

## Contagious Communities: Medicine, Migration, and the NHS in Post War Britain

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**Reviewer:** Julian Simpson

Much has been written about the UK's National Health Service but as Martin Gorsky pointed out in a detailed review of its historiography published to coincide with its 60th anniversary in 2008, accounts of its past have tended to privilege traditional political narratives focused on national politics and the workings of the civil service.<sup>(1)</sup> In the case of Charles Webster's two tomes on British healthcare since the war and his shorter, political history of the NHS, this was a deliberate and conscious choice and it is undeniable that political intrigue and decisions made at the centre form a key part of this history. The overwhelming focus of Webster and others such as Rudolf Klein and Geoffrey Rivett on high politics and Westminster-centric developments has however been to the detriment of the emergence of a more rounded account of the organisation's past. John Lister's *The NHS after 60* offers an alternative and stimulating perspective that engages with the views of staff and patients but one that is unapologetically partisan (Lister has for decades been associated with the campaigning group London Health Emergency) and that is built around national political developments.<sup>(2)</sup> Naturally, other work has focused on healthcare in Britain in the post-war period but discussions of the organisation itself and its development are dominated by national narratives with an implicit assumption that change is unproblematically driven from the top down. It is paradoxical, given the role that the NHS plays in British society and the way it defines Britain's sense of self (the dancing patients and nurses of the London Olympics' opening ceremony being the latest illustration of Nigel Lawson's quip about it being akin to a national religion) that until very recently few historians have offered different perspectives on its past. We still know relatively little about issues such as the impact of patient views on policy (for all that it has been subject to neoliberal reform the NHS remains a bastion of the welfare state), the relationship between the professions and organisational change (both when it comes to supporting and subverting it) and more generally the range of diverging and contradictory influences that have been brought to bear on it both within and outside of Westminster and within and beyond the UK's borders.

What might a different history of the NHS look like? There is no easy answer to this question and focusing on national political developments is undoubtedly one way of avoiding the discomfort that it provokes. With its remit of providing care from the cradle to the grave, its impact on the lives of millions of individuals living in Britain and as one of the main employers in the world (1.3 million people currently make up its workforce), the NHS is a diverse and multiform organisation. Its history has naturally been shaped by local

contexts, professional cultures, patient activism, and immigration – amongst many other factors. The devolution of responsibility for healthcare within the UK (now being implemented in Greater Manchester after Wales, Scotland and Northern Ireland) reinforces the sense that there can only be histories of the NHS rather than a history. In recent years, evidence of this has been provided for instance in terms of the influence of patient organisations, the nature of consumerism and the role of the migration of healthcare professionals in the development of provision.<sup>(3)</sup> The fruitfulness of decentered approaches to the history of healthcare in the UK had already been demonstrated in the 1990s by Virginia Berridge's exploration of the British policy response to the spread of HIV/AIDS.<sup>(4)</sup> Historical research nevertheless still only finds itself in the early stages of what promises to be a protracted exploration of a complex past.

*Contagious Communities* offers an important contribution to this emerging picture of a multi-layered history of the NHS and shows why we need to conceive of it as an organisation subject to diverse and at times contradictory influences. This involves recognising that it is subject to transnational forces and does not exist in an immutable and impermeable national frame of reference. *Contagious Communities* also performs an important task in linking migration history to the historical mainstream and critically assessing the relationship between migration, politics and the development of medicine.

Roberta Bivins' book is therefore at the intersection of several bodies of literature and serves not only to redefine our understanding of aspects of the development of the NHS but also to reframe our perception of the role of immigration by showing its impact on the centre rather than defining migrants solely through their difference. *Contagious Communities* both broadens our understanding of the history of the NHS and brings the history of migration into our understanding of the development of medicine. It offers an exploration of three interconnected questions: the extent to which migration policies were shaped by medicine, the influence of post-colonial migration on British medical research and culture and the ways in which different groups of migrants were perceived in the context of medicine, health and disease. The focus is on the period between 1948 and 1991 and on groups constructed as distinctive from a physical, medical or cultural point of view rather than on all migrants who came to the UK during this period. It offers an examination of how the development of medicine and healthcare in Britain shaped and was shaped by the changing policy context of immigration and 'race'.

This is an ambitious task; one which is approached through a series of case studies. They take the reader from an initial description of the immediate post-war period where an 'open door' immigration policy allowed non-white migrants from the rapidly disintegrating British Empire free access to the metropole through to the changing context of the 1960s with laws restricting immigration but also efforts to improve 'race relations' and on to a survey of the latter part of the period under examination which incorporates the role of community activists in shaping their care and the impact of genetics. The first part of the book deals with perceptions of tuberculosis in the 1940s and 1950s, contrasting attitudes towards Irish or European migrants to a growing racialisation of responses by the end of the 1950s as the numbers of West Indian and South Asian migrants increased. The second part focuses on the 1960s through the prism of outbreaks of smallpox and discourses of control – of tuberculosis, immigration and 'race relations'. A third and final section addresses itself to discourses and policies related to the childhood deficiency disease rickets as well as its adult form osteomalacia and uses the blood disorders sickle cell anaemia and thalassaemia to explore the evolving relationship between genes and 'race'.

This approach brings to the fore the contingent nature of care. It offers a broad perspective on the range of factors that came into play in shaping healthcare, the shifting nature of priorities but also the ongoing racialisation and othering of particular groups as well as the profound effects that this has on the practice of medicine and the elaboration of healthcare and immigration policies.

This deeply original, clearly written and well-researched book makes a persuasive case that the development of medicine and healthcare, shifting notions of race and immigration and immigration policy are intertwined. It does so while embracing complexity and offering a nuanced interpretation of the developments that it describes. Bivins for instance rejects explanations based on what she terms 'simple racism' (p.109). Difference in a broader sense is emphasised as a key factor when it comes to perceptions of the alterity of specific groups and the effect that this has on policy and practice. Bivins notes for instance the way in which Muslim Pakistani migrants could be contrasted with African-Caribbeans viewed as more 'British' and therefore less problematic. Political context is also identified as a key factor when it comes to understanding public and policy responses, witness the contrast between the attention paid to the outbreak of smallpox in 1961–2 when hostility to new Commonwealth migration was gathering pace as compared to earlier episodes which were afforded a much lower profile. Similarly the British Medical Association's position on immigration control shifted significantly in the late 1950s – towards greater controls on those coming to the UK.

This is not a simple exercise in charting the effects of discrimination and racism. The history of what came to be known as 'Asian rickets' (reflecting the condition's increased prevalence amongst South Asians in Britain) between the early 1960s and the beginning of the 1980s, thus suggests that perceptions of migrants shaped approaches to the condition by constructing them as outsiders. It also hints at the fact that increasing sensitivity around racism may have contributed to official reticence to engaging with skin pigmentation as a factor in explaining differential rates of the disease amongst ethnic minorities and when it came to envisaging initiatives targeted selectively at the Asian community. Media criticism of the failures of government policy however pinpointed race as a factor in the neglect of patients to maximise political embarrassment and encourage intervention. Towards the end of this period, racialized migrant communities themselves become more prominent in the policy making process and at least began to make their voices heard – for instance through the involvement of South Asian doctors and community representatives in the government sponsored Stop Rickets campaign of the early 1980s. However, responses within the Department of Health and Social Security were not universally positive. One official, in an intriguing echo of colonial methods, complained that the Asian people she was working with were trying to go beyond what she saw as their natural function of disseminating messages from the centre to 'their people' (p. 284).

In the final chapter of the book, Bivins reflects on the ways in which traditional approaches to human differences and notions of 'race' interacted with what she calls the impact of genetic thinking, concluding that continuity with the past was as much in evidence as rupture. Community perspectives are also reflected here as Bivins documents how the US experience of dealing with sickle cell anaemia and its association with racial injustice as well as black communities' suspicions of the motives of the medical profession influenced British policy makers and practitioners. She also argues that thalassaemia, associated principally in policy circles with 'Mediterranean' (i.e. mainly Greek Cypriot) populations was perceived as less politically sensitive and thus was a more attractive proposition when it came to medical intervention. She notes that understandings of the conditions which privilege biomedical models (and are not without parallels with eugenics and historical ambitions to eradicate particular characteristics) can serve to divert attention from interventions aimed at managing their effects.

However, if *Contagious Communities* incorporates perspectives from ethnic minority patients it stops short of questioning the very notion that there is a coherent official view of these issues which can be adequately summarised when it came to policy and practice in the NHS. It thus avoids embracing another layer of meaning and complexity. Individual GPs for instance enjoyed a huge amount of professional autonomy for most of the period Bivins is looking at (although there are some incursions into the very recent past, her narrative essentially ranges from the inception of the NHS to the Thatcher governments) and as she notes policy shifted in the direction of devolving responsibilities to primary care. Bivins states that her goal is 'to recognize and assess attitudes towards populations and individuals who were considered, between 1948 and 1991, to be physically, medically or culturally distinctive migrants to Britain...' (p.8). She also writes of 'medical and public health services' (p. 10) and of their relationship with migrant bodies. The question of

whose ‘attitudes’ are being evaluated and the extent to which they are homogenous receives too little attention. Many of the general practitioners working in areas with high percentages of ethnic minority populations were for instance born in South Asia – and could be vectors of different approaches to medicine. Whilst the book offers a welcome exploration of the relationship between migration and policy, and does allude to the roles of migrant professionals, it would have benefited from engaging in a deeper reflexion around the nature of the gaze that was directed towards migrants. One of the problems with writing about the NHS is that in spite of the way in which it is at times perceived, it is not a stable monolithic institution unambiguously subject to the effects of top-down change in a national framework. Migrants appear at times in this book as actors but mainly as members of communities rather than as part of the medical profession and the policy making process. Whilst the extent to which they were able to influence policy making is open to debate, the fact that a significant percentage of those delivering and therefore shaping healthcare services were migrants themselves is not.

Although this book draws at times on oral evidence (produced by other scholars), it would have undoubtedly been enriched by additional interviews with some of the protagonists. This would have potentially offered a different perspective on the influence of migrants themselves on healthcare. Politicians and civil servants may have put forward perspectives at variance from those contained in official documents deposited in archives. Particularly when it comes to issues viewed as highly sensitive, the passage of time can allow actors more freedom of expression – or indeed greater insight into their motivations. It seems paradoxical that Bivins, who has conducted an impressive amount of archival research for this book did not feel that oral history testimony could add anything to this picture – not least because research participants often provide access to documents that are not available in public archives.

Another reservation about this book concerns its subtitle which promises a general overview of ‘medicine, migration and the NHS in post-war Britain’. It would be interesting to know if this was the author’s choice. Describing the book in this way might make sense to a publisher looking for a market but it can only serve to disappoint any reader expecting a detailed survey of these questions. The subject is probably too vast to be treated in a scholarly fashion over the course of one volume. Bivins assumedly knows this as what she has succeeded in doing is to offer insights into this topic through a series of case studies reflecting developments at specific points in time. The book would have been better served by a different subtitle, one which reflected the author’s approach and did not imply that the book might for instance offer new perspectives on diabetes and heart disease in South Asian communities, the relationship between mental health professionals and the African-Caribbean population, a more general analysis of the history of health inequalities or indeed a detailed appraisal of the factors explaining the ‘invisibility’ of migrants racialized as white when it comes to discussions on health and migration.

*Contagious Communities* offers an intriguing exploration of the ways in which particular aspects of policy and practice were shaped by a range of evolving factors. It significantly enhances our understanding of the racialisation of medicine and healthcare and the medicalising of immigration policy. On those terms it is a success. It opens the way to approaches to the history of the NHS which embrace its nature as an organisation shaped by social and cultural forces, by the legacies of the past (for instance when it comes to ‘race’ and colonialism) and transnational forces. More generally the book shows that a detailed engagement with the history of migration can help reframe the history of the UK as whole, rather than solely existing in isolation with an emphasis on difference, culture and experience. The history of the NHS has been profoundly shaped by its responses to different groups of patients but also by the work of migrant professionals. The arguments eloquently put forward in *Contagious Communities* will make these dimensions of British healthcare harder to ignore in future accounts of its development.

## Notes

1. M. Gorsky ‘The British National Health Service 1948–2008: a review of the historiography’, *Social History of Medicine*, 2008, 21 (3), 437–60. [Back to \(1\)](#)

2. See C. Webster *The Health Services Since the War: Volume I* (London, 1988); C. Webster, *The Health Services Since the War: Volume II* (London, 1996); C. Webster, *The National Health Service: A Political History* (Oxford, 1998); R. Klein, *The New Politics of the National Health Service* (Oxford, New York, 2010); G. Rivett, *National Health Service History* <<http://www.nhshistory.net/> [2]> [accessed 5 February 2015]; J. Lister, *The NHS after 60: For Patients or Profits?* (London, 2008). [Back to \(2\)](#)
3. See A. Mold ‘Repositioning the patient: patient organisations, consumerism, and autonomy in Britain during the 1960s and 1970s’, *Bulletin of the History of Medicine*, 2013, 87 (2), 225–49; A. Mold, *Making the Patient-consumer: Patient Organisations and Health Consumerism in Britain* (Manchester, 2015); Glen O’Hara ‘The complexities of “consumerism”: choice, collectivism and participation within Britain’s National Health Service, c. 1961–c.1979’, *Social History of Medicine*, 2012, 26 (2), 288–304; J. Bornat, L. Henry, P. Raghuram, ‘The making of careers, the making of a discipline: luck and chance in migrant careers in geriatric medicine’, *Journal of Vocational Behavior*, 2011, 78, 342–350. [Back to \(3\)](#)
4. V. Berridge, *AIDS in the UK: The making of policy 1981–1994* (Oxford, 1996). [Back to \(4\)](#)

The author is happy to accept this review, and would just like to add a pointer to the new research they are doing on the cultural history of the NHS (only because it exactly addresses the gaps Simpson has indicated). This material can be accessed at [peopleshistoryNHS.org](http://peopleshistoryNHS.org) [3] and [www.warwick.ac.uk/NHShistory](http://www.warwick.ac.uk/NHShistory) [4].

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