INTRODUCTION

At the beginning of December 1946 the Sheffield Hospital Contributors' Association met for its one hundredth quarterly meeting. The association invited a number of local dignitaries to the meeting and also the Minster of Health, Aneurin Bevan, MP. Mr Bevan was, unfortunately, unable to attend but wrote urging the contributors to welcome, not fear, the new service. For:

> what is it we are taking away from the Hospitals? – not their independence, not their special characters and their treasured local associations, but only their anxieties – above all, their anxieties about money, and the difficulties that will disappear when each Hospital no longer stands alone. And at last we are to have a Hospital service in the true sense; from our present chaos of 3,000 Hospitals – some of them superlatively good, some by no means faultless, and almost none organically linked with their neighbours – we intend to create a single great service ... they will still be, not 'State' Hospitals, but your Hospitals – it will be your service and for you, with our help, to make of it what you can and will.[1]

In these few lines Bevan encapsulated many of the perceived characteristics of the pre-National Health Service (NHS) hospital system – financial anxiety, individualism and a chaotic lack of organization. Yet he also had to recognize some of its strengths – independence, voluntary effort and a sense of commitment and ownership. Most significant, however, was the importance of place, the rooting of the hospital system in the locality which was embodied in organizations like the Sheffield Hospital Contributors' Association. This book considers how hospital systems developed in a local context in the thirty years before the NHS and explores how the social, economic and political structures and cultures of specific places shaped the development of institutional treatment, especially Bevan's points of anxiety – finance and co-operation.

Viewing the development of hospital systems from the locality is essential to understanding hospitals before Bevan, for even among health historians much of the debate surrounding the strength of pre-NHS hospital provision has been based on national aggregate data, evidence drawn from London, and a patchy understanding of the wider experience of urban hospital systems in this period.[2] Moreover, although there have been some important regional studies,[3] there have

been few attempts to compare how hospital services developed in provincial cities or on a regional basis and in particular there has been little discussion of how these were shaped by local economic, social and political cultures.[4] Moreover, the politics of hospital provision remains largely unexplored.[5] For while there has been considerable discussion of debates at a national level involving parties, civil servants and various peak organizations,[6] studies of the factors shaping local decision-making remain rare. This is especially the case in relation to the involvement in, and attitudes of, local Labour parties and labour movements to hospital provision[7] which is often read off from national evidence and studies of bodies like the Socialist Medical Association.[8]

This book addresses these lacunae through an exploration of hospital politics in two Yorkshire cities – Leeds and Sheffield – in the first half of the twentieth century, with a particular focus upon the interwar years when public attitudes to hospitals shifted sharply from distrustful dependence to hopeful expectation of access and cure. This era was marked by the transition in voluntary hospital funding with its associated impact on access and management;[9] by the growth of municipal services, especially in the aftermath of the break-up of the poor law;[10] and by an eagerly anticipated – though not always realized – development of co-ordination and co-operation across the sectors.[11] Moreover, it saw the decline of many of the traditional diseases and threats of urban life and the emergence of new health challenges associated with affluence – including road accidents, cancer and the desire for institutional childbirth – creating a demand for specialist services influenced by local needs and crossing the existing rigid boundaries between voluntary and public hospitals.[12] In exploring the development of local hospital systems, it focuses on the experience of joint working in Leeds and Sheffield demonstrating that developments in this sphere were not linear. Underpinning the study is a recognition of the importance of the economic and social environment of the two cities and how this affected both demand for services and the ability of the locality to provide an adequate, integrated service.[13] Particular attention is paid to the role of class and gender in shaping service provision. Overall, the book argues that social and economic diversity, which influenced both the need for and the ability to provide adequate hospital services, is fundamental to understanding the diversity of provision across the nation in this period.

As this brief overview suggests, over the past twenty years historians have gone some way towards revising our understanding of hospital provision, management and politics in the half century before the inauguration of the NHS. Yet important and influential negative views remain evident. Writing in its official history, Charles Webster drew on Bevan's ideas to suggest that the NHS was 'designed to bring order' to a piecemeal collection of institutions 'deficient in system and planning' for which 'urgently required modernization and

improvement was held back by such limitations as anachronism, administrative complexity, duplication, parochialism, inertia and stagnation'.[14] Webster's work has been highly influential in shaping perceptions of interwar health care and the view that hospital access was governed by the elite; that voluntary hospitals were teetering on the verge of bankruptcy; that municipal and poor law hospitals were stigmatizing and inferior; and that the two systems were in constant conflict to the detriment of an effective service for the population. This remains the widely accepted view in general textbooks and popular culture.[15]

However, recent national studies of voluntary hospitals by Gorsky, Mohan and Powell and of municipal provision by Levene, Powell, Stewart and Taylor have challenged some of these assumptions through excellent macro-level statistical analyses and some illuminating case studies of a range of less familiar locations, such as Barnsley and Newport.[16] This work has demonstrated the patchy nature of provision before the Second World War though the source base has provided a rather pessimistic and external reading of the local experience. In many cases the Ministry of Health and other surveyors, such as Political and Economic Planning (PEP) tended to focus on the weaknesses in the system whilst playing down the massive improvements in service over the twenty-five years following the First World War.[17] Pickstone has drawn attention to this tendency for contemporaries and historians to counterpose the general pattern of existing hospital services 'to some ideal distribution of facilities; the difference is said to demonstrate the necessity of reform'.[18] Cherry is more optimistic about the progress of hospital provision and challenges the traditional narratives, with their focus on the big London hospitals and crisis moments like 1922 and 1938.[19] Together this work shows that both voluntary and municipal sectors adapted their funding base and responded to growing demand by expanding beds, buildings and specialisms and in some cases began to work with each other and the central state.[20] However, in general it lacks the richness of the local study and remains sceptical about the ability of either the voluntary or the municipal sector to deal with the challenges of increasing medical sophistication and rising costs. Moreover, it tends to show expansion of provision, rather than explain how it happened or why it might happen differently in different places.

To see how systems operated on the ground we need to turn to the relatively small number of fine local studies which do exist, including Pickstone's pioneering examination of the north-west of England, Rivett's survey of London, Mohan's work on the north-east, and various town studies by Gorsky, Cherry, Reinarz and Hayes.[21] While Pickstone and Mohan do explore the development of both the municipal and the voluntary hospital sector, their material on specific towns is in most cases exemplary rather than detailed, with the former providing good evidence for Manchester and Preston but less on the other towns of Lancashire, while Mohan tends to steer clear of the big cities and focus on the smaller

towns. Levene et al. do touch on aspects of the activities of the voluntary sector, as does Welshman, but this is not their key concern, while Reinarz makes no references to local authority provision so that, to date, only Gorsky has attempted a study of both sectors in one town.[22] These, and other specialist works focusing on the general history of hospitals, the growth of provision from place to place and the emergence of specialist services, have provided some insight into how the stock of hospitals expanded and how the work of the institutions became more complex, scientific and expensive.[23] Some have measured the provision of local services against a univeralist norm, but as John Pickstone observes, it was not that places failed to 'conform to some national plan' but rather that localities produced a 'variety of systems, formal and informal' in turn shaped by their political ecology.[24] As Levene et al. have shown for the municipal sector, local needs and resources as well as political cultures could demand that some areas of provision were privileged and others more or less neglected. Although historians of the public sector have observed this decision-making process it has played little or no part in our understanding of the distribution of voluntary general and specialist institutions. Indeed these continue to be viewed in a highly individualistic manner, with an emphasis on the interests of donors or doctors while other structural or political factors are downplayed.[25]

Yet the central contention of this book is that the form of hospital services provided, the way they were paid for and the nature of the politics and governance of that provision were all shaped by local economic and social factors and their impact on class and gender structures and relations. To this end the opening chapter reviews the economic, social and political development of Leeds and Sheffield in the later nineteenth and early twentieth century, paying particular attention to how these shaped, and were shaped by, class and gender relations. In particular, attention is focused on the contrast between the masculine, proletarian society created by Sheffield's heavy industrial economy, with its physical risks and limited employment roles for women, and the more middle-class and 'female' environment deriving from the diverse service and light manufacturing base in Leeds which provided opportunities for women in textiles, clothing and commerce. Together these factors shaped union power, voluntary organizations and local politics producing divergent forms of party competition for municipal control. Both anti-socialist and Labour strategies are addressed with particular attention paid to the way in which economic and social structures influenced the composition, ideology and focus of left and right, shaping the policy priorities and development of services demonstrated by municipal and voluntary providers.

Thus how hospitals came into being, survived and developed is the subject of Chapter 2. Paying particular attention to the growth of sites, buildings and bed numbers in the voluntary, poor law and municipal sectors, it explores the acute and general medical services along with municipal provision for infec-

tious diseases, pulmonary and non-pulmonary tuberculosis. Mental health inpatient services are not included in the study as neither Leeds nor Sheffield county borough had direct responsibility for mental health patients. These were accommodated in asylums managed for the cities and the West Riding County Council by a county board with five institutions across West Yorkshire.[26] It explores the factors influencing the expansion of the hospital estate, including finance, ideology and need and examines the largely overlooked growth of ancillary services, technological developments and administrative facilities between the wars which proved as necessary as extra beds in the campaign to satisfy the demand for mass health care.[27] Chapter 3 assesses the substantial increase in patient numbers which transformed the hospital from a site for the sick poor to a centre for popular health care. The question of who attended hospital has been rather overlooked in the recent debates over finance and specialization with considerable uncertainty remaining around issues of class, age and especially gender. Therefore, this chapter reviews the number and types of patients admitted and where they were admitted to – including inpatient, outpatient and casualty services – examining the role of the almoner, another neglected topic, in gatekeeping access and considering the extent to which patient demographics were shaped by local socio-economic structures.

Building on these findings, Chapter 4 considers the extent to which specialist departments emerged, from traditional specialisms like ear, nose and throat (ENT) and skin complaints to more unusual departments like mental health outpatients. Furthermore, drawing on the ideas of Cooter and Sturdy, it examines the extent to which institutions invested in the organization and management of patients, especially through larger, more complex outpatient departments. These findings are brought together in an investigation of two specific areas where service provision was influenced by local needs and cultures – orthopaedics and the management and healing of accidental bone damage; and the challenge of the growing demand for institutional childbirth. Although the development of these services was part of national trends in the 1930s, they had very different outcomes in Leeds and Sheffield with the prevalence of workplace accidents promoting the creation of specialist orthopaedic services supported by industry and the labour movement in Sheffield, while the extensive maternity provision in Leeds suggests a link with both the more significant role of women in the economy and service provision.

Thus existing local and regional studies provide an essential long-term view of provision in the provinces but they give only a limited picture of how local hospital systems developed and none really address the issue of the politics of local hospital provision. Therefore, the second half of the book focuses on the hospital politics of the two cities, addressing finance, policy and co-operation. Recent research by Cherry, Gorsky and Mohan, Gosling, Reinarz, Daunton,

Hayes and Doyle has pointed to the importance of new forms of funding for both state and voluntary provision in the first half of the century.[28] Building on mutualist models from the late nineteenth century the interwar period saw the flowering of contributory schemes of varying types from works collections and Saturday Funds to full-scale citywide organizations with hundreds of thousands of members.[29] Debate has surrounded whether or not these schemes were sustainable, whether they would have allowed the voluntary sector to continue to expand, whether they were mutualist or 'merely' insurance schemes, and whether they represented a democratic alternative to both elitist voluntarism and state control. Current historiography favours the belief that they were part of a transition from voluntary to state with, as Daunton argues, the population increasingly choosing the certainty and simplicity of the state.[30]

Similarly, as Powell and others have shown, changes in the funding of and to the local state, especially appropriation and the growth of specific central funding for non-acute illness and disease, allowed for the expansion and increased professionalization of the state sector.[31] Municipal provision also moved towards delivering universal services especially for those not always covered by the voluntary sector, such as women and children, the elderly and the terminally ill.[32] However, the extent to which the municipal sector was improving, whether it was or even could compete with the voluntary sector, and the extent to which it was contributing to the development of urban and even regional systems remains uncertain. Recent work has also highlighted the strength of elements of voluntarism throughout the interwar period, especially community based fundraising, endowments, appeals and legacies. These served to strengthen a sense of ownership and democratized investment in, as well as use of, hospitals as community resources.[33]

In light of these historiographical developments, Chapter 5 explores the major forms of hospital finance, paying particular attention to the development of workers' contributions, the changing shape of voluntary income and donations and the growing role of the state both locally and nationally. In particular, it investigates the impact of the differing types of workers' funds – the Leeds Workpeople's Hospital Fund (LWHF) and Sheffield's Penny in the Pound scheme – on the management and administration of the voluntary hospitals and on issues such as access to treatment. It also provides an analysis of the shape of municipal hospital spending and assesses the growing role of patient payments in the ability of both the voluntary and state sectors to meet increased demand. Yet despite an enduring interest in hospital finance, few local studies have addressed the part played by ideology and party in the shaping of services, with a tendency to focus on structural issues rather than party as a determinant of policy choice.[34] Hospital politics have been explored by Stewart in his studies of the Socialist Medical Association and by Willis's work on Sheffield and Bradford whilst Taylor, Stewart and Powell's macro study has touched on the inspectors' views

of the influence of local politics in the early 1930s.[35] But in general this is a topic which is largely ignored and is in need of further investigation, not least because the outcomes are indeed complex and the impact of party and ideology is highly variable, strongly influenced by local economic and social factors.

Chapter 6 highlights the role of party, the labour movement and the traditional elite – as well as the medical profession and academics – in the nature and extent of hospital provision and explores the management of poor law and municipal hospital services, both at the political level of council committees and their membership and within the services, considering the role of the medical officers of health, medical superintendents and consultants from both sectors. It shows that local political cultures and the ideologies they created strongly influenced services. In particular it examines the way the labour movement debated the appropriate role of the state and the voluntary providers, questioning the degree to which labour opposed the voluntary approach and traditional elites limited the development of the state sector. The distinctive hospital politics of Leeds and Sheffield are highlighted and the underlying reasons for these differing approaches is assessed with particular emphasis on the form of the local labour movement, the importance and nature of mutualist structures and the size and strength of the traditional elite.

The central element of the critique of interwar hospitals was their failure to co-operate in the development of a rational system – although there is a tendency to assert rather than prove that relations between and within the sectors remained poor throughout the period. Manchester, Birmingham, Oxford, Bristol and Liverpool are usually highlighted as areas with good levels of co-operation, but these are frequently presented as exceptions.[36] Certainly there is much evidence of limited development such as Mohan's study of Durham and Northumberland which offers a very pessimistic view based on the survey reports of 1930–4, as does Levene et al.'s examination of West Hartlepool, but a number of other towns show gradual collaboration, including Barnsley, Middlesbrough and Aberdeen, where the Medical Officer of Health (MOH) was instrumental in negotiating integration; Newcastle, where collaboration was clearly quite advanced; and Leicester, where joint working was also progressing.[37] Moreover, Gorsky has shown the importance of medical schools in both Aberdeen and Bristol in bringing the disparate elements together, as has Pickstone in his study of Manchester. On the other hand, less has been written about individuals involved in the hospital management or doctors, including consultants and medical superintendents.[38]

Drawing together these elements, the final chapter examines the extent to which these cities were able to develop a hospital system in the fifty years prior to the establishment of the NHS. It considers the growth of integrated working within the voluntary sector and the local state's efforts to join up the elements

of council and poor law provision after 1929. It then explores the ways in which state and voluntary hospitals competed and co-operated, looking especially at the role of the workers' funds and medical schools in promoting joint working and the sharing of resources. Moreover, as much co-operation took place at an operational level it will investigate the role of medical, administrative and social and political actors in facilitating or blocking integration. Finally, the chapter assesses the growing pressure for a regional approach to hospital services and the role this played in promoting or limiting joint working.

Overall, this revisionist literature has provided a new framework for assessing the hospital sector in the first half of the twentieth century which acknowledges growth in capacity, capability and specialization, increased financial resources and the suggestion of a nascent cross-sector system at least in some urban areas. However, conclusions on each of these areas remain tentative whilst the place of politics, especially the role of traditional elites and the labour movement, remain under-researched. In order to address some of these issues this study will deploy a comparative case study approach to explore how hospital systems developed and whether they developed to meet the needs of their localities. By comparing two similarly sized industrial cities, it will examine how systems grew from local demand, local resources and how they met – or did not meet – the challenges they faced. To achieve this it will make use of Pickstone's concept of 'political ecology' which encompasses the 'complex interrelations between the hospitals and the communities they were built to serve'. In particular, it will follow the way he 'tried to show how the formal and informal structures of hospitals and similar institutions were related to the economic, social and political structures of the cities or towns or villages which created them'. In his survey of hospital provision in the Manchester region Pickstone noted that 'towns which to a distant observer might seem similar, in fact showed remarkably different patterns of medical services – differences which can be explained by, or at least linked to, these different political structures'.[39] This holistic urban history approach has not been widely adopted by hospital historians in the ensuing twenty-five years. It does inform Welshman's work on Leicester, but was not deployed by Mohan or Gorsky, or Cherry for his East Anglian study.[40] This study employs it to compare two Yorkshire cities to investigate a wider range of stakeholders and policy formers and attempt a broader analysis of the economic, social and cultural backgrounds than Pickstone was able to achieve in a regional study.

To this end the book utilizes case studies of Leeds and Sheffield, cities which were chosen because, while physically close and on the surface quite similar, being industrial cities in northern England with populations of around half a million, they actually differ quite significantly in their economic and social make-up, their regional role and their local politics. For these reasons they offer fertile ground to explore five key issues: what hospital services were available in

the cities and how did these grow and change over the period of study; in what ways did local cultures impact upon the approach to specific medical concerns of the interwar period such as maternity and orthopaedic services; how were these services funded both by the local and central state and by the voluntary sector; what were the key political factors determining the operation of hospital services, especially the role of the labour movement, the traditional elite, medical professionals and institutions like medical schools and the city health department; and to what extent had a unified hospital system emerged by the 1940s.

In addressing these issues particular attention has been paid to the economic, social and political development of the towns.[41] Little research has been undertaken on their medical services. Sheffield has received attention from Tim Willis and Steve Cherry[42] as well as from a number of traditional medical historians.[43] Leeds is less well served, relying heavily on the largely antiquarian work of Stephen Anning.[44] Given their centrality and their significant place in the regional hierarchy of the NHS, the neglect of their hospital systems seems strange and in need of revision. The choice of Leeds and Sheffield as case studies is based largely on their political make-up, their economic structure, regional position and the fact that they had important medical infrastructure, including large general hospitals, extensive municipal services and medical schools. Politically Leeds proved to be one of the most polarized and complex cities of the interwar period with control of the council see-sawing between Labour and a dominant Conservative party, while Sheffield was the first major provincial city to fall to Labour (in 1926) and the party dominated for the rest of the interwar period.[45] How these political landscapes and the social and economic structures which created them affected hospital policy, practice and provision is a key focus of this book.

Overall the book contends that the heavy industrial nature of the economy of Sheffield, with its relatively small middle class and heavily unionized male workforce, created both different medical needs and labour movements to those in Leeds, with its more diverse economy, large female workforce and old middle class. This diversity was underpinned by different forms of hospital funding – contributory schemes or mutualist collection funds – and political responses to the local working arrangements. However, it shows that co-operation and co-ordination were neither linear and consistent, nor always at their most fruitful, in organized committees. In particular it challenges the accepted view of Sheffield as possessing a highly sophisticated integrated service while revealing productive relations between voluntary and municipal sectors behind the political posturing in Leeds. Thus, while these towns were moving at different speeds towards a hospital system, each moved a long way towards unified working over twenty-five years, underlining Pickstone's view that close attention to the local reveals how 'these different arrangements illustrate the range of potential systems of which the NHS was but one'.[46]