Club practice

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SUMMARY. There were many forms of club or contract practice in the nineteenth century, but the friendly societies were the most important. A brief history of the friendly societies is given. As they grew in numbers and importance so did the dissatisfaction of the doctors who worked with them. Discontent among the doctors led at the end of the century to a battle between the medical profession and the clubs. The issues which divided the clubs and the doctors were clearly defined but, although the battle was protracted, the doctors did not win or manage to change the system of medical provision for the poor. The club system was ended by Lloyd George when he introduced his National Insurance Act, 1911.

Introduction

THE foundation of modern general practice was laid in the nineteenth century in response to the industrial revolution and the medical and social problems it produced. Yet the Factory Act of 1833 and the Poor Law Act, 1834, although they were to provide the basis for two important areas of work for the nineteenth-century general practitioners, did not mention medical care as such. The role of the certifying surgeons and the union doctors was incidental to the legislation (Bloor, 1980, 1981). The major agency for medical care in the second half of the century was the club system or contract practice. Clubs had been pioneered by the labour movement (Abel Smith, 1972), and it was their influence and power, particularly that of the friendly societies, which moulded and dominated nineteenth-century general practice until the great landmark of the National Insurance Act in 1911.

Origins and history

The early guilds were concerned with mutual help and the proper provision for burial of the dead (Morrah, 1955). However, most of the guilds did not survive Tudor times and the poor had to rely on the harsh Elizabethan Poor Law (1601). The principle of self-help is, however, very strong and village clubs were formed to ensure a proper burial. They usually met in an inn and had a box for donations by way of casual relief and a box with locks for securities, documents and uninvested cash (Brabrook, 1898). These box clubs gave sickness as well as death benefit and became prominent during the last decade of the seventeenth and the early part of the eighteenth century. One of the earliest of these clubs, founded in 1634, was the General Sea Box in the Scottishburgh of Borrowstounness (Wilson and Levy, 1937).

These box clubs were the forerunners of the friendly societies, the first of which were established by the immigrant Huguenots in Spitalfields in 1687, 1703 and 1708 (Brabrook, 1898). Governments were initially wary of these societies because they were afraid that they might be a disguise for a trade union but, as time went on, their growth was encouraged and "An Act for the Encouragement and Relief of Friendly Societies" was passed in 1798. By this time the industrial revolution had begun. With it came a tremendous growth in the number and members of the societies. Mr Tidd Pratt, the Registrar of Friendly Societies, reported in 1867 that some 38,315 were formed between 1793 and 1867 and that 13,935 had collapsed (Wilson and Levy, 1937). It was the instability of some of the societies that led to a Royal Commission in 1871. Its major recommendations were incorporated in the Friendly Society Act, 1875.

Organization

Friendly societies are self-governing organizations for the purpose of providing, by voluntary subscription, certain benefits for their members. In the past these were usually:

1. Payment of money during sickness.
2. Payment of small sums on the death of a member.
3. Medical attendance.
4. Compensation for the loss of tools.
5. A travelling allowance in order to find employment.

The two chief societies were the Independent Order of Oddfellows of the Manchester Unity and the Ancient Order of Foresters, but there were many more, often with fascinating names. For instance local branches of the Oddfellows were called 'lodges' (for example, Loyal Heart of Oak Lodge, Loyal Beacon Lodge, Loyal Caldicot Castle Lodge). Branches of the Foresters were 'courts' (Chorlton, Cobden, Court Star of Suffolk), and The Rechabites used the term 'tent' (Mizpah Tent, Anchor of Hope Tent). Membership was initially confined to adult males who on entry had to have a medical examination and produce a certificate of fitness. This was usually carried out by the lodge doctor, who received no fee for this initial examination. Gradually some societies admitted other members of the family, some admitted working women in their own right and eventually there were even societies specifically for juveniles.

Doctors were employed on a contract basis and their work with the various clubs was called 'contract practice'. They were appointed by a general meeting of the Lodge and their tenure of office was usually at the pleasure of the Lodge, although it could be annual or for a fixed term. There was rarely any written contract other than acceptance of the rule book. Rule 20 of the Forester Court of Northampton stated that:

> "A surgeon or surgeons shall be elected who shall continue in office during the pleasure of the Court. It shall be his duty to examine all candidates; attend the sick members residing within three miles of the courthouse, and provide them with proper and sufficient medicine during their affliction. . . . The surgeon shall receive for each financial member, residing within the distance of three miles from the courthouse, 1*s.* 6*d.* per half-year for his services, which shall be considered full remuneration for the surgeon's trouble and care, which shall be paid from the management fund of the Court." (Gosden, 1961).

The area in which the doctors practised was usually confined to a radius of three miles from the club's headquarters and could be confined to certain types of work. For instance surgery, fractures, obstetrics and vaccination were usually excluded.

Links with the medical profession

When the Apothecaries Act was passed in 1815 there was no evidence that the medical profession was working with the friendly societies. The problem of determining whether sickness was genuine was left to the stewards of the society. Rule 12 of the Friendly Society of Joiners in Newcastle required that when any member notified the secretary that he was sick, the stewards were to visit him within 24 hours if he lived within one and a half miles of where the society held its meetings. They were to continue to do this each week and report to the secretary. If a member lived beyond a mile and a half away a certificate was to be produced which had to be signed by a parson or two churchwardens, the employer or two respectable householders, and had to declare where and how the man came by his disorder (Gosden, 1961).

It was probably the requirement of a certificate to prove incapacity that gradually drew in the doctors and the notion of medical benefit. This was clearly stated in the rules of the Burford Friendly Society in 1826 (Gosden, 1961). Medical attendance as a benefit might well have been encouraged by the local society and its patrons, such as the squire and parson, who would be intent on protecting their funds, had no time for shamming and did not like giving medical relief on the rates. Many Oddfellow Lodges were providing medical attendance benefit by 1840 and there seems no doubt that the great impetus had been the 1834 Poor Law Act.

The growing connection between the medical profession and the societies was recognized by the Medical Act (1858), which stated that no persons should hold any appointment as a physician, surgeon or other medical officer to any friendly society or other society for affording mutual relief in sickness, infirmity or old age, or as a Medical Officer of Health unless they be registered under the Act (Gosden, 1961).

Private clubs

The simplest of the various other kinds of club was the Private Club run by the doctor, who laid down the rules of admission and terms, and whose only restraint was competition from his fellow practitioners. Towards the end of the nineteenth century, because of increasing discontent amongst doctors working for the friendly societies, many doctors came together to form larger clubs. These were known as Public Medical Services and were often called the 'Provident Medical Association' of a particular town. These associations were run solely by doctors and membership was restricted to persons unable to pay the usual medical charges. A wage limit was imposed. People of all ages and both sexes were admitted provided they were certified as fit by the doctor. Most doctors in a district took part in such a scheme and the patients had a free choice of doctor.

Works clubs

Works clubs differed in some respects from all the other clubs. They were constituted under a special provision of the 1831 Truck Act which enabled workmen to enter into contracts with their employers for the regular deduction of a certain amount of money from their wages for the provision of medical attendance and medicine for themselves and, in many cases, also for their families. These work clubs were based mainly on collieries, mines and quarries. The simplest arrangement was for the employer to engage a doctor to look after his workmen, but more usually the workman was left to

nominate any doctor in the district. In other cases the general body of workmen at a particular works or mine would nominate a doctor and set up a committee to supervise the arrangements (Bloor, 1978).

Dividing societies

These were friendly societies which worked the dividing principle. They allowed no surplus funds to accumulate, and so yearly, or at other irregular intervals, the funds would be divided amongst the members. They had such names as 'yearly' or 'breaking' societies, 'tontines', 'slate clubs' and 'cock and hen clubs', and probably represent an early stage in the evolution of friendly societies. People following irregular employment or having to move from place to place found these societies to their liking and they were popular among sailors and dockers (*British Medical Journal,* 1905). There were many such slate clubs in Grimsby, most of them run by publicans. In this ingenious system a member paid the publican six pence each week. The surplus money was divided out at Christmas and the doctor was paid 2*s.* 6*d.* per member per year. There were no overheads, no secretaries, committees or having to register the society; the publican did all the work and was unlikely to run off with the money for he was assured of regular custom (*Lancet,* 1895). A neat but disgraceful variation of this occurred in a club run solely for women at a public house in Walsall. Their subscription had to be paid fortnightly by attendance and the purchase of three halfpence of ale. This ale was put out and had to be paid for even on non-attendance; those in arrears were fined (*Lancet,* 1896). On the other hand there were many slate clubs run by chapels and churches which were extremely helpful and registered as friendly societies.

Friendly Societies Institutes

In many large towns friendly societies formed combinations for the provision of medical and allied benefits and appear to have modelled themselves on the provident dispensaries. These bodies were exceptional in making very precise and clear contracts with their doctors and in stating a definite period for termination of contract (usually three months). The supplying of medicines and dispensing were usually excluded from the contract, but, on the other hand, confinements and vaccinations were included. A doctor was usually employed full-time and private practice was expressly forbidden; he lived usually on the premises, rent free, but often had the responsibility of keeping the surgery clean. The doctor was usually paid a fixed salary with an allowance for rent and rates and horse hire. In Hull in 1894 the eight lodges which formed the dispensary had 4,000 members who were given 20,000 consultations and received some 7,000 visits. Arduous work, poor pay and loss of independence led to great dissatisfaction with these particular clubs.

Medical aid societies

The medical aid society clubs were purely commercial and were run by businessmen. A considerable amount of canvassing, touting and advertising was carried on. The first one was founded in Preston in 1869 (Parry, 1976). They grew fairly rapidly, but by the turn of the century they had become so unpopular with the doctors that they faded out. The doctors had no say in the running of them, and they were given written contracts which were clear, definite and restrictive. There were two medical aid clubs in Birmingham in 1896, the Edgbaston Medical Self Supporting Society and the Minerva Medical Aid Society. The Minerva had some 30,000 members and employed 49 doctors; the patients paid 1*d.* a week (4*s.* 4*d.* a year) and the doctor was paid 3*s.* per patient a year and had to buy and supply the drugs. It was these clubs more than any other which encouraged the doctors to fight the clubs towards the end of the century.

Provident dispensaries

The provident dispensaries, although part of club practice, stand somewhat apart from other clubs. They were originally established as public charities with the object of providing medical attendance for members of the community who did not qualify or perhaps desire relief under the Poor Law. They differed fundamentally from other clubs by having a governing committee which consisted of representatives of the beneficiaries, medical staff and members of the general public who subscribed but drew no benefit. The institution usually owned the building at which the patients attended; the doctors, one or more or all the local general practitioners, were paid a percentage of the payment made to the beneficiaries. The provident dispensaries usually admitted people as members even if they were unfit, provided they paid a small extra fee. Most other clubs would have nothing to do with unfit people.

The problem of the unqualified assistant

The Industrial Revolution increased the demand for medical care, and the congregation of people in and around cities highlighted the public health problems of water and food supply and the disposal of sewage. During the nineteenth century new medical schools opened, new regulations were passed and standards improved, but the doctors could not cope and began to employ more unqualified assistants. This was particularly so in the large cities and in the many mining and colliery areas, where one doctor would have several branch surgeries run by unqualified assistants who were really employed as dispensary assistants. Dr Cox, who later became Secretary to the British Medical Association, started as a dispenser in such a colliery practice in 1886 (Cox, 1950). His consulting hours were 09.00-

11.00, 14.30-16.00 and 18.00-21.00 for six days a week. On Sundays he did the morning surgery, but only one hour in the afternoon and evening. He lived on the premises and was paid £1 per month. The patients who paid were charged 1*s.* for a consultation, 1*s.* 6*d.* for a visit and 10*s.* for a confinement. The doctor for whom Cox worked was doing between 200 and 300 midwifery cases a year. The employment of unqualified assistants was finally stopped by the General Medical Council in 1891 (Little, 1932).

The battle of the clubs

The rapid growth of the friendly societies and in the amount of work the medical profession was doing with them soon gave rise to friction. At first quarrels were sporadic, like that between the local doctors and the Dorset Friendly Society in 1848 (*Provincial Medical and Surgical Journal,* 1848). Then there were louder murmurings (in Birmingham in 1868), followed by guerilla warfare until the open pitched battles of the last decade of the nineteenth and the first decade of the twentieth century. The battle against the clubs is very important in the history of general practice, and, fortunately for us, there are two major sources of information about them.

In 1895 Dr Squire Sprigge, Editor of the *Lancet,* appointed a special commissioner, Adolphe Smithe, to tour the battle fronts and write a report. He was "noted as a man of much experience in such pursuits, of fair judgement, without prejudice and of good literary and descriptive ability" (*Lancet,* 28 December 1895). He visited a great many towns and cities, investigated local conditions and interviewed a large number of doctors. His reports were published weekly in the *Lancet* between 1895 and 1896 and came from such places as Eastbourne, Derby, Grimsby, Hull and York. The second source of information is "an investigation into the Economic Conditions of Contract Practice in the United Kingdom", which was carried out by the BMA in 1903. Their 90-page report was published as a supplement in 1905 and was based on a questionnaire sent out to 1,548 doctors.

These two reports make clear that there were many causes of discontent and many battles, but the principal grievances were as follows:

1. *Poor pay and conditions.* For example, during the year 1894 the Hull Dispensary, run by six friendly societies, had given some 20,000 consultations and conducted 7,000 visits. The total pay to the doctors was £208, which gave just over 7 farthings per consultation (*Lancet,* 23 November 1895). The money was always less than if it was paid by a working man directly to his doctor. Doctors disliked having to live over the surgery, to keep it clean and having no private practice.

2. *No wage limit on membership.* It was this problem which caused the greatest discontent. Doctors accepted that the real purpose of the club system was to prevent patients who could not afford to pay a doctor directly seeking help under the Poor Law. But people such as farmers, teachers and shopkeepers were increasingly using the club system when they could well afford to pay the doctor themselves. The friendly societies always resisted the demand for a wage limit, maintaining that medical treatment was only one of the many other benefits they gave.

3. *Children and women.* It was soon recognized that children and women produced proportionately more work for the doctor, and yet he was usually paid much less for attending them than for attending a man.

4. *Choice of doctor.* There was no real free choice of doctor and the patient, if he was unfit on entry to a club, received no club medical treatment at all.

5. *Management.* Doctors had no say in the management of the clubs (other than their own private ones). As time went by the friendly societies became more centralized, more powerful and more remote from the doctors.

6. *Commercialization.* Doctors resented the increasing commercialism, canvassing and overt advertising, particularly of the medical aid societies.

7. *Standards.* The sheer volume of work and the conditions under which it was done encouraged the practice of poor medicine. The unqualified assistants usually looked after the club patients while the doctor attended his private patients and other jobs.

The battle of the clubs lasted more than 20 years and ended only with the passing of the National Insurance Act in 1911. There was an early victory at Eastbourne (*Lancet,* 1895), where the doctors had to fight a very commercialized medical aid society and two of the most powerful insurance companies, the Prudential Assurance Company and the Liverpool Victoria Friendly Society, who were canvassing hard and offering medical attendance as a fringe benefit to policy holders. The doctors, without exception, withdrew from the clubs and formed their own Eastbourne Provident Medical Association. They were then able to negotiate as a body and lay down their own terms. The neighbouring town of Bexhill-on-Sea followed the example of Eastbourne. The first five rules of their constitution (*Lancet,* 1895) were as follows:

1. *Object.* This Association is a self-supporting society to enable those who cannot pay for medical attendance at the usual charges to secure for themselves and their families the advantage of medical attendance, advice, and medicine during illness.
2. *Management.* It shall be managed by a general committee, which shall consist of the whole of the medical men in Bexhill who shall sign the undertaking. The general committee shall appoint a chairman and honorary secretary annually. The whole of the business of the Association shall be managed by the general committee, which shall hold an annual meeting and, in addition, shall meet as often as the business of the Association demands. Four members shall form a quorum.
3. *Undertaking.* Any duly qualified and registered prac-

titioner residing in Bexhill (not practising as a homeopath) may become a member of the staff subject only to his appointment being approved by the Committee. All members of the staff must also sign an undertaking—1. Not to conduct clubs of their own at all (other than friendly societies registered under the Act) unless it be at rates the same or higher than those of the Bexhill Provident Medical Association. 2. To have no professional intercourse whatever with any medical man who associates himself with any of the companies known as Medical Aid Societies or with similar institutions so long as the methods adopted by these societies include (a). canvassing for members in the interests of individual practitioners, (b). the virtual sweating of their medical officers by the inadequate remuneration offered for the work done.

4. *Membership.* Artisans and their families, and others who may be considered suitable by the committee, shall be eligible for membership, provided they live within 2 miles and a half from the Town Hall. No person can become a member who is in receipt of parochial relief. All applicants must be in good health on joining, and must first be passed as such by one of the medical officers. If persons in indifferent health are to be admitted at all it can only be at special rates determined by the committee. Each medical officer shall receive the subscriptions from the members' honours list, and render to the monthly meeting a list of defaulters and new members.

5. *Wage limit.* Although a most desirable matter, it is very difficult in practice to adopt a hard-and-fast "wage limit", and therefore it would appear that the best way of preventing abuse of the Association by persons who are too comfortably off will be by leaving absolute discretion in the hands of the committee to consider the case of every applicant on its own merits. But, as a general rule, it may be laid down that in the case of families they shall be eligible, if the combined incomes of the parents do not exceed 30*s.* a week, at the rate of 2*d.* a week each adult—i.e., over 14 years of age—and 1*d.* a week for each child. It will be expected that the whole of the family shall be entered on the lists (exception being made in the case of any members who may be already members of a registered friendly society), but in large families not more than six children shall be charged for. Any person who has been a member in childhood can, on completing his or her fourteenth year, continue as an adult member by paying the additional penny a week.

The message from such victories was clear; doctors must join together locally and produce a united front. Similar societies were formed up and down the country. The names of a few were as follows: the Birmingham and District Medical Practitioners Union; the Manchester Medical Guild; the Medical Ethical Society of Hull; the Norfolk and Norwich Medico-churgical Society; the Northumberland Medical Association; and the York Medical Society. Despite this movement, the imaginative reporting of the *Lancet* in the early years and the crystallization of opinion through the BMA's report of 1905, the doctors did not win the battle of the clubs.

The war was ended by Lloyd George (Bruce, 1961), but his National Insurance Act of 1911 had to face bitter opposition not only from his political opponents but from three powerful pressure groups—the doctors, the friendly societies and the insurance companies. His skill in making some concessions to these pressure groups was matched by his determination to see an end to the club system.

The Act could not be implemented on the appointed day (15 July 1912) because of opposition by the doctors. The most vocal of the profession were the consultants and the hierarchy of the BMA, but Lloyd George soon realized that they did not represent the overwhelming numbers of club doctors, the very people who would work the new system. He repeatedly assured these doctors that they would be better off under his proposed panel system; they believed him and, after the failure to implement the Act, began resigning from the BMA in large numbers. By the beginning of 1913 resistance to the Act had crumbled and Lloyd George was able to announce that he had some 10,000 doctors to work the new service (Cartwright, 1977). The Act was fully implemented by the end of 1913. The battle of the clubs was over, but the club system and the insurance companies provided the administrative framework and pattern of care for the new system. They became 'approved societies' under the Act and local insurance committees with general practitioners on them supervised local arrangements. Now a patient had a choice of a doctor from a local panel of general practitioners.

Conclusion

The club system started as a local affair, but expanded rapidly after the Poor Law Act of 1834 until, at the end of the century, millions were covered by it. The system typifies the Victorian age, with its aggressive industrial expansion, its commercialism, its emphasis on the principle of self-help and its belief in charitable institutions. Inventiveness knew no bounds and it was a time when there was a club for everything. Although doctors did not bring about a change in the system of medical provision, there can be no doubt that their discontent with the clubs acted as one catalyst in the general movement of social reform from 1905 to 1914.

The change from club practice to the panel system seems in retrospect to have been a natural evolutionary process (Honingsbaum, 1979). What then had been achieved by the long period of discontent with club practice? The patient had been given the fundamental right of a free choice of doctor and the doctor had been freed from the shackles of the club employer. The struggle with the clubs demonstrated quite clearly that doctors could have some influence in affairs which concerned them only by joining together, not just locally but nationally. Above all it ensured that general practitioners were at the heart of the system.

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Health problems amongst ethnic minorities

It is often thought that ethnic minority groups in the UK have difficulty obtaining satisfactory medical care because their major medical problems are unusual and specific to their own community—for example sickle cell disease, rickets and TB. In an attempt to meet such needs, an experimental telephone advice service was set up in London in 1979 staffed by volunteer Asian and Afro-Caribbean health workers who were mostly doctors or health visitors. The service was announced on Radio London by the volunteers in their own language and in English. Over a six-month period, 2,542 calls were taken, the majority from Asians. However, most of the calls were for relatively straightforward problems such as asthma, hay fever, family planning and nutrition. A surprisingly high number of calls were about diabetes. Ninety per cent of the callers had previously consulted their family doctor but were discontented, and often disturbed, by the help they had received either because of communication difficulties or, in some cases, because of the doctor's lack of sensitivity to cultural mores. At times the volunteers attempted to mobilize local health resources to help the callers, but they were often met by indifference and even antagonism from both general practitioners and nurses.

Source: Webb, P. (1981). Report of an ethnic health project 1979/1980. *Health Education Journal,* **40**, 69-74.