HOUSING IN LONDON

AN ANALYSIS OF THE LIVING CONDITIONS OF 503 FAMILIES IN HAMMERSMITH

BY

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About a year ago I was consulted by a patient who suffers from psoriasis. He is employed as a carpenter by a teaching hospital (not in this area of London), and he had been attending the dermatology out-patient department there for some time. At his last attendance he had been given treatment which involved a daily bath—but he had no bath at his home. I was not surprised that this was so, for I knew that bathrooms were a relative luxury in Shepherd's Bush; but when I mentioned this story to a friend at hospital he seemed surprised at the lack of what are regarded as essential amenities. I therefore thought it would be worth while making a more detailed analysis of the living conditions of my patients.

My practice is mainly in Shepherd's Bush, part of the Metropolitan Borough of Hammersmith in the west of London. Local landmarks are the B.B.C. television studios, and, medically, Hammersmith Hospital and Queen Charlotte's Hospital, the latter being at the other end of the road where my surgery is situated. The majority of the houses in the immediate vicinity were built at the turn of the century. Here and there are new blocks of flats, mainly small council developments. Only a small part of the neighbourhood (two small roads) are officially designated slums, and they are at present being cleared preparatory to being redeveloped by the Borough Council. The large estate built by the London County Council at the White City just before and after the last war is about half a mile due north of my surgery, and I have few patients from that estate.

It has not been possible to survey the whole practice—indeed, that would be wellnigh impossible, for it is constantly changing. Approximately one-third of my patients have been registered with me less than a year. In the last twelve months about 1,100 new patients signed on my list, while in the same period about 500 left. For the same reason an age–sex index is accurate only for the day it is completed, and as yet I do not know if the age distribution of the new patients is the same as that of those who have gone elsewhere. Table I shows clearly how the practice is dominated by young children and their parents. How these young mothers cope in the face of difficulty is a great tribute to them and a rebuke to us as a community.

Material Investigated

I decided to collect information from about 500 families. I asked questions of every patient I saw until I had the requisite total. I excluded the 12 young men who said they were living in "digs" (that is, they lived in the home of a "landlady" who prepared whatever meals they ate at home), but I included the 88 patients who said they lived alone but did their own housekeeping. I defined a family as any group sharing the same cooking facilities and food, and who regarded themselves as a family; under this definition lodgers were excluded from the total of members of the family (when the lodger himself presented as the patient he was not included in the survey and he was not asked for any further details). A "family" usually consisted of a husband and wife (including those not actually legally married), together with their children and frequently one or more grandparents. Sometimes cousins and other relatives were counted in, particularly in the West Indian families. In all cases the decision on who was a member of the family rested with the informant.

Shepherd's Bush is an area where a large number of immigrants live, and I have attempted to record differences in the housing of the various nationalities. I realized that a racial classification is difficult, but in no case did the patient have any doubt about his nationality.

TABLE I.—*Age and Sex of Patients in Practice*

	0–5	6–10	11–15	16–20	21–25	26–30	31–35	36–40	41–45	46–50	51–55	56–60	61–65	66–70	71–75	75+
Male	284	88	93	92	197	271	191	130	114	89	77	73	50	29	17	29
Female	245	98	86	110	246	210	138	102	103	91	83	70	60	68	46	81
Total ..	529	176	179	200	443	481	329	232	217	180	160	143	110	97	63	110

TABLE II

No. in Family:	One						Two						Three										Four								
No. of Rooms:	Ttl.	1	2	3	4	5	Total	1	2	3	4	5	Total	1	2	3	4	5	6	7	8	9	Ttl.	1	2	3	4	5	6	7	8
English ..	45	28	12	3	1	1	72	12	43	9	3	5	65	7	30	17	4	3	1	1	1	1	51	6	9	13	12	6	1	3	1
Irish	12	12					20	16	2	2			20	12	4	3	1						10	2	6	1		1			
W. Indian ..	18	17	1				40	31	8	1			12	6	6								16	6	9	1					
W. African ..	10	10					4	3	1				2	1			1						0								
Miscellaneous	3	2	1				4	3	1				17	7	6	2		1	1				5	1	2	1		1			
Total ..	88	69	14	3	1	1	140	65	55	12	3	5	116	33	46	22	6	4	2	1	1	1	82	15	26	16	12	8	1	3	1

TABLE II (*Continued*)

No. in Family:	Five							Six							Seven							Eight					Nine					Ten
No. of Rooms:	Total	1	2	3	4	5	7	Total	1	2	3	4	5	7	Total	2	3	4	5	6		Total	4	5	6	9		Total	3	6	8	9		2
English ..	29	1	8	5	9	5	1	6			2	2	1	1	11	2	1	3	4	1		3	1	1	1			1		1				
Irish	4	1	3					4		2	2				0							1				1		3	1		1	1		
W. Indian ..	6		3	2	1			2		1	1				0							0						0					1
W. African ..	0							0							0							0						0					0
Miscellaneous	3		1	1		1		3	1	2					0							0						0					
Total ..	42	2	15	8	10	6	1	15	1	5	5	2	1	1	11	2	1	3	4	1		4	1	1	1	1		4	1	1	1	1		1

The four major groups living in this area are the English, the Irish, the West Indian, and the West African. There are not many Scots, Welsh, or Northern Irish families on my list, and the term "British" is hard to define. I finally decided to include in the "English" group only families where both parents had been born in England. The "Irish" group refers to families from Eire and not from Northern Ireland. In the "West Indies" group I did include a few families from British Guiana. The "Miscellaneous" group includes the Scots, the Welsh, the Northern Irish, and families from other parts of the Commonwealth or the rest of the world. There were also a few families where intermarriage made my classification impossible; I put them with the miscellaneous.

Only just over half the families (56%) were English. Seventy-four families (one in seven of the total) were Irish. Ninety-five (nearly one in five) were from the West Indies. Sixteen (3%) came from West Africa. There were 35 families in the miscellaneous group. Table II shows the sizes of the families in each national group. From it can be calculated that 1,499 people came into this survey. They cannot all be called patients, because for ethical reasons I did not ask the informants who of their family was or was not registered with me. However, in Shepherd's Bush, unlike other districts, most people seem to choose the same doctor for all members of the family.

Nationality of Patients Surveyed

Of the 503 families who finally came into the survey, 78 (15.5%) occupied a house (either owned or rented). Of the English families, 18% had a house, but only 12% of the Irish and West Indians (Table III). None of the West African families had a house, but few of them propose to stay in England permanently, even though many have been here several years already. Quite a number of English families had Council houses, but none of the other national groups had. All the Irish families who had a house took in lodgers, usually young Irish labourers whose rent helped to pay the mortgage. All the West Indian families with a house sublet rooms or shared their property with one or more other West Indian families (mostly cousins).

TABLE III.—*Housing Accommodation*

	Unfurnished		Furnished		House		Total	
	No.	%	No.	%	No.	%	No.	%
English	192	67·8	39	13·8	52	18·4	283	56·3
Irish	13	17·6	52	70·3	9	12·1	74	14·7
W. Indian ..	3	3·2	80	84·2	12	12·6	95	18·9
W. African ..	1	6·2	15	93·8	—	—	16	3·2
Miscellaneous ..	10	28·6	20	57·1	5	14·3	35	6·9
Total ..	219	43·5	206	41	78	15·5	503	100

The other 425 families were almost evenly divided between those who had a furnished "flat"* and those who rented one unfurnished. This difference will mean most to those who are aware of the intricacies of the Rent Acts; for example, security of tenure is assured only to those who have an unfurnished flat whose rateable value is less than £40 and who have lived in it continuously since 1957. Of the English families in flats 85% managed to find one unfurnished, but 70% of the Irish, 84% of the West Indian, and 94% of the West African families were in furnished apartments. Here the tenant can appeal against his rent to a tribunal, in which case he is given only three months' security of tenure.

*The term "flat" is used here to include all accommodation that is not a complete house. Rarely does it imply, as will be shown, a self-contained apartment in either a block or a proper conversion of a house.

Deficiency of Accommodation

The Englishman's home is his castle, but to be a castle it ought to be possible to shut a door and know that only your own family is behind it. Of the 503 families I asked, over two-thirds (68%) did not have self-contained accommodation. They had no front door of their own. Even among the English less than half (44%) lived in a self-contained flat or house. Among the 185 immigrant families only six had complete privacy when they wanted it.

In what other ways was the accommodation deficient? How many families, for instance, had a bathroom? Tables IV and IVa give this information for the various groups. Altogether 44% of my families had no access to a bathroom in the house they lived in; most of the other 56% had to share their asset with another family (except those few families in self-contained accommodation, which also possessed a bath). Forty-eight per cent. of the English families had no bathroom, and 57% of the Irish were in the same position. But only 31% of the West Indian families and a similar proportion of the West Africans were without a bathroom. Oddly enough, more families in furnished accommodation (65%) than those (42%) whose flat had been rented unfurnished had access to a bathroom. As expected, the highest percentage of bathrooms was found among the families having their own house, though even 27% of these were still without one.

No family admitted to being without access to a lavatory (W.C.), though often it was outside, which cannot be very comfortable in winter. Less than half (47%) of the families had their own lavatory (Tables IV and IVa); the rest had to share with another family. Almost all the West African families (94%) had their own W.C., and 59% of the English similarly did not have to share. Only 42% of the Irish had this degree of privacy, and as few as 10% of the West Indian families.

In the Table several families who have a house are shown as sharing a lavatory. This always implies that there is another family unit in the house with them: as explained above, many families join together to buy a house.

The kitchen is where two families sharing any part of the accommodation are most likely to find friction, and over 80% of my families had managed to get a kitchen of some sort of their own (Tables IV and IVa), even though it was only (as is so often the case) a gas-stove on the landing (see Fig.). Almost all the English families (96%) were in this position; and even the Irish (who

TABLE IV

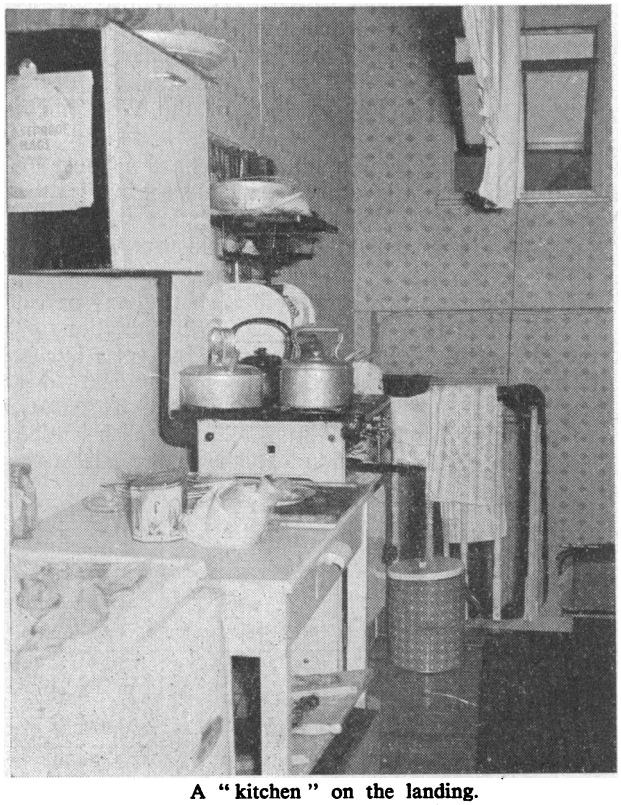
	Total	W.C.				Kitchen				Bathroom			
		Own		Shared		Own		Shared		Available		Not Available	
		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
English	283	167	59	116	41	271	96	12	4	147	52	136	48
Irish ..	74	31	42	43	58	57	77	17	23	32	43	42	57
W. Indian	95	9	9	86	91	48	51	47	49	66	69	29	31
W. African	16	15	94	1	6	9	56	7	44	12	75	4	25
Misc.	35	16	46	19	54	26	74	9	26	25	71	10	29
Total	503	238	47	265	53	411	82	92	18	282	56	221	44

TABLE IVA

	Unfurnished								House							
	W.C.				Kitchen				Toilet				Kitchen			
	Own		Shared		Own		Shared		Own		Shared		Own		Shared	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
English	114	59	78	41	190	99	2	1	48	92	4	8	51	98	1	2
Irish	11	85	2	15	13	100			9	100			9	100		
W. Indian	2	67	1	33	2	67	1	33	2	17	10	83	7	58	5	42
W. African ..	1	100			1	100										
Miscellaneous ..	6	60	4	40	10	100			4	80	1	20	5	100		

are not so lucky with their bathroom or lavatory facilities) did not often have to share a kitchen: 77% had their own. On the other hand, nearly half the West Indian (49%) and West African (44%) families have to share cooking facilities. Where two races share a "kitchen" (often just a stove on the landing) their different foods and spices often spark the quarrel which might not otherwise have been ignited.

What about the actual living accommodation itself? From personal observations when I visited them I already knew that many families have to sleep in the room they have been sitting and eating in—and in some cases they also have to wash themselves and cook in the same room. What I did not know was just how common an occurrence this was. Table II gives the details of how cramped families of different sizes are. Not unexpectedly, more than three-quarters of those who lived alone were found to have only one living-room. But even among the couples who lived together (usually husband and wife, but sometimes two girls or two men sharing a flat) nearly half also had only one room (65 of the 140 couples—46%). This is reasonable; but not so happy was my finding that one in five of the families with three, four, or five members were just as limited in living-space and could get only one room for the whole family to live in. The English have not fared too badly: only 10% of the 137 families with three to five members were so cramped, but 40% of the 69 Irish and West Indian families of this size had to live in one room. Table V emphasizes this racial difference by showing the mean number of living-rooms available to families of different sizes within each national group.



A "kitchen" on the landing.

TABLE V.—*Mean Number of Living Rooms in Families of Different Sizes and Different Nationalities*

	Size of Family							
	1	2	3	4	5	6	7	8
English	1	2	2	3	4	4	4	5
Irish	1	1	1	2	2	2–3		
W. Indian ..	1	1	1–2	2	2	2–3		
W. African ..	1	1	1					
Miscellaneous ..	1	1	2	2	3	3		

Rents

Finally, I looked at the rent my patients had to pay for their home. Some owned their home; others by virtue of their employment (for example, school caretakers) had free accommodation. Rents will naturally be greater for furnished than for unfurnished flats, and the Rent Acts emphasize this difference (only unfurnished flats have their rents controlled). The majority of immigrants live in flats, and so I propose to compare only these rents. The mean rent paid by an English family for a flat is between 30 and 40 shillings a week, but the immigrants have to pay between 60 and 70 shillings. However, the great majority of the immigrants are in furnished flats, and for such accommodation the English also pay a mean rent of 60 to 70 shillings a week. So few immigrant families (only 17) live in unfurnished flats that it is not reasonable to draw definite conclusions, but their mean rent is 50 to 60 shillings a week as compared with 30 to 40 shillings paid by the English in this position. This low rent paid by the English for unfurnished flats reflects their ability to get either a council flat or a rent-restricted flat in a house which, incidentally, their family have often occupied for many years.

The difference can best be brought out by considering the extremes of rents paid in this district. Forty-seven per cent. of the 231 English families living in flats pay less than 30s. a week in rent, and only 5% pay more than £5 a week. But among the 154 immigrant families in flats only 3% pay under 30s. a week, while 13% pay over £5. Only one English family in the higher-rent group had unsatisfactory accommodation. This is a family of five who had one living-room, a gas stove on the landing, and shared the lavatory with the other three families in the house. There was a bathroom, but it was unusable. It is perhaps not irrelevant to add that this family had been evicted from a council flat for some reason or another (their excuse and the council's explanation did not tally). Only one immigrant family paying more than £5 a week had

a self-contained flat. All the four Irish families in this group had three living-rooms and a bathroom as well as their own kitchen, indicating that they got some value for their money. But only three of the eighty-three families from the West Indies paying a high rent aspired to such luxury, and they had to pay, respectively, £6 6s., £6 10s., and £7 7s. a week. Incidentally none of these three families had their own bathroom or W.C., but they did get their own kitchen.

Comment

I have already mentioned that this area is not officially designated a slum. How much overcrowding there exists will depend on what definition of "overcrowding" is used. The official standards permit up to two people in one room, three people in two rooms, five in three rooms, and so on. Only living-rooms are calculated, and children between the ages of 1 and 10 years count as half a person; babies under the age of a year do not count. When I asked my patients for information for this survey I deliberately avoided the official approach, and I did not attempt to assess the legal overcrowding which I know, from what they tell me, is often hidden from officials.

It is of course right to point out, as can be seen from the practice age–sex register (Table I) that young families form a large proportion of my practice. Perhaps as the children grow up the family is able, either through the local authority or by its own efforts, to get a flat or house more adequate for its needs; I hope this is so, though I do not know whether it is or not.

What does the classification by nationality bring out? In essence it is as follows, and my findings in the survey are confirmed by my own experiences of cleanliness and so on when I visit their homes. The English consider a separate kitchen to be top priority; the West Indians try to find a flat in a house with a bath; while the Irish seem to get the worst of practically everything.

As a general practitioner I am in a way an agent of the Welfare State. Through me my patients are able to obtain any drug, however expensive. I can arrange their admission to hospital or get them a convalescent holiday if they need it. I can introduce them to the National Assistance Board when they are short of money. But, however inadequate their housing, there is nothing I can do about it. I have long realized the futility of medical recommendations to the local authority; I know they have no accommodation to spare, however desperate the need. What worries me is the apparent perpetuation of the problem. About seven years ago, when I was new to general practice, I came across a family of seven living in one room. I was so horrified that I wrote a very stiff letter to the L.C.C. They acted swiftly, and the family were given a house on a new estate. One Friday evening the mother came to see me to say good-bye and to thank me for my efforts. The next morning a new patient came to see me, bringing with her several medical cards—for herself, her husband, and her five children. She said they had moved into the room vacated by Mrs. X, and would I give her a letter to the Council like I had given the other lady.

The publication of the *Annual Report of the Victorian Bush Nursing Association 1960–1961* celebrates half a century of service in the Australian bush. The first centre was established at Beech Forest in February, 1911.

DISEASES OF GENETIC AETIOLOGY

CONFERENCE AT GLASGOW

[FROM A SPECIAL CORRESPONDENT]

A conference on diseases of genetic aetiology was held in the Faculty of Physicians and Surgeons, Glasgow, from November 15 to 17 under the auspices of the Glasgow Postgraduate Medical Board.

Neoplasia and Hyperplasia

After an introduction by Professor L. S. PENROSE, F.R.S., under the chairmanship of Dr. J. H. WRIGHT, Dr. W. M. COURT BROWN opened the first session with a paper on the role of genetic change in neoplasia. He discussed the possible role of such change both in the initiation of the neoplastic process and also in its evolution from the early initial changes in a cell, or group of cells, right through to the stage of clinical cancer. This discussion included a general survey of cancer susceptibility and the problem of ageing and carcinogenesis.

Dr. C. A. CLARKE described two families in which an extremely high incidence of oesophageal cancer occurred associated with tylosis. He postulated that the striking association of these two conditions might well be due to a single gene mutation. The present position of chromosome aberrations in myeloid leukaemia both in the chronic state and during its acute transformation was dealt with by Dr. A. G. BAIKIE. He also discussed the possibility that certain drugs might selectively act on certain cell lines which could be distinguished on a chromosome basis.

Biochemical Lesions

In the afternoon session, under the chairmanship of Professor T. SYMINGTON, some biochemical lesions of genetic aetiology were discussed. Professor G. PONTECORVO, F.R.S., reviewed the history of studies relating genes to the synthesis of enzymes in particular and proteins in general. He referred to the classical studies of Garrod on inborn errors of metabolism, which, he felt, had been published at a time when neither medicine nor genetics was ready to appreciate them fully. Garrod's concept on one-gene-one-enzyme was an oversimplification, and we now had evidence of the activity of regulator genes which influenced other genes without the mediation of a protein synthesized for the purpose. Other recent advances had come from the analysis of the genetic material itself with a reawakening of interest in D.N.A. and appreciation of its heterogeneity. Many of Professor Pontecorvo's points were illustrated by subsequent papers by Dr. H. LEHMANN on the haemoglobinopathies; by Dr. A. S. DOUGLAS on haemophilia and related coagulation defects; and by Dr. A. GOLDBERG on the porphyrias.

Amino-acid Metabolism

Under the chairmanship of Professor PONTECORVO, the session on genetically determined biochemical lesions was opened by Dr. J. P. JEPSON, who gave a comprehensive general account of the amino-acidurias much appreciated by those who had no specialized knowledge of this field. He followed this by a discussion of Hartnup disease, a rare condition the occurrence of which was consistent with its being determined by an autosomal recessive gene. The only constant physical finding was a photosensitive rash identical with that found in pellagra. However, paper chromatographic study of the urine of individuals with Hartnup disease showed that they were excreting large amounts of a wide but characteristic range of amino-acids. This was thought to be due to a disorder of amino-acid transport into all cells of the body, particularly those of the renal tubules and the jejunum. Dr. Jepson stressed the need to carry out chromatographic analysis of the urine of all patients presenting with symptoms of pellagra, as this was the only way a differential diagnosis between pellagra and Hartnup disease could be made.