

EDUCATION FOR PUBLIC HEALTH*

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ONE feels deep humility standing in the shadow of the great pioneers of your country to whom an appreciative world must ever pay homage. These men first described and employed the principles of epidemiology and preventive medicine from which spring the rich fruits of personal and community health. There comes to mind the contribution of Snow establishing the fact that cholera prolongs its stay in communities the drinking water of which becomes the bearer of the infection. He brought forward the evidence against the "Broad Street Pump," a case which has become a classic in the history of epidemiology. It is interesting to note that even this great man was not immune to the critics who, so frequently, to-day add to the vicissitudes of the medical officer of health. The College of Physicians investigated the claim of Snow that the disease was transmitted by water, and while admitting there was much to justify his belief, it was most likely that the cholera poison was carried from place to place by the wind. The International Sanitary Conference assembled at Constantinople in 1866 affirmed that cholera is never known to extend from place to place faster than man can travel; that it never lingers in a locality unless the water supply becomes contaminated. Time and persistence, seasoned by the art of keen observation, are, indeed, virtues to be cultivated and encouraged. It is this great stamina which has always characterized the giants of public health in your country, Budd, Chadwick, Simon, Farr, Newsholme, Jameson, Daley, Pickles, Stocks, Parry, Mackintosh, and many others who are here to-day and whom we respectfully salute not only for the victories in this country but for contributions to the progress of public health in the United States and throughout the world. It was the work of Budd on typhoid and Snow on cholera as well as typhus from Ireland during the years of the potato famine which made it possible for Stephen Smith to organize the first metropolitan health service in New York City.

The early advance toward health education and instruction in health matters was engendered largely by the scholarly students of sanitary science and public health practice. Sanitary conventions were held not only to assure sanctions for trade relations between nations, but invariably served to widen the understanding of vast populations with regard to the means through which disease is spread. Edwin Chadwick in seeking public good will through community organization accomplished much in implementing your Public Health Act of 1848. Stephen Smith found a citizen's committee indispensable to the furtherance of the public health movement in New York. Henry Baker, the first epidemiologist in Michigan, saw the need of health instruction. Even before Koch discovered the tubercle bacillus in 1882, Baker introduced a simple textbook on physiology throughout the Michigan school system which explained that tuberculosis is a communicable disease, spread largely through intimate contact within the family group. Baker's principles were not without scientific background. Some fifteen years before (1865) the French physician, Villemin, had succeeded in producing lesions of tuberculosis in healthy animals through the introduction of infected sputum from tuberculous animals and humans. Basing his action upon this evidence, Baker made a noteworthy contribution to the education of the native Michigander, with the result that for many years, until the advent of the automobile age which brought new elements into the population, Michigan enjoyed the lowest tuberculosis death rate of any state in America. Five years later (1887) the state legislature provided funds for the construction of the first hygienic laboratory in the United States and the regents authorized the first full time professorship of hygiene at the State university.

People in every democratic action eventually see that their wants are met. Progress may be sporadic and irregular, but goals are reached in terms of self-preservation and perpetuity with reasonable comfort and a wholesomeness of life compatible with business, economic and social needs.

Since we are discussing the essentials of professional education in public health, we must first understand the area for which preparation is offered. Frazer and Stally-

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brass¹ have aptly defined public health, in its widest sense, as the application of scientific knowledge to insure healthy conditions of life to the individual living as a member of a community. This definition appeals because it begins with the individual whose personal health, unencumbered by physical or mental impediment, may be integrated into a social environment or community with maximum good to each. Public health is in substance the summation of personal health, and no community can be considered healthy without an understanding participation of the family in terms of healthful living. Diphtheria has disappeared and tuberculosis will soon do likewise in those areas where the individual has learned to do his part by personal protection and by supporting community action for health departments, hospitals, sanatoria, case-finding facilities, control of environmental health, rehabilitation and financial aids as needs arise. The surrender of the tubercle bacillus is no chance of nature. It results only from a well-planned attack against the biological, social and environmental maladjustments which formerly favoured the etiologic agent. Healthmen may share the award for honours in this struggle between the bacillus and the human and animal host, but nothing could have been accomplished without public support and understanding which begins at family level.

A good public health programme keeps very close to the people it aims to serve and stimulates participation on the part of everyone. The democratic approach to health betterment is fundamental to the spectacular and satisfying results now recorded for our two great countries.

Public health represents a dynamic field which embraces a blend of the biological, social and natural sciences. Community health practices vary in time and place as the new products of research and observation are tested, evaluated and reconciled. The administrator of a successful public health programme must harmonize and utilize the varied contributions of biology, medicine, dentistry, sanitary science and nursing, together with sociology, cultural anthropology, economics, political science, business administration and general education. Public health practice is essentially concerned with the manner in which conditions harmful to health arise, decline or recur in a population. It aims to establish the factors which govern these occurrences and directs efforts toward their control. Basically, then, the scope and influence of public health depends upon the successful synthesis of the biological and social sciences. Therefore the teaching of public health must be continuously enriched by association with many disciplines in an educational environment which affords the means of achieving this synthesis.

Public health practice can no longer be considered as limited to the prevention of communicable disease, laboratory studies and like activities. Public health embraces the total health of all people in society, individually and collectively, and is concerned primarily with community organization for self-protection against controllable or preventable causes of illness and accidents. The public health student must be trained to exercise leadership in health programmes; he must have a broad concept and understanding of the natural forces which influence man's relations to his fellow man and to his environment. These forces tend to keep health practices in a relative condition of flux and elasticity with the facets of health work changing constantly. Thus, the common communicable diseases are now largely of historic interest in the more favoured parts of the world and other conditions of adult life, such as the chronic diseases, heart, cancer, diabetes and the ever-increasing incidence of accidents in the home and elsewhere, add new interests and problems to the public health student.

Nation-wide and, in fact, world-wide events in the health, social and peace movement raise a distinct question relative to the position and the policies of the schools of public health. As it is now, the schools in the United States are largely tied to the existing programmes and the outlook of the existing official health agencies. But there is a difference between the health agency and the health movement. The latter is more comprehensive and more dynamic. Hence the question that arises is: Should the training programme, in the overwhelming total of its teaching and research activities, be linked with the official functions of official health agencies? Or should it serve as the centre of teaching and research for what constitutes the health movement as a whole? The questions do not pose minor distinctions. In our judgment, in planning curriculums and programmes of study, one may not assume that now or in the near future a particular activity will become or will be omitted as an accepted part of the health department administrative programme. Hospital administration and medical

care programmes offer good examples. Whosoever administers such programmes, the public health personnel has a part to play in working educational and professional services into a total pattern for public good.

World health constitutes a distinctly new facet in the health movement. At the turn of the century public health considerations were strikingly provincial, limited to town, village or city, accounting for the early part-time health organization. People living in London had little interest in health conditions in Yorkshire. Then came the industrial and social revolution, new means of communication, a travelling population, and all was changed. The manufacturer in London who flies to Manchester or motors to his camp in the northland has a distinct interest in a nation-wide health programme. This flow of health concern is in two directions and has now become world-wide. Nutrition, agriculture, population control, industry, socio-economic factors all loom high on the horizon of public health. These problems do not exist in isolation but in varying combinations, characteristic of the time and place. One-fifth of the human race, living in the countries of Western Europe, North America and the British Commonwealth, have a mean income of \$461 per person per year and an average life span of sixty-three years. Two-thirds of the human race, living in Africa, South-east Asia, the islands of the Pacific and Latin America, have a mean income of \$41 per person per year and an average length of life of thirty years. The problems of poverty and disease in underdeveloped areas are complex and different, but represent a very realistic part of the new look on world health and in the conservation of peace among nations.

Every health movement requires the ingredients of men, money and material, and these can best be found among the very people whom it is intended to serve. The latent resources of undeveloped countries must be activated to enhance production and efficiency. Improvement of environmental and personal health may well bring this to pass. Methodology should vary with the culture and mores of the people, but temporary paternalistic handouts will never turn the trick. There must be basic education to stimulate undeveloped populations to help themselves with self respect and understanding attuned to local behaviour and customs. Needs for trained personnel vary greatly from one place to another according to the problems and cultural patterns of the population. Schools of public health should include in the curriculum the essentials and principles universally needed for the promotion of the health movement so as to provide professional personnel who, in turn, may train technical assistants and aids and stimulate lay participation, ever mindful of the need of keeping the public health programme close to the people. The goal of the modern healthman is to work with people in conformity with their particular needs and resources and to make personal and community health an accepted part of life. This cannot occur spontaneously—it must be carefully planned and worked at over a long period of time. We have long since learned the inadequacy of doing things *to* or even *for* people. We now realize that the best way is to do things *with* people. One of the great advantages of getting groups of the public to participate actively in public health planning and programmes is that such groups spontaneously interpret and apply the health aims and procedures in terms of their own simple understanding. We should merely help people to help themselves.

Society operates in a very delicate balance, particularly in a field that may have as prompt and far-reaching influence as does public health. While it is true that progress in one cultural direction inevitably results in progress in other aspects of culture, it is equally true that the artificial stimulation of great sudden advancement in one phase of a culture alone may bring about at least a temporary social difficulty, if not disaster. If we suddenly and rapidly apply exclusively all of our present public health knowledge to a situation we may well provoke embarrassment in some places. There may be danger of bringing about a sudden increase of population in one generation without having done anything to meet the other basic needs of such additional people. The result may be increased hunger, economic unbalance and political unrest. We need not be discouraged, but surely should be realistic about this. It illustrates the need of public health workers moving ahead with those who work in related fields—agronomy, education, government, industry, and many others.

The public health aspects of food entered the arena through problems of sanitation, food preservation and adulteration. In some respects the problem of adequate nutrition is different from other health problems. It is related to crop production, agricultural management, transportation and processing, distribution, preservation and storage.

It must be approached with a view of the needs of normal civilian life, famine, over-production, military necessity, civil defence and variations by place, time and age, behaviour, mores and customs of the people served. It touches people in every part of the world and involves many professions and disciplines other than that of the healthman. Preventive education, diagnosis and treatment of specific dietary diseases are as important here as in the attack upon tuberculosis or one of the common communicable diseases of childhood.

The growing emphasis on problems of the aged, as a concern of public health, is attributable to the pressures of clinical and statistical evidence. The opportunity to deal with the chronic diseases, including cancer, and heart disease, is magnificently large and extraordinarily vague. As underlying causes are understood, certain chronic diseases may become less important a few years hence. Meanwhile, it remains for public health to develop the ways and means of early diagnosis and adequate treatment to the end that the productive plateau of the individual may be extended. The problems of an aging population are in a limited sense not unlike those of infancy and pre-school age as they confronted public health administrators three and four decades ago. The setting has been transferred from the beginning to the end of the life span. Involved are not only health but economic problems and those of dependency. Health education remains a thread of major emphasis, but represents only one phase of the problem. As is the case in the child health services, it is necessary to discover those in need of hospital and home care and rehabilitation as well as to provide continuous preventive supervision for adults considered as being in reasonably normal health. Numerically, the mental diseases make an overwhelming inroad upon our manpower, both in peace and war time. Healthmen seek a well-defined approach to the problem, characterized by the more objective control procedures such as are applicable to the preventable diseases.

Industrial health in its broadest sense comprises adult health. Part of it is physical—the fitness to perform the functions of the job. Part of it is mental—how the individual affects and is affected by his environment. And all of it, the total, determines the usefulness of the employee to industry and the satisfaction of the employee in industry. The ramifications of industrial health and safety are as complex as industry itself. New industrial processes bring an increase in the scope and intensity of research in industrial toxicology to prevent occupational diseases. Accident prevention continues as the chief means of reducing the deaths and physical impairments connected with various types of employment. These are but a part of the almost limitless field of industrial health.

It was in the field of sanitation that public health has made its most dramatic progress. Brilliant scientific investigation showed the danger of contaminated water, and this was followed by the impressive findings relative to milk. Over the world went the wave of effort to protect water and milk supplies as a means of controlling specific diseases. Progress was made and the results were extremely gratifying. Then began the expansion of existing knowledge—multiplication of efforts directed toward water and milk—with a retarded effort to extend knowledge to new areas of sanitation. What happened was predictable: with each year that passed the existing problems that had received little attention became more acute and new problems were generated by the changing modes of life. Sanitation, therefore, presents an illustrious history, a chaotic present and a challenging future. Consider, if you please, the cold fog of London, the smog of Los Angeles, the fumes of Donora and the polluted air that engulfs New York City and Detroit. Only a thin veil protects many of our major cities against self-pollution of atmosphere and the ever-mounting hazard of unwanted noise in shop and street.

What is the basic philosophy for professional education and training in public health? Ultimately public health programmes will be as successful as people *want* them to be. We must understand public *wants*, many of which are in keen competition—automobiles, radios, televisions, washing machines, kitchen gadgets frequently claiming priority over medical and health care, an operation, rehabilitation, disability services, and the like. Health services can be transposed into wants for comfort, wholesome life, business opportunities, gainful occupation and survival. The trained healthman can make this transposition. And so public health is only as successful as the people in it. Success hinges largely in improving the quality of career personnel through careful selection and recruitment and through improved training adjusted to

the many social and industrial factors that we have discussed. Flexibility is the keynote in all formal training procedures. In surveying the schools in the United States and Canada, Winslow² has appropriately stated: "Perhaps the most promising thing about the development of our schools of public health is their freedom from any form of crystallized standardization. The strait jacket of a fixed and uniform curriculum has not been imposed and we hope will never be imposed on our discipline." The Committee on Professional Education of the American Public Health Association has refrained from recommending standard regulations for formal programmes of study but has adopted criteria based on general principles, a minimum of required courses, leaving a broad field of electives. The teaching programme would be barren without relating basic disciplines to actual practice, and so throughout the sessions in a school a determined effort should be made to relate every teaching course to a concurrent, practical situation found only in the field. While residency training following the academic period should be strongly emphasized or made a fixed requirement, field training and directed observation as a part of academic training under an organized faculty staff is essential. This can be provided in co-operation and participation with selected official and voluntary health agencies, medical and hospital service plans and with industry.

The members of the public health team possesses many professional and experiential backgrounds. They must learn to work together and in harmony, each contributing his expertness in medicine, dentistry, sanitary science, nursing, health education, clinic and hospital management, to teamwork which demands public respect and understanding. An awakened public is not concerned primarily with the individual member of the team, whatsoever may be his professional background, but the public is distinctly interested in the performance of the health service as a whole. Every member of the health staff has an important position on the team, from the medical director to the less experienced technical assistant, and the outcome of the programme depends on wholehearted teamwork for which there is no substitute.

The public health administrator must have the ability to develop a morale—an *esprit de corps*—in his team. He should be able to imbue his personnel with the feeling that each individual's work is important and worth doing, and that each who does his or her work well will find self-satisfaction in the knowledge that his work has added materially to the health and happiness of the people of his community. The administrator who is a leader should supervise, guide and stimulate, but at the same time permit the free play of each individual's own creative ability. Thus is real progress achieved. Frequent staff conferences are especially helpful in the development of teamwork. Group thinking among health workers which comes from discussion prevents individuals from carrying on little shows of their own which are harmful to each other, and preserves a solid front to the public. The entire health department personnel should be kept informed regarding the major objectives to be sought. Incidentally, the administrator may then rest assured that the general policies, understood by all his staff members, will be continued while he is absent on vacation or attending a public health convention.

There is an ever-changing panorama in public health practice. Health departments were born in the nauseating, offensive airs and vapours of the open sewer which gave forth its offending gas; in the emanations from the deadly swamps and marshes: in the aesthetically disagreeable associations of the garbage dump. A few healthmen remain smugly complacent and make little or no effort to relate their programmes to changed conditions. Public opinion and smartness is rapidly exposing such weakness. The demand for the advantages of modern health services is becoming universal. Knowledge exerts heavy pressures toward conservation of human life in terms of intelligent lay participation and co-operation. Many health directors feel that certain preventive services which in the past have been provided by health organizations, both official and non-official, should be transferred to other governmental agencies and to the physician and dentist in his own office and to the alert business man and industrialist in his shop. Such programmes broaden the influence of the health organization, multiply the opportunities for health education and result in conservation of both life and money. The office of every prepared physician becomes a health centre from which flows not only knowledge regarding the prevention of disease but services which protect the family and the community—diphtheria immunizations, tuberculosis case finding, early diagnosis of cancer and chronic diseases, correction of mental and physical

handicaps which deprive the individual of normal growth and development and the wholesomeness of life which he deserves. A good health plan stimulates parental responsibility for the welfare of the family, teaches the individual that health is a purchasable commodity, and that within reasonable limitations the responsible head of the family can determine the future health of the members of his household.

The public health practices of the future will be concerned with the broader interests of the masses. Education has dissipated the mysticism of the healing arts concealed in a terminology of the classics. It has brought forth the realization that the eternal fight for good health is a people's struggle against ignorance, superstition and poverty. In the absence of health man cannot survive. To your great statesman, Disraeli, we express our gratitude for the reminder that health is wealth and that it is the prime obligation of government in partnership with people.

REFERENCES

¹ FRAZER, W. M., and STALLYBRASS, C. O. Text-book of Public Health. Livingstone, 1940.

² Report of the Committee on Professional Education of the American Public Health Association. *A.J.P.H.*, 43, 61. May, 1953.

DISCUSSION

Mr. A. Denton Ogden (Deputy Chairman of Council of the Institute) in opening the discussion, said the name of Henry Vaughan was known and honoured throughout the whole of the Public Health Service of the United States, just as it was to all on this side of the Atlantic who interested themselves in United States public health.

Mr. Ogden said he was privileged to spend several days with Dr. Vaughan in the School of Public Health of Michigan University at Ann Arbor last autumn, where he saw a good deal of the methods of teaching and training of non-medical personnel. He attended at lectures, he talked with members of Dr. Vaughan's staff and he was profoundly impressed by them and by the team spirit and *esprit de corps* throughout the whole school. Those two desirable conditions mentioned by Dr. Vaughan permeated the whole atmosphere there, fostered as they were, by him.

Much pioneer work had been done there and continued to be done. As long ago as 1887, the first chair of professor of hygiene was inaugurated in Michigan University, and the professor was Dr. Vaughan's father, who came there fresh from working with Koch and Pasteur. In 1897, Michigan University inaugurated its first M.P.H. (Master of Public Health) degree and the first recipient of that degree was Dr. Edna Day. That was the degree which he believed the American Public Health Association considered should be possessed by every sanitarian. As recently as 1945, only six States had training programmes for public health workers, but now twenty-two states had such programmes—so much progress had been made in the last nine years.

Wherever he visited the U.S.A. he was most of all impressed with the high standard of food hygiene, with the attitude of the health inspectorate in what Dr. Vaughan described as "doing things *with* the people" rather than "to" or even "for" them. That was particularly so in Detroit, where Dr. Vaughan was health commissioner for over twenty years. His influence in that city still remained—in fact the name of Detroit and Vaughan would always be closely linked. There was a type of friendly co-operation there and a mutual desire on all sides to do the right thing for the good of the general public—and it was certainly done!

Another impression was the activity of the health education sections of state and city health departments. He would like to see such sections firmly established in this country. What better means could there be for making people health conscious—beginning in the schools, which was surely the best way of having the public health service "doing things *with* the people." Mr. Ogden paid high tribute to the fine work of the Central Council for Health Education, but asked how many local authorities had health education officers. The duties of medical officers, health visitors and sanitary inspectors did not permit of more than a very small proportion of time being given to that important work. He referred to the staff of five health education officers in Boston, Mass., where it was considered there

should be one to each forty-thousand population and where one of them was in charge of the health education of fifty-nine schools, consisting of 34,000 children. It was in the schools, he said, that the most valuable work was done, by instilling into the children the importance of health and hygiene, which was the surest way of having the public health service and the people doing things *together*, or as Dr. Vaughan had so aptly described it, the health department "doing things *with* the people."

Miss N. C. Daniells (Health Visitor Tutor, London C.C.) said that some time ago she had the privilege of spending seven weeks in the School of Public Health, Ann Arbor, Michigan, of which Dr. Vaughan was Dean. It had been said that where there was no vision the people perished. Dr. Vaughan was not only a visionary but a man of action with a dynamic approach to public health.

There were three things which were impressive about Dr. Vaughan's work:

(i) The quality of technical training given to all post-graduate public health students, not only the doctors, nurses and sanitarians, but the public health economists and statisticians.

(ii) That team work was not an idle dream. All persons entering the public health field studied together in the same school, sharing some lectures and meeting informally: they thus started with an appreciation of one another's training and special contribution, and really co-operated.

(iii) As Health Commissioner of the City of Detroit before becoming Dean of the University School he started the integration of public health in the practical undergraduate work of both doctors and nurses and the easy relationship between hospital, health and voluntary agencies in that City was most marked.

Dr. John Burton (Central Council for Health Education) said that Dr. Vaughan, in his excellent paper and speech, stressed the idea that public health was people. Undoubtedly if they were thinking in terms of environmental medicine the most important factor in the environment of man was the other men and women in it.

It was curious and regrettable that that idea did not appear to influence the clinical training of students or the public health training of doctors. Psychology was conspicuous by its insignificance in the medical school curriculum, and group psychology, community work and health education only attracted lip service in many public health syllabi.

It would continue to be difficult for junior workers, such as health visitors, to make full use of their training in those fields until their superiors and their employers had a better understanding and training in the effective ways of working "with" the people and making health genuinely public.

He made a strong plea that health education and its associated social sciences be given a much more important place in the training of doctors at all stages. That was only logical since doctor in his Latin dictionary meant teacher, and not as was so often assumed, physician.

Dr. F. Charlotte Naish (Medical Women's Federation) said that preventive medicine, in all forms, was the worst paid part of the National Health Service. She would like to see a closer co-operation between health visitors, sanitary inspectors and general practitioners, because they could take the work *to* the people. Fear of the public health authority was still operative amongst the aged.

The best reading, if well written, was the medical officer of health's annual report.

Miss E. Robinson (Chief Nursing Officer, London C.C.) said that Dr. Vaughan had stressed the need for the members of the public health team to work together in promoting the health of the community. He had said that frequent staff conferences were especially helpful in the development of teamwork.

Staff conferences of the field workers were generally accepted. It was not usual, however, to think of the officers working in the central office as staff. Yet teamwork was as essential there as it was with those who had access to the public. The members of a team, e.g. the medical officers of health, nursing officers and administrative officers, would be encouraged to work in harmony if they frequently met together. Dr. Vaughan expressed that very clearly when he said "Group thinking . . . which comes from discussion prevents individuals from carrying on little shows of their own which are harmful to each other. . . ."

Miss W. M. Warden (University of London Institute of Education) supported the necessity for team work in health education which had been stressed by previous speakers, and made a plea for the inclusion of those concerned in the educational field in that work; both the teachers in schools, who had direct contact with the children and frequently with their parents, and those who trained teachers. In all teacher-training programmes there was included a course in health education.

She then spoke of the need for a professional training in health education in which all those concerned, whether from the field of public health or from education, would acquire the background knowledge necessary for a health educator, and work out together the best means of getting ideas across, getting people to accept such ideas and to act upon them.

With that in mind, the University of London Institute of Education was to begin in October 1954, a full-time one-year course leading to a Diploma in the Content and Methods of Health Education open to anyone working in the field of health education. In the running of the course, the Institute was receiving the co-operation of the London School of Hygiene and Tropical Medicine on the public health aspects of the course; of the University of London Institute of Child Health on the special problems of the health of children, while the sociological aspects of health and problems of method and procedure in health education would be worked out jointly in co-operation with the Central Council for Health Education.

REPLY TO THE DISCUSSION

Dr. Vaughan, in his reply, said that Mr. Ogden had inquired about the relative advantages and disadvantages of strong state authority in health matters in the United States. As their name implied they were in fact a true federation of states, organized for the common good, maintaining state sufficiency, but transferring certain authority to the Federal Government by their constitution and the amendments thereto. Health, *per se*, was not mentioned, but interpretation of several provisions of the constitution providing for the general welfare, granted considerable authority to the Federal health services. Especially significant were the Federal grants to the states in funds and professional services. On the whole, however, the prime responsibility for health matters remained with the state, and the latter assigned much of that responsibility to the local authorities, county and city. Local autonomy was encouraged as they desired to keep their public health programme close to the people whom they served and thus encourage lay participation and health education. The greatest disadvantage was to the professional public health workers, who, generally, did not enjoy the free opportunity of appointment in the several states.

The other speakers had emphasized the need for productive programmes in health education and professional participation. With those they were in full accord.

Abraham Lincoln left a few words of wisdom which should be known to every public health worker: "The legitimate object of government is to do for a community of people whatever they need to have done but cannot do at all or cannot do as well for themselves in their separate and individual capacities. In all that the people can do as well for themselves, the government ought not to interfere."

And your own Florence Nightingale wisely declared: "The secret of national health is to be found in the homes of the people."