As a result, the percentage of sick paupers within the Union's population almost doubled over the period from just over two per cent to four per cent. The guardians became concerned at the rapid increase in medical work, but accepted that they had the responsibility for providing a medical service to sick paupers. As one of the guardians remarked: 'not a remedy or a comfort ought to be withheld; the sick and the infirm, the destitute infant and the helpless aged, are our charge'.[21]

According to the Workhouse Medical Officer, one reason for the later increase in sick inmates was the erection of fever wards in a detached building at the end of 1844, and the subsequent influx of 'fever patients'.[22] Their number increased to such a degree that, in the

19 Wolverhampton Archives and Local Studies (hereafter WALS), Master's Journal (hereafter MJ), PU/WOL/U/2, 16 April 1842.

20 WALS, Wolverhampton Board of Guardians' minutes (hereafter WBG), PU/WOL/A/3, 24 March 1842; PU/WOL/A/4, 28 October 1842 to 29 March 1844; MJ, PU/WOL/U/2, 16 August 1845.

21 WALS, *Wolverhampton Chronicle* (hereafter *WC*), 2 December 1846.

22 WALS, *WC*, 2 December 1846.

Table 1 **Outdoor and indoor medical relief, Wolverhampton Union, 1841–1846**

Year	Healthy paupers	Sick paupers	Proportion of paupers sick %	Healthy inmates	Sick inmates	Proportion of inmates sick %
1841–42	5,983	1,164	16	1,663	336	17
1842–43	4,238	2,078	33	1,778	767	30
1843–44	3,605	2,678	43	1,538	576	27
1844–45	3,441	1,307	38	1,408	619	31
1845–46	3,104	1,974	39	1,427	823	37

Source: Wolverhampton Archives and Local Studies, *Wolverhampton Chronicle*, 2 December 1846.

Table 2 **Inmates, patients and annual alcohol consumption in Wolverhampton workhouse, 1842–1846**

	1842	1843	1844	1845	1846
Inmates (mean number)	442	478	419	374	–
Patients (mean number)	40	69	69	63	–
Ale (pints)	5,321	7,057	9,489	10,536	11,497
Wine (pints)	163	244	166	413	446
Brandy (pints)	1.5	10.5	5	8.5	9
Gin (pints)	173	307	457	685	823

Source: Wolverhampton Archives and Local Studies, *Wolverhampton Chronicle*, 2 December 1846; Master's Journal, PU/WOL/U/2, 16 April 1842 to 16 August 1845.

midsummer quarter in 1847, they made up 66 per cent of the 593 patients admitted.[23] There is good evidence that they were being actively treated for their condition, and were not simply being isolated from the community to control the spread of infection. In the mid nineteenth century the mainstay of the treatment for fevers was the medicinal use of alcohol, sometimes in high dosage.[24] Between 1842 and 1845, the number of inmates in the workhouse declined by 15 per cent while the number of patients increased by 58 per cent and the annual consumption of ale rose by 98 per cent, wine by 153 per cent and spirits by 375 per cent.[25] This combination, especially the large increase in the consumption of spirits, strongly suggests patients were receiving the appropriate treatment for the time (Table 2). There is little direct evidence of Wolverhampton Union's participation in the local health economy apart from 1866, when the Medical Officer reported that the annual number of admissions was 1,706 compared with only 750 to the local voluntary hospital.[26]

The poor law arrangements and the medical culture in Birmingham were very different. A local act of parliament in 1783 established Birmingham parish as a poor law

23 WALS, WBG, PU/WOL/A/6, 29 January 1847; WC, 20 September 1847.
24 S.E. Williams, 'The use of beverage alcohol as medicine 1790–1860', *Journal of Studies in Alcohol*, 41 (1980), pp. 543–66 (here at p. 551).
25 WALS, *WC*, 2 December 1846; MJ, PU/WOL/U/2, 16 April 1842 to 16 August 1845.
26 WALS, *WC,* 3 October 1866.

incorporation administered by a board of guardians and, in 1831 a new local act increased their number to 108. The first workhouse had been built in 1733 at a time when the population of Birmingham was just over 20,000. By 1766, an infirmary wing had been added, but in the last decade of the century, the accommodation for sick paupers was felt to be so inadequate that a detached building was erected adjacent to the workhouse in 1793, as the 'Town Infirmary'.[27] By 1818, the medical staff included four surgeons with duties in the workhouse, in the dispensary and for domiciliary visiting, plus one medical officer resident in the workhouse, at a time when around 94 patients were being treated in the infirmary.[28] After the New Poor Law came in, Birmingham Parish continued to function under the local act, which restricted the influence of the Poor Law Commissioners, although the central authority gained greater control over the guardians by the 1850s. It is important to note that Birmingham parish was smaller geographically than the Borough of Birmingham and the parish population of 138,000 in 1841 comprised 75 per cent of those resident in the Borough.[29]

From the surgeons' quarterly reports, it is possible to track the medical activity in the infirmary, in the poor law dispensary and in paupers' homes in the years before and after the New Poor Law (Table 3). The number of admissions to the workhouse infirmary and the proportion of sick inmates within the workhouse showed little change as a result of the Poor Law Amendment Act. Discharges of patients 'relieved' or cured, calculated as a proportion of patients in the infirmary at the start of the year plus the number admitted in the same year, varied between 56 per cent and 74 per cent, with deaths averaging around 15 per cent. After 1840, between half and three quarters of patients discharged were described as 'cured', rather than 'relieved'. On average, there were around 18 admissions per week and about 125 patients in the infirmary each day in the late 1830s rising to 160 in the early 1840s. Outdoor medical relief declined by around 10 per cent between 1840 and 1843 despite the 1831 population having increased by 25 per cent to 138,216 ten years later.[30] The high turnover of patients within the infirmary indicates significant medical activity with most of the illnesses treated being of an acute nature, contradicting the general view that the workhouse only catered for those with chronic disease and disability.

The acute nature of much of the sickness in workhouses is also borne out by data from a national survey that took place on one day in December 1869. Almost 30 per cent of the 154,276 inmates in English workhouses were on the workhouse medical officers' relief books as sick and, of these 45,731 patients, 23 per cent were recorded as having an acute medical or surgical condition, although there was considerable variation among workhouses, ranging from 6 per cent to almost 50 per cent. The proportion with acute

27 W. Hutton, *An History of Birmingham*, 6th edition (Birmingham, 1835), p. 375; Birmingham Central Library (hereafter BCL), Birmingham Board of Guardians' minutes (hereafter BBG), GP/B/2/1/1, 3 June 1793.
28 BCL, BBG, GP/B/2/1/2, 2 June, 11 August 1818.
29 P.A. Tolley, 'The Birmingham, Aston and Kings Norton Boards of Guardians and the politics and administration of the Poor Law, 1836–1912' (unpublished PhD thesis, De Montfort University, 1994), p. 396.
30 BCL, BBG, GP/B/2/1/3-5, 1829–1843.

Table 3 **Medical relief in Birmingham, 1829–1843**

Year	Workhouse infirmary admissions n	Workhouse infirmary discharges n	%	Workhouse infirmary deaths n	%	Proportion of inmates sick at year end %	Outdoor medical relief n
1829	954	813	73	96	9	26	11,303
1830	862	737	74	115	12	27	13,730
1834	860	647	60	161	15	39	14,260
1835	663	469	57	154	19	38	13,800
1840	936	601	56	177	16	38	10,786
1841	973	734	65	177	16	38	7,073
1842	1,108	866	68	183	14	30	8,799
1843	1,010	738	62	187	16	31	9,866

Source: Birmingham Central Library, Birmingham Board of Guardians, GP/B/2/1/3-5, 1829–1843.

Notes: The percentages for discharges and deaths were calculated as a proportion of patients in the infirmary at the start of the year plus the number admitted during the designated year.

illness was relatively high in Birmingham (29 per cent) and Wolverhampton (32 per cent), no doubt due to the prevalence of illness in densely populated urban conurbations, as a result of infectious diseases and exacerbated by poverty.[31]

At the time of the survey, the total number of inmates (2,047) and the number of sick inmates (711) in Birmingham Workhouse had greatly increased compared with the 1840s. Indeed, the steadily rising numbers had caused the guardians to erect a second workhouse in 1852 to accommodate around 1,600 inmates with an infirmary for 310 patients in wards geographically separated from the main building, with additional detached accommodation for fever and infectious cases.[32] However, patient numbers continued to increase. In the first two months of 1855, the Medical Officer admitted 448 patients to the workhouse, with a daily average of 318 in the infirmary, compared with only 255 admissions in the first three months in 1843.[33] By then the medical staffing had been changed under the influence of the Poor Law Board to one resident surgeon to cope with all the patients in the workhouse and six district medical officers to provide outdoor medical relief.[34]

We can gauge Birmingham Workhouse's contribution to the local health economy in the years just before and after the New Poor Law by comparing its medical activity with the local voluntary hospital, bearing in mind that the latter also admitted patients from the whole of the Borough and neighbouring counties (Table 4). Admissions were around 60 per cent of those to the hospital, but outpatient activity was much greater at the poor law dispensary than at the hospital until the early 1840s. However, if we include sick paupers

31 House of Commons, *Return of Numbers of Paupers on District and Workhouse Medical Officers' Relief-Books in England and Wales, 1869–70*, BPP, 1870 LVIII (C. 468), pp. 2–3, 21, 23; A. S. Wohl, *Endangered Lives: Public Health in Victorian Britain* (London, 1983), p. 4.

32 J. A. Langford, *Modern Birmingham and its Institutions* (Birmingham, 1871), pp. 381–3.

33 BCL, BBG, GP/B/2/1/15, 14 and 28 February 1855.

34 BCL, BBG, GP/B/2/1/7, 15 March 1850.

Table 4 Medical activity in Birmingham, 1829–1843

Year	General Hospital		Poor Law Medical Service		
	Inpatients	Outpatients	Inpatients	Outpatients	At Home
1829	1,556	2,878	954	7,335	3,968
1830	1,417	2,999	862	8,815	4,915
1834	1,474	4,767	860	9,783	4,477
1835	1,455	4,376	663	8,882	4,918
1840	1,749	7,461	936	6,674	4,112
1841	1,745	9,639	973	4,604	2,469
1842	1,617	10,000	1,108	5,150	3,649
1843	1,616	10,485	1,010	6,282	3,584

Sources: Birmingham Central Library, Birmingham Board of Guardians, GP/B/2/1/3-5, 1829–1843; G. Griffith, *Free-Schools, Colleges, Hospitals and Asylums of Birmingham* (London, 1861), pp. 292–3.

who were seen in their own homes without charge, a service only available under the Poor Law, non-inpatient activity is almost equal.[35] Thus, the poor law medical service was an integral component of medical care to the poor in Birmingham at that time. With the growth of voluntary hospitals in Birmingham, the workhouse's contribution diminished. For instance, in the first six months of 1876, there were 10,276 admissions to the General Hospital, 8,023 to Queen's Hospital, 7,127 to the Children's Hospital and 1,898 to the workhouse infirmary. The opening of the Children's Hospital six years before had provided an alternative inpatient facility to the workhouse for a client group excluded from the other voluntary hospitals. This was especially the case for patients suffering from infectious diseases, of which the majority (535 of 869) went to the Children's Hospital. The two general hospitals admitted only 62 cases, leaving the remaining 272 to gain admission to the workhouse.[36] I shall return to the question of the isolation of these patients in the following section. Voluntary hospitals had the advantage of being able to discharge patients with chronic conditions to the workhouse, helping to promote their patient turnover. For instance, Ann Hackett was transferred to Birmingham Workhouse from Queen's Hospital in 1844 because she was 'crippled with rheumatoid arthritis and suffered spinal caries'. When the guardians expressed their concern over her fitness for transfer, they were informed by the Honorary Officer of the hospital that 'it is contrary to the rules of this Institution to allow incurable cases to remain in the Hospital'.[37]

Infectious disease

One particular group that guardians had little option but to take under their umbrella was 'fever' patients, particularly during epidemics or local outbreaks of infectious disease. The

35 BCL, BBG, GP/B/2/1/3-5, 1829–42; G. Griffith, *Free-Schools, Colleges, Hospitals and Asylums of Birmingham* (London, 1861), pp. 292–3.
36 The National Archives, MH12/13326, Medical Officer of Health's Report for 1876.
37 BCL, Infirmary Sub-committee, GP/B/2/4/1/2, 16 May 1884.

Public Health Acts of 1866 and 1875 empowered sanitary authorities to build hospitals and permitted compulsory isolation of patients, but the development of isolation hospitals by local authorities was slow, so that only one fifth had made any provision by the 1890s.[38] Additionally, until the 1880s, fever hospitals were small, usually containing around 70 beds and voluntary hospitals refused admission to patients with suspected infectious disease.[39] Thus the need to provide isolation facilities fell to the poor law authorities for most of the nineteenth century. As Edmund Robinson, medical officer at Birmingham Workhouse succinctly put it in 1866 'the workhouse as a matter of course is the receptacle for all classes of disease'.[40] However, the important part provincial workhouses played in caring for patients with infectious disease and in providing additional facilities to cope with epidemics has been largely overlooked.

When Asiatic cholera first arrived in England from India in 1831, Bilston was one of the worst affected places, resulting in 3,568 cases out of a population of 14,500 with a fatality rate of 21 per cent.[41] The second outbreak arrived in Wolverhampton Union in August 1848, once again at Bilston Brook, causing 550 deaths in a population of 22,000 within the first month.[42] When 267 cases were recorded in the Union's districts in one week in August 1849, the guardians bought land to erect a cholera hospital in co-operation with the Committee for Health of Wolverhampton.[43] By the end of 1849, the epidemic had subsided and the hospital was demolished. Four years later the guardians agreed a joint plan with the town council in anticipation of further outbreaks. The main emphases of the strategy were to keep cholera victims at home rather than admitting them to a cholera hospital, to provide houses of refuge for healthy relations and to arrange dispensaries to give out anti-diarrhoeal medicines.[44] Birmingham guardians also provided treatment to the poor in general during the epidemic in 1832, by resolving that the Town Infirmary be 'thrown open' for the purpose of administering medicines to those afflicted with bowel symptoms 'without a ticket'.[45]

The Poor Law's capacity to provide isolation facilities and to collaborate with the sanitary authorities is illustrated in the case of the smallpox epidemic in 1871–1872 as it affected Birmingham. This epidemic was regarded the worst of the century, resulting in 42,084 deaths in England and Wales.[46] William Sharp, master of Birmingham workhouse, provided the guardians with a detailed report on the impact of the epidemic locally. The first case to arrive on 11 March 1871 was a servant girl from Hockley, followed on 27 April

38 J.V. Pickstone, *Medicine and Industrial Society: a History of Hospital Development in Manchester and its Regions 1752–1946* (Manchester, 1985), pp. 156–8.
39 Wohl, *Endangered Lives*, p. 138; F.B. Smith, *The People's Health 1830–1910* (London, 1979), p. 241.
40 BCL, BBG, GP/B/2/1/33, 23 May 1866.
41 Smith, *People's Health,* p. 237.
42 WALS, *WC*, 3 October 1848.
43 WALS, WBG, PU/WOL/A/2, 13, 18, 21, 28 August 1849.
44 WALS, WBG, PU/WOL/A/8, 21 September 1853.
45 BCL, BBG, GP/B/2/1/3, 29 August 1832.
46 A. Hardy, *The Epidemic Streets: Infectious Disease and the Rise of Preventive Medicine, 1856–1900* (Oxford, 1993), p. 126.

Table 5 Admissions and deaths of patients with smallpox, Birmingham Workhouse, 1871–1873

Month	Admissions	Deaths	Mortality rate %
October 1871	5	0	0
November 1871	15	2	13
December 1871	26	4	15
January 1872	109	13	12
February 1872	70	10	14
March 1872	94	12	13
April 1872	118	15	13
May 1872	113	16	14
June 1872	99	12	12
July 1872	94	14	15
August 1872	69	9	13
September 1872	31	11	35
October 1872	63	12	19
November 1872	32	6	19
December 1872	28	5	18
January 1873	16	4	25

Source: Birmingham Central Library, House Sub-committee, GP/B/2/3/3/3, 28 January 1873.

by four children from London and later by four more. The disease had not displayed 'much of an epidemic nature' at that time, but the number of admissions increased rapidly after Christmas, for instance 109 admissions in January 1872 compared with 26 in the month before. Admissions peaked at 118 in April and declined significantly by the end of 1872. The greatest number of patients in the wards at any one time was 94 on one day in April and two days in June. The average case fatality rate of 17 per cent was similar to that in the Metropolitan Asylum Board's infectious disease hospitals in the same period (Table 5).[47] Visits from relatives and friends were strictly prohibited, even when the sufferer was dying, to ensure complete isolation. The concern that the health of the inmates already present in the workhouse would be endangered proved unfounded as only 12 contracted the disease.[48] The guardians had appointed a temporary medical officer, Mr Edward Burton, to care for smallpox patients in the workhouse and prevented him from seeing private patients, unless they had smallpox. Eliza Matthews and Elizabeth Fellon were appointed as additional nurses specifically for patients with smallpox. When Burton commenced duties on 19 December 1871, there were 21 patients in three wards, but, by 10 May the next year, this had increased to 75 patients in seven wards and the time spent treating them had increased from two and a half hours per day to between four and five hours. By the time his services were no longer required on 8 February 1873, Burton had treated 982 patients.[49]

47 C. Creighton, *A History of Epidemics, Vol. 2*, 2nd edition (London, 1965), pp. 618–19.
48 BCL, House Sub Committee (hereafter HSC), GP/B/2/3/3/3, 28 January 1873.
49 BCL, BBG, GP/B/2/1/40, 10 January 1872; GP/B/2/1/41, 19 March 1873; Visiting and General Purposes Committee (hereafter VGPC), GP/B/2/8/1/6, 10 May 1872.

During the epidemic, the guardians provided an isolation service to the whole community, not just to those who were destitute, by allowing the Borough sanitary authorities to arrange six per cent of admissions to the workhouse facility. There was no alternative form of custodial care at that time, as an isolation hospital was not erected until the early 1880s, though even then it was intended only for scarlet fever cases. Future arrangements for the isolation of smallpox sufferers in Birmingham involved greater collaboration between the guardians and the Town Council. Two straw sheds and several stone-breaking sheds at the rear of the workhouse had been converted into wards in the 1860s because of the threat of cholera. They were used for smallpox cases during the 1871 epidemic, but became overcrowded within ten months of the first admission. In co-operation with the Borough authorities, two buildings to hold 30 acute cases were completed as well as two wards for convalescent smallpox patients.[50] The guardians requested payment from Birmingham Corporation for the maintenance of 599 cases sent to the 'smallpox hospital' by the Sanitary Commission between 7 December 1871 and 8 February 1873, an amount totalling £1,388 for 11,101 days at 2s 6d per patient per day. The following year they agreed to let the buildings containing the smallpox wards to the town council, who decided to build additional wards for patients with infectious diseases on land in the workhouse grounds.[51] However, over the next 10 years, there was continual haggling over the length of tenure of the lease, but eventually the guardians agreed the Corporation could purchase the smallpox buildings and have tenancy of the land as long as it was required. It was arranged that the building in the workhouse grounds would only be used for smallpox, with paupers requiring admission being given priority. In addition, the Borough isolation hospital would admit all scarlet fever cases including paupers. Co-operation did not end there, because, in the more severe epidemic of 1893–1894, the Town Council had again to request the use of the stone yard sheds at the workhouse as an additional facility for treating smallpox cases.[52]

Wolverhampton Union also had the responsibility of admitting smallpox cases during the 1870s epidemic. The guardians agreed to a request from Wolverhampton Town Council to accept non-pauper patients in the infectious wards of the workhouse on a payment per case basis.[53] Between 100 and 200 patients were admitted from November 1871 until February the next year with between 22 and 30 cases in the workhouse at any one time.[54] Conversely, during the 1884–1885 epidemic, arrangements were made for pauper patients to be admitted to Bilston infectious hospital on payment of 3s per removal, 15s per week and the cost of the funeral.[55] In the epidemic of the early 1890s, Willenhall Local Board

50 BCL, HSC, GP/B/2/3/3/3, 28 January 1873.
51 BCL, VGPC, GP/B/2/8/1/6, 31 January, 14 February 1873; BBG, GP/B/2/1/43, 19 August and 9 December 1874.
52 BCL, VGPG, GP/B/2/8/1/7, 25 July 1878; GP/B/2/8/1/9, 9 November 1883 and 7 December 1884; BBG, GP/B/2/11/52, 19 March 1884.
53 WALS, WBG, PU/WOL/A/15, 5 April 1872.
54 WALS, WBG, PU/WOL/A/14-15, 27 October 1871 to 21 June 1872.
55 WALS, WBG, PU/WOL/A/19, 3 August, 7 September 1883.

were informed that the isolation wards at the workhouse were not for the admission of outdoor paupers.[56] However, as there was no isolation hospital in Willenhall, a man living in that district, who had contracted smallpox in 1893 while working in Derby and was sleeping in the same bed as his wife and newborn child once back home, required urgent admission to the workhouse.[57]

There are only a few recorded instances of attempts at shared responsibility between poor law and sanitary authorities for the isolation of patients with infectious disease. In the 1870s the guardians in Reading agreed that non-paupers could be admitted to Battle workhouse fever wards, but this was not always acceptable to patients. In 1876 a girl aged 25 with smallpox refused admission because of the stigma of pauperism.[58] Salford guardians allowed non-pauper patients to be admitted to the workhouse during the 1870s epidemic. Afterwards their request to the council to collaborate in the provision of a single isolation hospital was rejected with the result that each authority proceeded to erect their own isolation facility.[59] The extent of the collaboration between poor law and sanitary authorities in Wolverhampton and Birmingham was greater than has previously been noted elsewhere and in the case of Birmingham appears to have been exceptional.

Conclusion

The poor law medical service was the dominant player in the control of the spread of infection within local communities, rural as well as urban, before isolation hospitals were erected and continued to be an important resource afterwards.[60] This responsibility for controlling the spread of infection within the local community went beyond the guardians' poor law responsibilities and has not been given sufficient recognition by historians. More generally, poor law medicine was an important element in the lives of the poor from the beginning of the New Poor Law to well into the twentieth century. Few paupers' letters of thanks exist, but one such illustrates the extent to which medical relief affected their lives. In 1895, the chairman of the Board of Wolverhampton Guardians read a letter from a resident at Blakenhall, who 'wished to tender his sincere thanks for their kindness in supporting him and his family during the five years he had been unable to work' (presumably with outdoor relief). He 'had kept at work as long as he was able … had been an inmate in the infirmary for some weeks and came into workhouse infirmary as he thought to die'. He had been discharged 'completely cured' after a few weeks and been able to resume work to support his family.[61]

This article has demonstrated that Birmingham and Wolverhampton Infirmaries were an important part of the medical landscape of each town. Recent research has shown that

56 WALS, WBG, PU/WOL/A/24, 10 February 1893.
57 WALS, WBG, PU/WOL/A/24, 3 February 1893; *WC*, 8 and 15 February 1893.
58 M. Railton and M. Barr, *Battle Workhouse and Hospital 1867–2005* (Reading, 2005), pp. 57–9.
59 Pickstone, *Medicine and Industrial Society*, pp. 166–8.
60 Wildman, '" He's only a pauper"', pp. 30–2.
61 WALS, *WC*, 22 May 1895.

workhouses were more complex medical institutions than previously thought by providing care to a larger range of patients and illnesses. However, it is not possible to generalise as to the nature and standard of the care provided within them, as it varied enormously throughout the country. Nevertheless, it was at times impressive and humane, even from the early days of the New Poor Law. In areas such as Wolverhampton, the medical service grew out of the arrangements of the New Poor Law. In other places, such as Birmingham, with an existing medical service, a later movement took place to bring it into line with the central authority's guidance. Thus, there was no national distinct watershed in medical provision after the New Poor Law and the medicalization of English workhouses was not, as previously suggested, a late nineteenth century phenomenon. Despite the relative neglect of sickness as a cause of pauperism in the act of 1834, the workhouse did, in fact, become the single most important institutional setting for the provision of medical care by the early twentieth century.