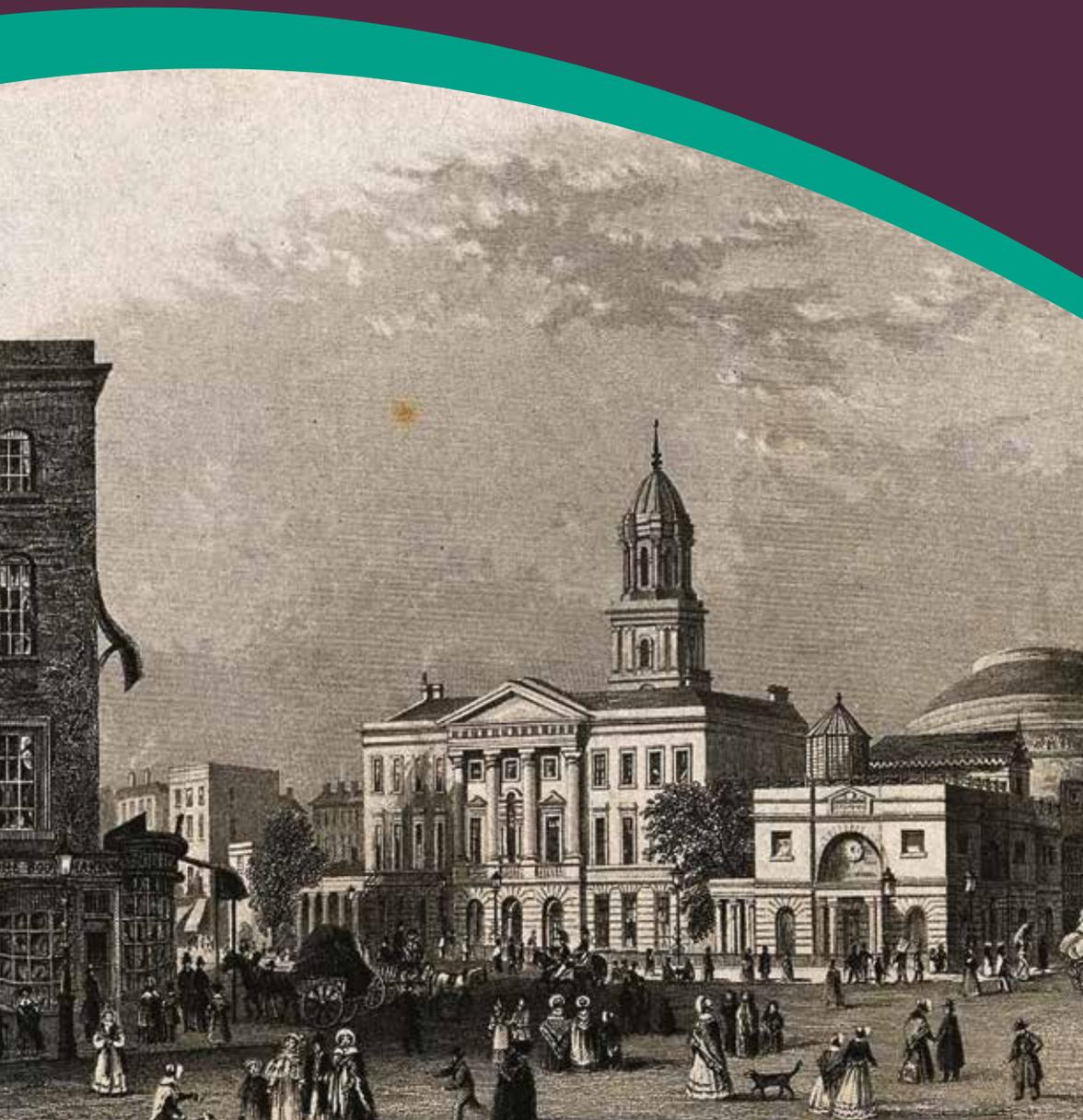


Healthcare in Ireland and Britain from 1850

Voluntary, regional and comparative perspectives

Edited by Donnacha Seán Lucey and Virginia Crossman



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Abbreviations

A.G.M.	Annual general meeting
<i>B.M.J.</i>	<i>British Medical Journal</i>
B.M.H.	Bureau of Military History
D.C.C.A.	Dublin City Council Archives
D.C.D.A.	Belfast, Down and Connor Diocesan Archives
<i>D.E.G.</i>	<i>Devon and Exeter Gazette</i>
D.H.C.	Devon Heritage Centre
D.N.A.	District Nursing Association
D.S.A.	Dublin Sanitary Association
<i>Econ. Hist. Rev.</i>	<i>Economic History Review</i>
<i>Eng. Hist. Rev.</i>	<i>English Historical Review</i>
<i>Irish Hist. Stud.</i>	<i>Irish Historical Studies</i>
G.P.	General practitioner
L.G.B.	Local Government Board
L.M.A.	London Metropolitan Archives
<i>M.E.</i>	<i>Merthyr Express</i>
N.A.I.	National Archives of Ireland
N.A.V.L.	National Anti-Vaccination League
N.G.O.	Non-governmental organization
N.H.I.	National Health Insurance
N.H.S.	National Health Service
<i>O.E.D.</i>	<i>Oxford English Dictionary</i>
<i>O.D.N.B.</i>	<i>Oxford Dictionary of National Biography</i>
P.E.P.	Political and Economic Planning
P.L.G.s	Poor Law guardians
P.R.O.N.I.	Public Record Office of Northern Ireland
Q.N.I.	Queen Victoria's Jubilee Institute for Nurses
R.C.D.H.	Royal City and Dublin Hospital
R.C.P.I.	Royal College of Physicians of Ireland

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R.C.S.W.G.A.C.S	Report of the Joint Committee on Social Work to the General Assembly of the Church of Scotland
R.G.A.U.F.C.	Reports to the General Assembly of the United Free Church of Scotland
R.S.C.H.S.	Records of the Scottish Church History Society
<i>Soc. Hist. of Med.</i>	<i>Social History of Medicine</i>
T.N.A.	The National Archives of the U.K.
U.C.D.	University College Dublin
U.C.D.A.	University College Dublin Archives
W.L.A.	Wellcome Library Archives
<i>W.M.</i>	<i>Western Mail</i>
<i>W.M.N.</i>	<i>Western Morning News</i>
<i>W.T.</i>	<i>Western Times</i>
R.D.&E.H.	Royal Devon and Exeter Hospital
R.V.H.	Royal Victoria Hospital, Belfast
U.F.C.	United Free Church
Q.N.I.	Queen's Nursing Institute
Q.U.B.	Queen's University Belfast
V.H.W.M.C.	Victoria Hospital's Working Men's Committee
W.N.H.A.	Women's National Health Association

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Introduction

Donnacha Seán Lucey and Virginia Crossman

A recent exchange of letters in *The Guardian* newspaper highlighted the disjunction between academic and popular views of voluntary hospitals in the period before the creation of the welfare state in Britain. While historians have been eager to rehabilitate the voluntary system, pointing out that it was more cost effective and more popular than often assumed, those who still remember the nature and quality of the care provided were anxious to stress its defects and inequalities, pointing out that provision was minimal for panel patients and that care for the elderly, the chronic sick and the mentally ill was uneven and often inadequate.¹ A fresh assessment of voluntarism throughout the United Kingdom from the late nineteenth to the twentieth century is, therefore, both necessary and timely. As Martin Gorsky notes in this volume, there remains some confusion over the exact meaning of the term voluntarism. Its current usage appears to have emerged at a time when the welfare state was a goal rather than a reality and the voluntary principle thus carried very different political and social connotations from those shaping current debates.

Voluntarism in healthcare has attracted a notable degree of attention from historians in recent years. In particular, the contribution of the voluntary sector to British hospital provision prior to the introduction of the National Health Service in 1947 has been examined from a variety of perspectives. Issues relating to finance, the extent to which voluntary hospitals were democratized under the influence of workers' representatives, and the importance of fee-payment in determining access have all been explored.² Nevertheless, there remain significant gaps in the literature. These derive to a large extent from the limited geographical focus of the existing

¹ *The Guardian*, 13 May 2014.

² S. Cherry, *Medical Services and the Hospitals in Britain, 1860–1939* (Cambridge, 1996); B. Doyle, 'Power and accountability in the voluntary hospitals of Middlesbrough 1900–48', in *Medicine, Charity and Mutual Aid: the Consumption of Health and Welfare in Britain, c.1550–1950*, ed. A. Borsay and P. Shapely (Farnham, 2007), pp. 207–24; B. Doyle, 'Labour and hospitals in three Yorkshire towns: Middlesbrough, Leeds, Sheffield, 1919–38', *Soc. Hist. of Med.*, xxiii (2010), 374–92; M. Gorsky and J. Mohan, with T. Willis, *Mutualism and Healthcare: British Hospital Contributory Schemes in the 20th Century* (Manchester, 2006).

historiography, which has concentrated largely on English and Welsh case studies.³ Some work on hospital provision and governance in Aberdeen, Dundee, Edinburgh and Glasgow has been undertaken, but Scottish voluntary healthcare remains under-explored.⁴ Analyses of voluntary healthcare in Ireland are similarly lacking beyond the outline of national policies and traditional institutional histories, useful though these are in highlighting Irish contributions to scientific and medical innovation.⁵ While the centrality of voluntary hospitals to the development of Irish healthcare policy has been identified, understanding of this process remains under-developed.⁶ Similarly, despite recent advances in the history of welfare in Ireland, attention has focused either on state provision, specifically through the Poor Law, or the organization of charity; there has been no detailed study of Poor Law or charitable healthcare.⁷

This volume offers new perspectives on the central relationship between state and voluntary healthcare provision throughout the constituent parts of the United Kingdom. A number of recent surveys have highlighted the importance of geography in the delivery of healthcare but have concentrated on examining provision either at a European-wide level or in countries and regions that may be termed ‘welfare peripheries’.⁸ Covering the north and

³ K. Waddington, *Charity and the London Hospitals, 1850–98* (Woodbridge, 2000); Doyle, ‘Labour and hospitals in three Yorkshire towns’; A. Tomkins, “‘The excellent example of the working class’: medical welfare, contributory funding and the North Staffordshire Infirmary from 1815’, *Soc. Hist. of Med.*, xxi (2008), 13–30; S. Thompson, ‘To relieve the sufferings of humanity, irrespective of party, politics or creed? Conflict, consensus and voluntary provision in Edwardian South Wales’, *Soc. Hist. of Med.*, xvi (2003), 247–62.

⁴ Important exceptions include M. Crowther and M. Dupree, *Medical Lives in the Age of Surgical Revolution* (Cambridge, 2007) which examines medical graduates from Glasgow and Edinburgh voluntary hospitals and their careers.

⁵ For general histories of the development of healthcare policy, see R. Barrington, *Health, Medicine and Politics in Ireland, 1900–70* (Dublin, 1987); B. Hensey, *The Health Services of Ireland* (Dublin, 1979). For specific institutional histories, see H. Burke, *The Royal Hospital, Donnybrook: a Heritage of Caring, 1743–1993* (Dublin, 1993); E. Malcolm, *Swift’s Hospital: a History of St Patrick’s Hospital, Dublin, 1746–1989* (Dublin, 1989); F. O. C. Meehan, *St Vincent’s Hospital, 1834–1995: an Historical and Social Portrait* (Dublin, 1995).

⁶ M. E. Daly, “‘An atmosphere of sturdy independence’: the state and the Dublin hospitals in the 1930s’, in *Medicine, Disease and the State in Ireland, 1650–1940*, ed. E. Malcom and G. Jones (Cork, 1999), pp. 235–40.

⁷ V. Crossman, *Poverty and the Poor Law in Ireland 1850–1914* (Liverpool, 2013); V. Crossman, *Politics, Pauperism and Power in Late 19th-Century Ireland* (Manchester, 2006); P. Gray, *The Making of the Irish Poor Law, 1815–43* (Manchester, 2009); A. Jordan, *Who Cared? Charity in Victorian and Edwardian Belfast* (Belfast, 1993); J. Prunty, *Dublin Slums: a Study in Urban Geography* (Dublin, 1998).

⁸ *Medicine in the Remote and Rural North, 1800–2000*, ed. J. T. H. Connor and S. Curtis (2011); *Being Poor in Modern Europe: Historical Perspectives, 1800–1940*, ed. A. Gestrich, S. A.

Introduction

south of Ireland, England, Scotland and Wales, the collection highlights and explores the local and regional character of healthcare, and points the way towards further comparative regional studies. Many of the chapters focus on Ireland. As Catherine Cox and Maria Luddy have observed, Irish examples offer a means of ‘not simply “filling in”, but testing many of the concepts and the hermeneutic devices of medical history’.⁹ The Irish case studies included here provide new insights into varieties of voluntarism, central-local relations and the role of religion in shaping the development of healthcare.

By the middle of the nineteenth century Ireland possessed what has been described as ‘one of the most advanced health services in Europe’, at least in terms of organization, being ‘to a large degree state-supported, uniform and centralised’.¹⁰ Free medical care was available to the poor in hospitals, lunatic asylums, dispensaries and in their own homes. The British government, it has been noted, was ‘far more interventionist’ with regard to public health in Ireland than elsewhere in the United Kingdom, and took an active role in shaping and directing medical provision.¹¹ Significant advances in public medicine had been made in the late eighteenth and early nineteenth century with the passage of legislation providing for the establishment of public dispensaries (1805), county infirmaries (1765) and fever hospitals (1818), to be funded partly from local taxation together with some government grants, and partly by voluntary contributions. By the mid eighteenth-thirties there were around 500 dispensaries, forty-one county and city infirmaries, and seventy fever hospitals.¹² The Irish medical profession was well established, the College of Physicians having been chartered in 1667 and the College of Surgeons in 1784.

The eighteenth century had also seen the establishment of a number of voluntary hospitals in Irish towns and cities. The earliest and most notable were in Dublin, reflecting what James Kelly has described as the ‘vibrancy’ of the city’s charitable culture.¹³ They included the Charitable Infirmary

King and A. Tomkins (Oxford, 2006); *Welfare Peripheries: the Development of Welfare States in 19th and 20th Century Europe*, ed. S. A. King and J. Stewart (Oxford, 2007).

⁹ C. Cox and M. Luddy, ‘Introduction’, in *Cultures of Care in Irish Medical History, 1750–1970*, ed. C. Cox and M. Luddy (Basingstoke, 2009), p. 3.

¹⁰ O. MacDonagh, ‘Ideas and institutions, 1830–45’, in *A New History of Ireland: Ireland under the Union 1801–70*, ed. W. E. Vaughan (Oxford, 1989), p. 210.

¹¹ E. Malcolm and G. Jones, ‘Introduction: an anatomy of Irish medical history’, in Malcolm and Jones, *Medicine, Disease and the State in Ireland*, p. 6.

¹² *Poor Inquiry (Ireland): Second Report of the Commissioners for Inquiring into the Condition of the Poorer Classes in Ireland* (Parl. Papers 1837 (68), xxxi), app. 5, p. 15.

¹³ J. Kelly, ‘The emergence of scientific and institutional medical practice in Ireland’, in Malcolm and Jones, *Medicine, Disease and the State in Ireland*, p. 28.

(1718), Dr. Steevens's (1721), Mercer's (1734), the Incurables' (1744), the Lying-In (later the Rotunda, 1745), the Meath (1753), the Lock (later the Westmoreland, 1755) and St. Patrick's (1757). Examples outside Dublin included the North Charitable Infirmary (1744) and South Charitable Infirmary (1762) in Cork and the Belfast Poorhouse and Infirmary (1774). Some voluntary hospitals were intended for particular groups such as the insane (St. Patrick's) and ex-servicemen (the Incurables'); most aimed to help the deserving industrious poor. As in England, many voluntary hospitals also took paying patients, the criteria for admission comprising a combination of need, ability to pay and type of illness. For example, the Charitable Infirmary (known from 1786 as Jervis Street Hospital) was admitting semi-private patients from the early nineteenth century.¹⁴

With the introduction of the Poor Law in 1838, Ireland acquired a new type of medical practitioner, the Poor Law medical officer, and a new location for hospital services, the workhouse, although the patient had to qualify as a pauper to access this. Initially a relatively minor part of the Poor Law system, medical provision became an increasingly important element of its administration. In 1847, as part of the expansion of the Poor Law system in response to the Great Famine, boards of guardians were empowered to establish separate hospitals 'for the reception and treatment of "poor persons" affected by dangerous contagious disease'. As a result many of the fever hospitals that had been set up by grand juries under previous legislation closed. In 1847 there were 104 grand jury fever hospitals, together with sixty-three under the control of boards of guardians. In 1852 there were just forty grand jury hospitals remaining, and 147 Poor Law fever hospitals.¹⁵ The expansion of Poor Law medical services continued in the decades after the Great Famine. In 1851 dispensary provision was reorganized and reconstituted as part of the Poor Law system, and in 1862 workhouse hospitals were opened to the non-destitute poor.¹⁶ County infirmaries and voluntary hospitals continued to operate as before. The result was the development of two parallel systems. Surveying hospital provision in the early twentieth century, the Vice-Regal Commission noted

¹⁴ *The Charitable Infirmary Jervis Street Dublin 1718–1968*, ed. J. D. H. Widdess (Dublin, 1968), p. 10.

¹⁵ *Second Annual Report of the Commissioners for Administering the Laws for Relief of the Poor in Ireland, under the Medical Charities Act* (Parl. Papers 1854 (1759), xx), p. 12.

¹⁶ For discussion of Poor Law medical services, see L. M. Geary, 'The medical profession, health care and the Poor Law in 19th-century Ireland', in *Poverty and Welfare in Ireland 1838–1948*, ed. V. Crossman and P. Gray (Dublin, 2011), pp. 189–206; V. Crossman, 'Workhouse medicine in Ireland: a preliminary analysis, 1850–1914', in *Medicine and the Workhouse*, ed. J. Reinartz and L. Schwarz (Rochester, N.Y., 2013), pp. 123–39.

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that there were ‘at present in Ireland two systems of public hospitals for the poor ... These may loosely be described as the “County” and the “Union” systems’.¹⁷ Despite general agreement that a unified system would be more efficient and cost-effective, reform was slow and partial.

The organization of public health services in mid nineteenth-century Ireland set it apart from Britain and other European countries. While many aspects of health provision in Britain were similar to equivalents in Ireland (medical charities, voluntary hospitals and workhouse infirmaries, for example, operated along similar lines throughout the United Kingdom), collectively health services in Britain could not, it has been suggested, ‘be called a “system” of health care’.¹⁸ Even in Ireland, the existence of a healthcare system was more apparent than real. With so much of the early legislation permissive rather than mandatory, and so much thus depending on local initiative, the quality and availability of services was both variable and unpredictable. The poor inquiry drew attention in the early 1830s to the regional disparity in the distribution of fever hospitals, noting that while there were thirty-one in Munster and twenty-nine in Leinster, there were just three in Connacht.¹⁹ County infirmaries and fever hospitals tended to be small and accessible only to those living in the immediate vicinity. The Poor Law commissioners reported in 1854 that county infirmaries served people who lived within a ten-mile radius, with the catchment area for fever hospitals being even smaller (eight miles). Furthermore, neither the income nor the number of beds available in county infirmaries bore any relation to medical need, or the size of the local population. For example, in 1852 the County Mayo infirmary, with fifty beds, served a population of 275,000 on an annual income of £846, while that of County Louth provided forty beds for a population of 91,000 on an income of £996.²⁰ The funding situation was also unsatisfactory. Local authorities could only contribute fixed maximum sums towards the costs of the infirmary irrespective of need or demand (unless there was a significant deficit in any particular year), in contrast to the Poor Law system where Poor Law guardians could defray any expense thought necessary. Furthermore, the burden of county cess was distributed equally even though those living in remote districts received little benefit from county institutions. Even in cities, infirmaries and voluntary hospitals

¹⁷ *Report of the Vice-Regal Commission on Poor Law Reform in Ireland: Volume I* (Parl. Papers 1906 [Cd. 3202], li), p. 19.

¹⁸ C. Edwards, ‘Age-based rationing of medical care in 19th-century England’, *Continuity and Change*, xiv (1999), 227–65, at p. 234.

¹⁹ Cited in L. M. Geary, *Medicine and Charity in Ireland 1718–1851* (Dublin, 2004), p. 88.

²⁰ *Second Annual Report ... Medical Charities Act*, pp. 9–11

were often small and could provide for only limited numbers of patients. As a result, and as in England, Poor Law infirmaries became the main provider of hospital beds for the physically ill.

Large parts of the Irish countryside had no accessible medical institution. Those living in remote rural areas with no immediate access to a doctor made use of a range of other practitioners from apothecaries and druggists to wise women and traditional healers, or self-medicated. Kelly has noted the enthusiasm for compiling medical recipe books in the seventeenth and eighteenth centuries and this remained an element of rural life well into the twentieth century.²¹ Most people were nursed at home rather than in hospital, with family members acting as the primary care-givers. It was often assumed that home care was deficient, particularly when the householders were poor. Peasant cabins, one west of Ireland clergyman noted in 1867, were not conducive to patient recovery due to the lack of cleanliness, sanitation and medical competence. The Irish peasant, he maintained, was 'ignorant of the use of medical remedies, and is frequently unable to follow the directions of a physician in the treatment of a tedious illness'.²² Nevertheless, mortality rates in the Irish countryside were considerably lower than those in cities, reflecting not only the prevalence of epidemic disease in urban areas, but also the likelihood of picking up an infection in hospital.²³

In the mid nineteenth century, there was a level of satisfaction in Ireland regarding public health. The Poor Law commissioners opined in 1863 that 'probably no country' possessed 'a more comprehensive and better organised system of intern and extern medical relief, established and secured by law, than Ireland',²⁴ a view largely endorsed by Sir John Lambert in 1866. Having visited Ireland to see the dispensary system in action, Lambert accepted that the Medical Charities Act had 'proved to be universally beneficial' and recommended its extension to England and Wales. Its benefits, he argued, lay not only in the provision of a 'sufficient supply of all necessary and proper medicines and medical appliances' for the sick poor, but in the existence of organizational structures that were

²¹ Kelly, 'The emergence of scientific and institutional medical practice in Ireland', pp. 32–3.

²² Revd. W. Anderson, 'Workhouse hospitals in the west of Ireland', in *Transactions of the National Association for the Promotion of Social Science, Belfast Meeting 1867*, ed. G. W. Hastings (1868), p. 519.

²³ G. Jones, *'Captain of all these Men of Death': the History of Tuberculosis in 19th and 20th Century Ireland* (New York, 2001), pp. 42–7.

²⁴ *Annual Report of the Commissioners for Administering the Laws for Relief of the Poor in Ireland* (Parl. Papers 1863 (3135), xxii), p. 353.

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‘ready, and capable of expansion if necessary, to meet any outbreak of epidemic disease’.²⁵ Doctors in Ireland and England acknowledged that the system appeared to be having beneficial consequences. In 1871, Benson Baker, district medical officer of Christchurch, Marylebone, noted that the advantages of the Medical Charities Act had been referred to so often in the *British Medical Journal* ‘that it is almost a matter of supererogation again to mention them. The dispensary system has been at once productive of improvement in the health of the people, and of the most economic results to the ratepayers, thus proving the relationship that exists between sickness and pauperism’.²⁶

By end of the century, however, medical opinion was far less sanguine. From the eighteen-seventies the medical press in Ireland and Britain featured regular articles condemning the abuse of the dispensary system and recounting the hardships of dispensary doctors who, it was claimed, were grossly overworked and undervalued. The *B.M.J.* claimed that the work of Irish dispensary doctors was ‘harder and worse paid than in any other field in which medical practitioners exercise their beneficent activity’. The ticket system by which patients gained access to a doctor either at the local dispensary or in their own home was widely believed to be hopelessly abused, with tickets used as local currency rather than as a means of identifying those in need of treatment and unable to pay. Having been a source of pride, the dispensary system became a focus of professional discontent and a symbol of waste and inefficiency.

Easy access to medical relief, it was argued, created a culture of dependency. Introducing his *Guide for Irish Medical Practitioners* (1889), R. J. Kinkead contrasted the situation in England, where working people provided for themselves in sickness ‘by the agency of co-operative organisations such as “clubs” or by resort to cheap practitioners’, with that in Ireland, where they looked ‘as a matter of course to the tax-payer for medical relief’. Such dependency on state help in time of sickness, he suspected, was far from beneficial ‘because of the want of self-reliance and domestic providence which it inculcates’.²⁷ The contributory principle, which lay at the heart of the voluntary system, had a strong moral element to it. Ireland provided for many, a cautionary tale of the dangers of offering free medical treatment virtually on demand. Claiming that between 50 and 70 per cent of the population received free medical treatment, Thomas Hennessy, Irish secretary

²⁵ *Report of J. Lambert, Poor Law Inspector, to President of Poor Law Board, November 1866, on System of Medical Relief to Out-door Poor in Ireland under Dispensaries Act, 1851* (Parl. Papers 1867 (17), lx), pp. 4–5.

²⁶ *B.M.J.*, 28 Oct. 1871.

²⁷ R. K. Kinkead, *The Guide for Irish Medical Practitioners* (Dublin, 1889), pp. v–vi

of the British Medical Association, argued in 1919 that the 'gross abuse' of the system was not the fault of the people but of government, 'owing to the failure of the State to provide them, as in England and elsewhere, with a medical service within their reach on a contributory basis'.²⁸

Although fully integrated into United Kingdom and colonial medical networks, Irish doctors retained a separate identity and separate professional bodies. There was, as Greta Jones has observed, a 'distinctive character' to Irish medicine, and Irish doctors were responsible for a number of important innovations in the organization and practice of medicine.²⁹ But if Irish medicine was distinctive it was also deeply divided, being organized mainly along denominational lines. The first voluntary hospitals were established by Protestant patrons and run by Protestant doctors. A visitor to the Meath hospital in Dublin in the eighteen-twenties was discomfited to find bibles and tracts as well as bottles and pill-boxes, making up a 'miscellaneous battery of physic and divinity, for the overthrow of popery and disease'.³⁰ County infirmaries also tended to have a distinct Protestant ethos in the early decades of the system, although this changed in the early twentieth century when many infirmaries came under the control of nationalist-dominated county councils following local government reform. The aim of senior Catholic clerics in establishing Catholic institutions to minister to their own sick was to save them from proselytism as much, if not more, than ill-health.

Having originated as a largely Protestant profession, medicine became one of the few careers open to Catholics in the eighteenth century. Catholic doctors, however, had a lower status than their Protestant colleagues. Irish medicine developed on parallel lines rather like the parallel hospital systems. Catholic doctors trained in Catholic institutions and generally worked either as Poor Law medical officers and dispensary doctors or in Catholic hospitals. Medical training had a distinct denominational character. The impetus behind the establishment in the nineteenth century of Catholic voluntary hospitals such as St. Vincent's in Dublin (1834), the Mercy in Cork (1857) and the Mater Infirmorum in Belfast (1883) was in part to provide training institutions for Catholic doctors. By 1883 there were nineteen medical schools and training hospitals in Ireland, all with a particular denominational character.³¹ While this did nothing to break down sectarian divisions it may have helped to make the Irish medical profession more open in other respects. In her recent study of female

²⁸ *B.M.J.*, 29 March 1919.

²⁹ Jones, *'Captain of all these Men of Death'*, p. 10.

³⁰ Cited in Geary, *Medicine and Charity in Ireland*, p. 32.

³¹ *B.M.J.*, 22 Sept. 1883.

Introduction

doctors in Ireland, Laura Kelly concludes that the Irish medical profession proved to be surprisingly open to women, allowing them to train as doctors from 1877 and offering a less hostile reception than in other parts of the United Kingdom.³²

Nurse training was also organized along denominational lines and developed more slowly than in the rest of the United Kingdom, partly for this reason. As in Britain, the introduction of trained nurses to voluntary hospitals in Ireland was the result of pressure from within the medical profession for competent nurses who could follow instruction and monitor patients' progress, reinforced by the efforts of social campaigners who saw nursing reform as a way of improving public health, and individual nurses who wanted to raise the status of their profession. In Ireland, however, as Gerard Fealy observes, nursing was closely associated in the public mind with religious commitment.³³ Nursing was an integral part of the work of a number of Catholic female orders established in the early nineteenth century. Nuns were not formally trained, however, and initially stood aloof from the campaign for the professionalization of nursing. By the eighteen-nineties, in response to official pressure through the Dublin Hospital Commission which had reported in 1887, and financial incentives, nurse training schemes had been established at all the major voluntary hospitals in Dublin, including Catholic hospitals. Probationary nurses paid fees and nurse training became an important source of funding for voluntary hospitals.³⁴

Political divisions intersected with and reinforced religious divisions. Over the course of the late nineteenth and early twentieth century Irish nationalism became associated with and largely limited to the Catholic community in Ireland while Irish Protestants found their status and identity increasingly dependent on the maintenance of the union with Britain. Local government provided an important arena in which members of the Catholic community could exercise political power, and the growing dominance of Catholics on Poor Law boards outside the northern province of Ulster from the eighteen-seventies both reflected and accelerated the rise of the nationalist movement. While the precise consequences for the operation of the relief system are difficult to determine, one obvious sign of the changing character of Poor Law administration was the presence of

³² L. Kelly, *Irish Women in Medicine c.1880s–1920s: Origins, Education and Careers* (Manchester, 2012).

³³ G. M. Fealy, *A History of Apprenticeship Nurse Training in Ireland* (Abingdon, 2006), p. 10.

³⁴ Fealy, *A History of Apprenticeship Nurse Training*, pp. 31–8; S. Horgan Ryan, 'The development of nursing in Ireland, 1898–1920' (unpublished University College Cork Ph.D. thesis, 2004), pp. 13, 96.

Catholic nuns in workhouse hospitals as well as the growing number of Catholic doctors elected to dispensary positions.³⁵ Protestant doctors found themselves increasingly beleaguered; alienated from the local populace by class and religion, and caught between the demands of their patients for attention and their Board of Guardians for economy and efficiency. Many Irish people, the *B.M.J.* reported in 1904, looked on the dispensary doctor ‘as a portion of the ascendancy army now wholly out of power and authority’.³⁶ Tensions between popular and professional medicine were here compounded by undercurrents of religion, politics, class and culture.

The Edwardian era brought new concerns regarding the health of the ‘nation’ throughout the United Kingdom. In a move away from the traditional statutory emphasis on public health sanitary provision, new legislation placed greater emphasis on local authority provision of personal health services. By the inter-war era a welfare mix existed which included municipal, Poor Law and voluntary services. Reconstruction following the First World War brought new initiatives in public health, culminating in the replacement of the Local Government Board with the Ministry of Health in 1919, and the centralization of most health services. However, lack of financial and enforcement powers limited the potential for radical, top-down reform of local authority health services.³⁷

This era saw significant divergence in health policy within the United Kingdom. The establishment of the Scottish Board of Health in 1919, which was replaced by the Scottish Department of Health in 1929, helped to deepen the separation between Scottish administrative and health policies and the English ‘norm’. Scottish autonomy in social welfare dated back to the Edinburgh-based Board of Supervision for the Relief of the Poor in Scotland established in 1845, right through to the Highlands and Islands (Medical Services) Board of 1913.³⁸ Scotland’s ‘circumscribed autonomy’ encouraged a distinct approach to health planning, albeit constrained by the statutory and fiscal framework set in Westminster.³⁹ If Scotland maintained

³⁵ M. Luddy, ‘“Angels of mercy”: nuns as workhouse nurses, 1861–98’, in Malcolm and Jones, *Medicine, Disease and the State in Ireland*, pp. 102–17.

³⁶ ‘The Poor Law medical system in Ireland’, *B.M.J. Supplement*, 26 March 1904, pp. 11–12.

³⁷ B. Taylor, J. Stewart and M. Powell, ‘Central and local government and the provision of municipal medicine, 1919–39’, *Eng. Hist. Rev.*, cxxii (2007), 397–426.

³⁸ For the establishment of the Scottish Board of Health, see J. Jenkinson, *Scotland’s Health, 1919–48* (Oxford, 2002); for a description of medical services under the Scottish Poor Law, see D. Hamilton, *The Healers: a History of Medicine in Scotland* (Edinburgh, 1981), pp. 227–9.

³⁹ M. Gorsky, ‘An integrated hospital system in northeast Scotland, 1900–39’, *Soc. Hist. of Med.*, xvii (2004), 247–67, at p. 248

a degree of autonomy over health policy, its Welsh counterpart had far less independence. Also established in 1919, the Welsh Board of Health was administered directly under the general Ministry of Health Act although matters such as housing, health insurance and some public health authority duties were transferred to Cardiff. Charles Webster, the leading National Health Service historian, argues that the intransigence of the Ministry of Health over the relinquishing of power constituted a significant part of the explanation for the slow pace of moves towards Welsh devolution.⁴⁰ It has also been highlighted that although a separate Welsh Board of Health existed, there was no radical restructuring nor significant investment during the inter-war years, leading to a stagnation in nineteen-thirties hospital provision.⁴¹

The Irish clauses of the Ministry of Health Act established the chief secretary of Ireland as minister of health and created the Irish Public Health Council as an advisory body.⁴² The council reported in May 1920 and recommended a major overhaul in Irish health provision including greater integration and co-ordination, the reorganization of local health administration on a county basis, and the reform of services to ensure the best available treatment for all.⁴³ These recommendations were never fully implemented. In 1922 Ireland was partitioned following the establishment of the independent Irish Free State. Northern Ireland remained within the United Kingdom.

Irish independence brought about the first formal break-up of the Poor Law in Britain and Ireland. Persistent calls for Poor Law reform and the disassociation of medical relief from public assistance had been prominent in British and Irish welfare debates, and are evident in the writings of reformers such as Sidney and Beatrice Webb and the findings of both the Vice-Regal Commission on the Irish Poor Law and the Royal Commission on the Poor Law.⁴⁴ As in Britain, workhouses had become primarily institutions that provided care for the sick and infirm, with the able-bodied increasingly being relieved outside them.⁴⁵ Nevertheless, Irish nationalists, who regarded

⁴⁰ C. Webster, 'Devolution and the health service in Wales, 1919–69', in *Health and Society in 20th Century Wales*, ed. P. Michael and C. Webster (Cardiff, 2006), pp. 240–69, at p. 240.

⁴¹ P. Michael, 'An overview of the history of health and medicine in Wales', in Michael and Webster, *Health and Society in 20th Century Wales*, p. 32.

⁴² Barrington, *Health, Medicine and Politics in Ireland*, p. 82.

⁴³ *Report of the Irish Public Health Council on the Public Health and Medical Services in Ireland* (Parl. Papers 1920 [Cmd. 761], xvii).

⁴⁴ S. Webb, 'The end of the Poor Law', *Sociological Review*, ii (1909), 127–39.

⁴⁵ For the development of Poor Law medical relief in early 20th-century Ireland, see Crossman, *Poverty and the Poor Law in Ireland 1850–1914*; D. S. Lucey, 'These schemes will

the Poor Law as a colonial imposition, were intent on the abolition of the system and this was included in the 1919 Democratic Programme announced at the first meeting of the Irish revolutionary Dáil Éireann (Irish parliament). When the newly independent Free State government set about reforming local government, boards of guardians and Poor Law unions, together with the Local Government Board, were disbanded and replaced by boards of health and public assistance, which were committees of county councils. Workhouses were renamed county hospitals, district hospitals and county homes. Paraphrasing the 1919 Democratic Programme, J. J. Lee has observed that these reforms merely replaced a 'degrading and foreign' system with a 'degrading and native' one.⁴⁶ Economic constraints in nineteen-twenties independent Ireland prevented any extensive upgrading of existing facilities and thus greatly negated the potential for real change, although recent research has demonstrated that in some localities reform did have a positive impact.⁴⁷

Although couched in advanced nationalist rhetoric, the break-up of the Poor Law in independent Ireland was representative of policies already established, though not yet implemented, in Britain. Independence, however, also heralded policy initiatives that did not originate in London. The introduction of the Irish Hospitals Sweepstake in 1930 was designed to meet the financial crisis which was threatening to cripple medical voluntarism. The sweepstake represented a home-grown policy initiative partly born from political independence; British inter-war voluntary hospitals developed different sources of funding, largely from patient contribution schemes and traditional charity.⁴⁸ The sweepstake provided considerable sums for Irish hospitals. By 1940 close to £4 million had been granted to voluntary hospitals and £2.5 million to county and district hospitals.⁴⁹ While this represented unprecedented growth, the sweepstake also had a less positive impact. As argued by Mary E. Daly, the failure to invest in domiciliary care and non-institutional personal health services, such as maternity and child welfare, led to an over-abundance of hospital beds and a network of small hospitals which failed to rationalize and

win for themselves the confidence of the people": Irish independence, Poor Law reform and hospital provision', *Medical History*, lvii (2014), 46–66, at pp. 48–51.

⁴⁶ J. J. Lee, *Modern Ireland, 1912–85: Politics and Society* (Cambridge, 1986), p. 124.

⁴⁷ Lucey, "These schemes will win for themselves the confidence of the people".

⁴⁸ M. Coleman, *The Irish Sweep: a History of the Irish Hospitals Sweepstake, 1930–87* (Dublin, 2009); Gorsky, Mohan and Willis, *Mutualism and Health Care*; S. Cherry, 'Before the National Health Service: financing the voluntary hospitals, 1900–39', *Econ. Hist. Rev.*, I (1997), 305–26; M. Gorsky, J. Mohan and M. Powell, 'The financial health of voluntary hospitals in interwar Britain', *Econ. Hist. Rev.*, lv (2002), 533–57.

⁴⁹ *Department of Local Government and Public Health Annual Report, 1939–40* (Dublin, 1940), pp. 125, 129.

merge. By the mid nineteen-sixties Ireland had 7.2 acute beds per 1,000 of population compared to 4.3 in England and Wales, 5.5 in Northern Ireland and 4.9 in the United States. A hospital system as opposed to a healthcare system emerged in independent Ireland.⁵⁰

Officials in independent Ireland deliberately looked beyond Britain when devising new policies. The 1929 County Managers Act, for example, that saw the appointment of full-time officials to administer local government jointly with elected councils, was influenced by developments in North American municipalities. Here the British tradition of localism was eschewed for a more centralized and ‘modernized’ state.⁵¹ During the nineteen-twenties and nineteen-thirties Irish medicine also looked away from Britain. This was demonstrated most clearly in the development of children’s tuberculin testing in the nineteen-thirties, which was introduced through a network of connections between Irish and continental paediatricians.⁵² British models remained influential, however. The introduction of the 1932 means-tested Unemployment Assistance by the newly elected Fianna Fáil government was partly based on that recommended, and subsequently introduced, by the British Royal Commission on Unemployment Insurance.⁵³ Attempts to reform National Health Insurance in the late nineteen-thirties had direct input from U.K. government actuarial officials, and the establishment of the Department of Social Welfare in 1947 can be traced to the introduction of the 1942 Beveridge Report.⁵⁴ Although Irish politicians and officials consciously sought to develop policies which demonstrated Ireland’s independence, geographical and political reality ensured that U.K. developments and expertise continued to have an impact.

The role of the Catholic Church took ever-greater precedence in Irish social and medical policy. Legislation dealing with adoption, fostering

⁵⁰ M. E. Daly, ‘The cure of the Hospitals’ Sweepstake’, *HistoryHub: Connecting Past and Present* <<http://historyhub.ie/the-curse-of-the-irish-hospitals-sweepstake>> [accessed 10 Apr. 2014]; Daly, ‘Sturdy independence’.

⁵¹ For contemporary writings on adopting American models of local government, see J. J. Horgan, ‘City management in America’, *Studies: an Irish Quarterly Review*, ix (1920), 42–55; J. J. Horgan, ‘Local government developments at home and abroad’, *Studies*, xv (1926), 529–41. See also M. Potter, *Municipal Revolution in Ireland: a Handbook of Urban Government in Ireland since 1800* (Dublin, 2011).

⁵² A. MacLellan, ‘The Penny Test: tuberculin testing and paediatric practice, 1900–60’, in *Growing Pains: Childhood Illness in Ireland, 1750–1950*, ed. A. MacLellan and A. Mauger (Dublin, 2013).

⁵³ M. Cousins, *The Birth of Social Welfare in Ireland, 1922–52* (Dublin, 2003), p. 61.

⁵⁴ M. Cousins, ‘“Sickness”, gender, and National Health Insurance in Ireland, 1920s to 1940s’, in *Gender and Medicine in Ireland, 1700–1950*, ed. M. Preston and M. Ó hÓgartaigh (Syracuse, N.Y., 2012), p. 175. Cousins, *Social Welfare*, pp. 128–47.

and incest was implemented in inter-war Britain, but not in independent Ireland. Similarly, provision for contraception and abortion was rejected by Irish ministers on moralistic grounds.⁵⁵ The extent of Catholic influence over health policy was particularly prominent in maternity and child welfare. Despite Dublin's high infant mortality rate, the moral ethos of the Free State made maternal support difficult and the Catholic Church's concerns about state intervention in family life encouraged much social inaction.⁵⁶ Increased state provision and the prospect of universal healthcare in the nineteen-forties and early nineteen-fifties led to conflict between the state, the Catholic hierarchy and the medical profession, as demonstrated in the well-known Mother and Child Scheme debacle. Plans to introduce universal healthcare for mothers and children were successfully opposed by moralist and professional opinion from the Catholic hierarchy and the medical profession respectively, resulting in the resignation of the then minister for health, Noël Browne, and the subsequent fall of the government.⁵⁷

While the dramatic events of the early nineteen-fifties were some of the most infamous of mid twentieth-century Ireland, the influence of the Catholic Church was pervasive throughout social policy. Recent research on the emergence of child guidance clinics in the nineteen-forties and nineteen-fifties has demonstrated that in Britain the child guidance movement was central to campaigns of mental hygiene with an emphasis on the social and economic benefits of preventive medicine. In Ireland, however, the overriding consideration was framed as spiritual rather than material.⁵⁸ In rural Ireland traditional Catholic values combined with geographical impediments to medical services led to high maternal mortality rates throughout the early-to-mid twentieth century.⁵⁹ Opposition from the medical profession, voluntary hospitals and the Catholic Church ensured that a universal and free at the point of contact health system, such as the National Health Service, was never fully introduced in Ireland. The 1953 Health Act established a complex set of eligibility criteria for entitlement to

⁵⁵ For child welfare, see S. A. Buckley, *The Cruelty Man: Child Welfare, the NSPCC and the State in Ireland, 1886–1965* (Manchester, 2013); M. Maguire, *Precarious Childhood in Post-Independence Ireland* (Manchester, 2009).

⁵⁶ L. Earner-Byrne, *Mother and Child: Maternity and Child Welfare in Ireland, 1920s–1960s* (Manchester, 2007); L. Earner-Byrne, 'Managing motherhood: negotiating a maternity service for Catholic mothers in Dublin, 1930–54', *Soc. Hist. of Med.*, xix (2006), 261–77.

⁵⁷ E. McKee, 'Church-state relations and the development of Irish health policy: the mother-and-child scheme, 1944–53', *Irish Hist. Stud.*, xxv (1986), 159–94.

⁵⁸ T. Feeney, 'Church, state and family: the advent of child guidance clinics in independent Ireland', *Soc. Hist. of Med.*, xxv (2012), 846–62.

⁵⁹ C. Breathnach, 'Medicalizing the female reproductive cycle in rural Ireland, 1926–56', *Historical Research*, lxxxv (2012), 674–91.

health services, largely based on income and varied from service to service. Impressively, up to 85 per cent of the population were entitled to free or heavily-subsidized hospital care and specialist services. However, general practice remained untouched and while the dispensary system – a remnant from the Poor Law era – was reformed and the stigmatizing ticket system replaced with medical cards, entitlement was not extended; the majority of the Irish still had to pay to visit their local doctor.⁶⁰ Voluntary hospitals, and medical voluntarism, continued, albeit increasingly intermeshed with the state. The establishment in 1957 of the Voluntary Health Insurance Board, a non-profit, semi-state private insurance body, popularized medical insurance for hospital and consultancy services.⁶¹ Ireland's health system developed into a 'mixed' system of providers – public, voluntary and private – and sources of funding.

The establishment of Northern Ireland further entrenched differences in health provision within Ireland as Ulster Unionist step-by-step policy attempted to maintain parity of services with Great Britain. This was partly successful and unemployment and old age pension payments were all maintained at U.K. rates; in the nineteen-twenties the Northern Irish government introduced contributory pensions for widows, orphans and O.A.P.s identical to those in Britain. In 1930 medical benefit – excluded under the original 1911 National Insurance legislation and not introduced in the Irish Free State – was instituted in Northern Ireland.⁶² People in Northern Ireland were somewhat healthier than those living in the Irish Free State, as indicated in the lower rates of tuberculosis mortality. For the period 1931–41 this was 104 per 100,000 in Northern Ireland compared to 124 per 100,000 in the Free State. But while some health services and socio-economic conditions may have been marginally better in Northern Ireland, both sides of the Irish border lagged behind Britain. Tuberculosis mortality rates for the corresponding period were far lower in both England and Wales (seventy-three) and Scotland (eighty-five).⁶³

Financially the Northern Irish inter-war economy was in decline and was severely hit by the slump of the nineteen-thirties. Northern Irish local

⁶⁰ For the introduction and reforms of the 1953 Health Act, see Barrington, *Health, Medicine and Politics in Ireland*, pp. 222–50.

⁶¹ For an outline of health services in modern Ireland, see M. M. Wiley, 'The Irish health system: developments in strategy, structure, funding and delivery since 1980', *Health Economics*, xiv (2005), 169–86.

⁶² P. Martin, 'Ending the pauper taint: medical benefit and welfare reform in Northern Ireland, 1921–39', in Crossman and Gray, *Poverty and Welfare*, pp. 223–36.

⁶³ Jones, *Captain of all these Men of Death*, p. 136.

and central government authorities, like their southern counterparts, were characterized by parsimony, conservatism and lack of integration.⁶⁴ The failure of Northern Irish authorities to develop services at the same rate as in Britain has been demonstrated in relation to open-air education for tubercular children. Unlike in England, specialized education services were not forthcoming for the majority of children who were not in sanatoria; they were either treated in the public elementary school system or received no education at all.⁶⁵ Religion also played an important role in Northern Ireland's health policy. Although not as dominant as in the south, the influence of the churches was still strong and the Stormont government was at pains to uphold moral values. For example, the authorities turned to the churches over the issue of education about venereal disease, and fear of potential religious opposition significantly hindered the development of a family planning service.⁶⁶ When a family planning clinic was finally introduced in 1936 – fifteen years after the first English clinic – it was short-lived and a lack of political and financial support forced its closure in 1947.⁶⁷

Northern Ireland also failed to keep up with British developments in Poor Law reform. While 1929 brought the end of the Poor Law in Britain, the system remained in Northern Ireland until the 1948 nationalization of health services. It should, however, be noted that boards of guardians often reformed institutions locally. This was best demonstrated in inter-war Belfast where significant capital investment led to the city's workhouse developing primarily into a medical site that provided acute, chronic and maternity services. Some smaller workhouses were closed, and others amalgamated and transformed into district hospitals, which helped to erode the 'taint' of Poor Law medical services. Furthermore, voluntary hospital provision was more extensive than in many British cities, although municipal services such as maternity and child welfare remained under-developed. Recent research on British inter-war medical services has demonstrated a more resilient, expansive and integrated system than traditional interpretations have allowed. Overly negative appraisals of the voluntary system have been challenged, and the expansion of municipal health provision has been

⁶⁴ D. Harkness, *Northern Ireland since 1920* (Dublin, 1983), p. 6.

⁶⁵ S. Kelly, 'Education of tubercular children in Northern Ireland, 1921 to 1955', *Soc. Hist. of Med.*, xxiv (2011), 407–25.

⁶⁶ L. McCormick, *Regulating Sexuality: Women in 20th-Century Northern Ireland* (Manchester, 2009), pp. 127, 180; L. McCormick, 'Venereal disease in interwar Northern Ireland', in Cox and Luddy, *Cultures of Care in Irish Medical History*, pp. 191–207.

⁶⁷ G. Jones, 'Marie Stopes in Ireland – the Mother's Clinic in Belfast, 1936–47', *Soc. Hist. of Med.*, v (1992), 255–77.

examined more closely.⁶⁸ Some growth was evident in Northern Ireland, albeit not at the same rate as in more prosperous British regions.

By the nineteen-forties wide disparity in health services existed within the National Health Service. Even though a central objective of the creation of the N.H.S. was the eradication of regional and local differences, it has been widely contended that the new system inherited and perpetrated the inequalities and idiosyncrasies of pre-1946 healthcare.⁶⁹ In England inequalities in resource allocation of hospital beds and medical personnel between the poorly equipped Sheffield and better-supplied Oxford regions, for example, continued into the nineteen-seventies.⁷⁰ Regional differences within England and Wales have received some attention; the extent and consequences of differences in health organization and structures in the constituent countries of the United Kingdom have yet to be explored.

Universal health services were introduced across the United Kingdom by separate acts; the National Health Service Act (England and Wales) of 1946, the National Health Service (Scotland) Act of 1947, and in Northern Ireland a series of acts culminating with the 1948 Health Services Act (Northern Ireland). In Scotland teaching hospitals were fully integrated into regional structures of health, in contrast to England and Wales where independent boards of governors were retained with direct links to the central department, thereby avoiding subservience to the regional board.⁷¹ Although Scottish health services were subject to similar Treasury constraints on expenditure as elsewhere in Great Britain, a distinctively Scottish system emerged reflecting its relative autonomy, nature of governance, and more intangibly, culture and ethos.⁷² As part of the administrative unit 'England and Wales', Wales had the least potential for separate health policies in the mid twentieth century, although a separate Welsh Office was established in

⁶⁸ For recent reappraisals of inter-war health, see A. Levene, 'Between less eligibility and the NHS: the changing place of Poor Law hospitals in England and Wales, 1929–39', *Twentieth Century British History*, xx (2009), 322–45; Gorsky, Mohan and Powell, 'The financial health of voluntary hospitals in interwar Britain'; A. Levene, M. Powell, J. Stewart and B. Taylor, *Cradle to Grave: Municipal Medicine in Interwar England and Wales* (Bern, 2011); E. Jones, 'Nothing too good for the people: local Labour and London's interwar health centre movement', *Soc. Hist. of Med.*, xxv (2012), 84–102; J. Neville, 'Explaining local authority choices on public hospital provision in the 1930s: a public policy hypothesis', *Medical History*, l (2012), 48–71.

⁶⁹ C. Webster, *The National Health Service: a Political History* (Oxford, 2nd edn., 2002).

⁷⁰ J. Welshman, 'Inequalities, regions and hospitals: the Resource Allocation Working Party', in *Financing Medicine: the British Experience since 1750*, ed. M. Gorsky and S. Sheard, (2006), pp. 221–41.

⁷¹ Webster, *The National Health Service*, p. 19.

⁷² J. Stewart, 'The National Health Service in Scotland, 1947–74: Scottish or British?', *Historical Research*, lxxvi (2003), 389–410.

Cardiff in 1964. Governed by a separate parliament, Northern Ireland had a different path to nationalized health services. Politically Northern Ireland was out of step with the rest of the United Kingdom in the mid nineteen-forties, and the continuation of a conservative Unionist regime in Belfast contrasted with the election of a socialist administration in London, and led to something of a crisis of identity.⁷³ Political differences notwithstanding, the Northern Irish government was greatly influenced by the Beveridge Report, and reform of local government health services under the 1946 Public Health (Administration) Act ensured the province kept pace with British developments.

The Stormont government (1922–73) has generally been viewed as failing to develop distinctive policies, and merely copying London measures, the combined result of unionist ideology and the laziness of a dominant conservative party.⁷⁴ However, local initiative and differences were evident. The establishment in 1946 of the Northern Irish Tuberculosis Authority, which took responsibility for the direction, integration and co-ordination of tuberculosis provision and was partly modelled on the Welsh National Memorial Association, demonstrates that Northern Irish politicians and officials looked beyond London to other parts of Britain. Perhaps one of the most distinctive features of post-1948 Northern Irish healthcare was the continued role of the voluntary sector in general hospital provision: the Catholic Mater Infirmorum Hospital in Belfast remained independent of the health service, although other voluntary hospitals were nationalized. With the advent of devolution in the nineteen-nineties a greater appreciation of the contrasting nature of health systems across the United Kingdom has emerged, and resulting differences in health policies have been partly traced to long-standing processes of divergence; further research on the nature of health services in the post-war U.K. is, however, clearly needed.

One of the central aims of this collection is to contextualize Irish healthcare within local, regional and national frameworks. John Stewart's essay provides a critique of existing international, national and sub-national contexts for understanding welfare development. While welfare states, he suggests, can be determined by supranational contexts and clustered together for sharing commonalities of social policy and practice, sub-national and regional differences often characterize welfare regimes. Stewart's essay places Irish healthcare within a transnational context, and points towards future and developing research fields for Irish medical history, including missionary history. Stewart highlights the potential of the transnational conceptual

⁷³ Harkness, *Northern Ireland since 1920*, p. 106.

⁷⁴ S. L. Greer, *Territorial Politics and Health Policy: U.K. Health Policy in Comparative Perspective* (Manchester, 2004), p. 161.

framework of welfare peripheries for understanding healthcare in countries such as Ireland. As he acknowledges, the concept of a periphery has been controversial since it implies a negative relationship between the periphery and the core. Indeed, recent work has moved away from core/periphery models due to the inferior characteristics often and mistakenly attached to the periphery.⁷⁵ It is difficult, moreover, to see cities such as Glasgow, Belfast or Dublin as peripheral. As major industrial centres, Glasgow and Belfast were integral to the U.K. economy while Dublin's importance as a centre of medical education ensured that it had a level of medical specialism greater than the majority of British cities. Dublin's status as a European capital following independence presents further challenges to the idea of Ireland as a welfare periphery.

Despite such complications, it is clear that the core-periphery relationship has much relevance. As Stewart and King have noted, many peripheries were characterized by a weak central state and the prominence of non-state providers, particularly from the voluntary sector.⁷⁶ Seán Lucey and George Gosling's essay demonstrates the importance of medical voluntarism in hospital provision in post-partition Belfast and Dublin. Belfast's voluntary hospital provision was more extensive than in many similar industrialized British cities, although smaller than in Dublin which had the largest voluntary hospital system in either Ireland or Britain throughout the twentieth century. The essay by Steven Thompson indicates further complexities in core-periphery dynamics and highlights the extent to which regional characteristics determined developments in healthcare. Although South Wales was economically at the core of the industrial revolution and central to the British economy, healthcare in the region, Thompson reveals, was largely dominated by a distinctive proletarian voluntarism with limited local or central government provision.

If the strength of voluntarism in healthcare is a key aspect of a welfare periphery, then the Irish Free State, Northern Ireland and South Wales can be seen as peripheral. However, the contrasting character of voluntarism in these locations demonstrates that peripheries had far from common experiences, suggesting that health policies were determined by the specific social, economic and political make-up of each area as much as by any relationship with a perceived core. The core-periphery dynamic is arguably more apparent at the sub-national level. Stewart demonstrates that regional remoteness within individual countries often marked healthcare

⁷⁵ J. T. H. Connor and S. Curtis, 'Introduction', in Connor and Curtis, *Medicine in the Remote and Rural North*, p. 4.

⁷⁶ S. A. King and J. Stewart, 'Welfare peripheries in modern Europe', in King and Stewart, *Welfare Peripheries*, pp. 9–39, at p. 28.

services and highlights the semi-socialized Highland and Islands Medical Service as an example of core/periphery variations within states. Similar understandings are relevant to Ireland. Recent research on the Poor Law in the post-Famine era has demonstrated that poor relief was demarcated by regional trends; in this context the west of Ireland was clearly a welfare periphery.⁷⁷ Stewart notes Ireland's role in the development of medical missionaries, but the opposite trend is evident in the west of Ireland where Jubilee nurses – an English organization – introduced skilled nursing to much of the Irish countryside, where health provision was limited largely to the piecemeal dispensary and workhouse system, and a socially and culturally embedded ethno-medical layer of care.⁷⁸ As Ciara Breathnach shows, while sectarian and political tensions came to the fore, opposition from medical professionals, whose position was threatened by the influx of free charitable nursing, was also apparent. Such professional animosity was exacerbated by the lack of a substantial middle class in a poor socio-economic region, which limited the potential for private practice.⁷⁹

In Ireland and Scotland clear demarcations in healthcare between urban and rural regions, partly a result of the core-periphery dynamic, are apparent. Similar urban-rural gaps in provision might be expected in England. In her study of the rural south-west, however, Julia Neville demonstrates that the voluntary cottage hospital sector was relatively vibrant in the inter-war years. Although East Devon was largely rural, its health services were not disadvantaged by geography, and the core-periphery dynamic appears less relevant in this context. The East Devon example demonstrates that the evolution and expansion of healthcare systems evident in English cities at this time were also apparent in parts of rural England.

Sally Sheard and Ciarán Wallace provide further insights into the dynamics of place in public health provision. Sheard traces the development

⁷⁷ Research from the E.S.R.C. project 'Welfare regimes under the Irish Poor Law' has effectively demonstrated regional trends in Poor Law provision (see G. Laragy, 'Poor relief in the south of Ireland, 1850–1921', in Crossman and Gray, *Poverty and Welfare*, pp. 53–68; D. S. Lucey, 'Poor relief in the west of Ireland, 1861–1911', in Crossman and Gray, *Poverty and Welfare*, pp. 37–52; D. S. Lucey, 'Power, politics and poor relief during the Irish Land War, 1879–82', *Irish Hist. Stud.*, xxxviii (2011), 584–98; O. Purdue, 'Poor relief in the north of Ireland, 1850–1921', in Crossman and Gray, *Poverty and Welfare*, pp. 23–36).

⁷⁸ For ethno-medical care, see C. Cox, 'The medical marketplace and medical tradition in 19th century Ireland', in *Folk Healing and Health Care Practices in Britain and Ireland: Stethoscopes, Wands and Crystals*, ed. R. Moore and S. McClean (Oxford and New York, 2010), pp. 55–79.

⁷⁹ For an outline of the difficulties of medical careers in the west of Ireland, see L. M. Geary, 'The medical profession, health care and the Poor Law in 19th-century Ireland', in Crossman and Gray, *Poverty and Welfare*, pp. 189–206.

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of municipal infectious disease policies from a position of localism in the early eighteen-forties to the gradual regionalization of services by the end of the nineteenth century, and identifies the years between 1870 and 1914 as a period of unparalleled reorganization within British local administration. Legislation allowed national and local authorities to adopt essentially regional policies through the establishment of a Joint Hospital Board which permitted local authorities to cut across sanitary district boundaries in establishing isolation hospitals. Sheard argues that this can be seen as the genesis of regional healthcare planning, predating the better-known 1920 Dawson Report which presented the concept of a hierarchical regional health service. Wallace addresses similar issues in Ireland where, from the late nineteenth century, local government was increasingly becoming the vehicle for delivering national policies on healthcare and sanitation. In a major overhaul, the 1898 Local Government Act empowered local authorities to deal with a wide array of issues, both chronic and acute. Difficulties arose, however, when expensive emergencies, such as the 1902 smallpox outbreak in Dublin which forms the subject of his essay, called for greater resources than local rates could afford. A number of other essays also point to the development of wider regional health structures. The small cottage hospitals of East Devon and South Wales, for example, were reliant on the general and specialist services from neighbouring towns and cities.

Another central theme of the collection is the role of non-state providers of healthcare, particularly in the voluntary sector. The traditional Whig account of welfare history, which presented greater state intervention as inevitable, has been extensively challenged and revised.⁸⁰ In his wide-ranging historiographical essay, Gorsky examines the intellectual historical antecedents of 'voluntarism' in welfare debates. He traces the origins of the term to mid twentieth-century British economic, social and political intellectual thought. Although tied to the established descriptor 'voluntary', long applied to schools, friendly societies and hospitals, the concept of voluntarism was often ambiguous with little consistent content. Gorsky identifies three foci of historical research into voluntarism and healthcare: friendly societies, voluntary hospitals and, since 1948, newer forms of voluntarism including N.G.O.s and campaigning bodies. These historiographical trajectories, he argues, reflected prevailing contemporary political concerns including the nineteen-eighties neo-liberal agenda emphasis on voluntary alternatives to big government. Debates in the nineteen-nineties regarding local decision-making, choice and democratic

⁸⁰ M. Powell, 'The mixed economy of welfare and the social division of welfare', in M. Powell, *Understanding the Mixed Economy of Welfare* (Bristol, 2007), p. 5.

deficits in the modern-day N.H.S. encouraged further historical inquiry into voluntarism. More recently, work on post-war N.G.O.s, user and consumer groups, and campaigning organizations illustrates the emergence of the Big Society as an item on the policy agenda. Gorsky, however, highlights that this emphasis is somewhat misplaced since the lack of voluntary involvement in post-1948 curative services ensured that voluntarism remained on the fringes of health services. Although contemporary health policies increasingly embrace welfare pluralism, it is privatization and the resurgence of markets in healthcare, and not voluntarism, which is the major actor along with the state.

While Gorsky's essay offers a significant challenge to post-war historians of British healthcare, it also has relevance for Irish understandings. Recent explorations of the rapid growth of post-war Irish N.G.O. humanitarianism – seen as transforming non-governmental actors into key mediators between the West and the Third World – can be viewed as part of the wider trajectory in voluntary history writing identified by Gorsky.⁸¹ However, twentieth-century Ireland offers important contrasts to Britain. Medical and welfare voluntarism, particularly related to churches, continued to be far more extensive in Ireland, north and south. Medical voluntarism remained particularly strong in the Republic of Ireland where to this day many hospitals maintain their voluntary ethos, even if the structures of funding and management are integrated with the state.⁸² In this sense, understanding voluntary healthcare historically has contemporary relevance in Ireland that is not apparent in Britain.

Recent research has demonstrated that in the period leading up to the creation of the N.H.S. voluntary hospitals were far more financially robust than previously supposed,⁸³ while also facilitating class unity through voluntary hospital management and increased active citizenship.⁸⁴ A number of essays illustrate the vibrancy of medical voluntarism in the early-to-mid twentieth century. Lucey and Gosling's case study of the Royal Victoria Hospital demonstrates that the pan-class nature of Ulster Unionism facilitated the development of the institution in the inter-war years. Support

⁸¹ K. O'Sullivan, 'Humanitarian encounters: Biafra, NGOs and imagining the Third World in Britain and Ireland, 1967–70', *Journal of Genocide Research*, xvi (2014), 288–315.

⁸² For the continued role of voluntarism in late modern and contemporary Irish hospitals, see D. Fitzpatrick, *The Feds: an Account of the Federated Dublin Voluntary Hospitals, 1961–2005* (Dublin, 2006).

⁸³ Gorsky, Mohan and Powell, 'The financial health of voluntary hospitals in interwar Britain'.

⁸⁴ Doyle, 'Labour and hospitals in three Yorkshire towns'; A. Digby, "'Vision and vested interests': National Health Service reform in South Africa and Britain during the 1940s and beyond', *Soc. Hist. of Med.*, xxi (2008), 485–502.

from the city's elite, middle classes and, increasingly importantly, working classes ensured that the hospital developed into the region's most advanced medical institution. Neville identifies similar pan-class support for East Devon's voluntary cottage hospitals, with stakeholders expanding to embrace all those who contributed, including the working and middle classes. Devon's conservatism and traditional social structure, however, prevented any substantial democratization of the management arrangements of its medical institutions, and a patrician dominance remained. Comparable trends were evident in Belfast where the socially hierarchical character of Ulster Unionism was apparent in the Royal Victoria Hospital management. Although workers' representatives had a greater influence in the R.V.H. than in Devon hospitals, the institution remained in the control of the middle and upper classes. By contrast, Thompson demonstrates that in the particular proletarian society of the South Wales coalfields both voluntary and Poor Law medical provision was dominated by the working classes. Inter-war healthcare in this locale was one of the most democratized in Britain. In a significant addition to the literature, Peter Martin's analysis of the Belfast Mater Infirmorum Hospital, which refused to be nationalized post-1948, demonstrates the continued viability of medical voluntarism during the classic welfare state era. While the central role of voluntarism within the Irish hospital system has long been recognized, the United Kingdom context has received little recognition or attention.

Another recurring theme that runs through a number of the essays is the relationship between identity, nation-building and healthcare. Nation-building and welfare-building went hand-in-hand.⁸⁵ Stewart notes that healthcare can act as a cohesive force in society and cites the positive role of the N.H.S. and the Irish Hospitals Sweepstake in fostering national pride and sense of citizenship. The language of nation-building was also evident in the rhetoric behind the growth of the Royal Victoria. In promoting and fundraising for the hospital, the medical, social and political unionist elite highlighted the need for a leading modern hospital in the newly established Northern Irish state. Such activity further facilitated class collegiality within Ulster Unionism during a period when the Northern Irish Labour Party threatened unionist hegemony among the Protestant working classes. Voluntary healthcare, however, was reflective of the religious, political and ethnic divisions inherent in Northern Irish society. Although the Royal Victoria was popular among Catholic patients, the institution was very publicly an integral part of the unionist and Protestant establishment. Similarly, the refusal of the Belfast Mater to be nationalized, Martin argues,

⁸⁵ King and Stewart, 'Welfare peripheries in modern Europe', p. 34.

was partly out of a desire to maintain Catholic identity in the avowedly Protestant Northern Irish state. Martin demonstrates that identity and ownership were at the core of the conflict between the Mater and the state; Catholic ethics, doctrine and social teaching were of secondary importance. Local healthcare needs could overcome sectarian and political divides. In the context of heightened class tensions in Edwardian South Wales, voluntary hospitals fostered their own form of social relations which at times coincided with class or industrial relations but at others differed from or transcended them.⁸⁶

Many essays explore the relationship between voluntarism and other providers. Social scientists and historians have embraced the idea of a 'mixed economy' of providers to conceptualize welfare systems.⁸⁷ A mixed economy has also been identified in health services, particularly during the inter-war period.⁸⁸ Voluntary, municipal and Poor Law sectors existed alongside each other, but were often quite different in origin and development, and frequently catered for different types of people. As Thompson notes, however, little attention has been given to how the mixed economy of care developed across regions within countries, or how social, economic, political and cultural contexts determined the character of different mixed economies. Focusing on Glasgow, Janet Greenlees provides a fascinating insight into how would-be welfare providers entered the mixed economy. Increasingly side-lined from formal medical voluntarism in the professionally controlled hospitals, the Established Church of Scotland concentrated on housing provision after identifying gaps in the welfare market. A complex range of motivations including political aspirations, concerns about social reform and moral behaviour, and the changing nature of state provision prompted the church to take action.

⁸⁶ S. Thompson, 'To relieve the sufferings of humanity, irrespective of party, politics or creed? Conflict, consensus and voluntary provision in Edwardian South Wales', *Soc. Hist. of Med.*, xvi (2003), 247–62.

⁸⁷ *The Mixed Economy of Social Welfare: Public/Private Relations in England, Germany and the United States, the 1870s to the 1930s*, ed. M. Katz and C. Sachße (Baden Baden, 1996); N. Johnson, *Mixed Economies of Welfare: a Comparative Perspective* (Hemel Hempstead, 1999). For the extent of providers in specific services, see *From Idiocy to Mental Deficiency: Historical Perspectives on People with Learning Difficulties*, ed. D. Wright and A. Digby (1996); *Outside the Walls of the Asylum: the History of Care in the Community, 1750–2000*, ed. P. Bartlett and D. Wright (1996).

⁸⁸ A. Gray, 'A mixed economy of health care: Britain's health services sector in the inter-war period', in *Providing Health Care: the Economics of Alternative Systems of Finance and Delivery*, ed. A. McGuire, P. Fenn and K. Mayhew (Oxford, 1990), pp. 233–60; T. Willis, 'The Bradford Municipal Hospital experiment', in Gorsky and Sheard, *Financing Medicine*, pp. 130–44.

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Thompson examines the dynamics of the mixed economy in South Wales, showing how the region's mono-industrial character fostered working class self-help and mutualistic medical voluntarism. Worker-funded and controlled medical aid societies, as well as cottage hospitals, gave them considerable influence over medical professionals. There were, however, limitations to proletarian mutualistic health provision; the coalfields lacked general hospitals and remained reliant on the larger and more traditional voluntary institutions in nearby towns and cities. Outside services were often a vital element of the mixed economy, particularly in peripheral regions. In East Devon, by contrast, weak Labour organization and a traditional social structure ensured that mutualism remained limited. Hospital care, Neville shows, was provided by a combination of cottage hospitals representing traditional charitable upper-class activity, and Poor Law infirmaries. Both sectors were partially integrated by cross-membership of boards of guardians and governors, and the presence of local G.P.s as medical staff in both types of institutions.

In Ireland the often fraught relationship between local and central government, and between voluntary providers and the state, was inextricably bound up with politics, class and religion. As their role in public health grew, local councils increasingly operated between the voluntary hospital sector and the state. Dublin's voluntary hospitals, Wallace argues, were not equipped to cope with a crisis situation such as a smallpox outbreak; only the city (aided by the state) had the resources to act effectively. In a contrasting but complementary analysis of the 1918–19 influenza pandemic in Ireland, Ida Milne shows how the pandemic highlighted long-standing problems within the health system, and served to confirm the long-recognized and much-discussed need for reform of the Poor Law system.

The mixed economy framework provides a useful reminder that state welfare was always just one element of healthcare provision, embracing religious institutions, organized labour, mutual societies and philanthropic initiatives driven by civic pride and duty. The diversity of the mixed economy is evident throughout this collection. Equally evident is the formative role of religion in shaping the character and structures of healthcare.⁸⁹ The evidence

⁸⁹ While the role of religion in Irish philanthropy has been extensively studied, its influence on the organization and delivery of healthcare remains an under-researched topic. For philanthropy, see C. Clear, *Nuns in 19th Century Ireland* (Dublin, 1988); M. Luddy, *Women and Philanthropy in 19th-Century Ireland* (Cambridge, 1995); M. P. Magray, *The Transforming Power of Nuns: Women, Religion and Cultural Change in Ireland, 1750–1900* (Oxford, 1998); O. Walsh, *Anglican Women in Dublin: Philanthropy, Politics and Education in the Early 20th Century* (Dublin, 2005). For religion and healthcare, see Earner-Byrne, *Mother and Child*.

presented here highlights the contrast between the growing secularization of healthcare in Britain (advances in technology and changing funding mechanisms helped to secularize hospitals both in East Devon and in Glasgow) and the continued influence of the Catholic Church on hospital administration and management in Ireland. Medical institutions in Ireland, north and south, were generally founded and operated with a particular religious ethos that, as Martin acutely observes, ‘implied power’. Religion was a cause of tension and conflict. There are many examples here of clerical intransigence, whether in the form of the Anglican chaplain opposing the introduction of a Methodist minister to Budleigh Salterton or the Catholic bishop of Limerick’s willingness to deny care to a dying woman rather than have her nursed by a Protestant. But religion was also a motivating and energizing force. As many contributors remind us, religious competition was responsible for significant welfare initiatives, from the charitable housing provision described by Greenlees to the introduction of trained nurses in Ireland.

The collection also addresses healthcare in comparative and transnational contexts. While social and political scientists have frequently turned to the transnational model – most famously Gøsta Esping-Andersen in his *Three Worlds of Welfare Capitalism* – historians have been slower to look beyond national histories. Important exceptions include E. P. Hennock’s work which identified that social insurance played a larger and earlier role in Germany than in Britain.⁹⁰ D. M. Fox has argued that medical services in post-First World War America and Britain were increasingly organized around the concept of hierarchical regionalism – the belief that geographic areas in which medical expertise was centralized in leading hospitals were the most appropriate units to deliver medical care.⁹¹ More recently, it has been demonstrated that despite similarities between health services in inter-war Britain and America, the latter’s lack of a social democratic party, limited tradition of social insurance and commitment to workplace health security explains why a universal health service such as the N.H.S. failed to emerge.⁹² Such comparative history has tended to concentrate on social policy and national insurance systems. Stewart’s chapter in this collection highlights new potential avenues for transnational health histories. While

⁹⁰ E. P. Hennock, *The Origin of the Welfare State in England and Germany, 1850–1914: Social Policies Compared* (Cambridge, 2007).

⁹¹ D. M. Fox, *Health Policies, Health Politics: the British and American Experience, 1911–65* (Princeton, N.J., 1985).

⁹² M. Gorsky, ‘Hospitals, finance, and health system reform in Britain and the United States, c.1910–50: historical revisions and cross-national comparison’, *Journal of Health Politics, Policy and Law*, xxxvii (2012), 365–404.

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acknowledging the slowness of historians to consider health transnationally, he demonstrates that policymakers, social reformers and medical doctors frequently looked to other national systems, and points to cross-national sharing of policy and practice in healthcare, particularly within the relationship between Britain and its empire, as potential fields of research. That the transnational historian needs to proceed with caution, however, is evident from Gorsky's chapter which identifies inconsistencies in definitions of voluntarism in different countries.

While the international context of health policy formation and implementation offers much potential for historical research, this collection also demonstrates the value of understanding local and regional health across national boundaries. This is most explicitly demonstrated in Lucey and Gosling's chapter which highlights significant contrasts in hospital finances across Ireland and Britain. Direct user fee-payment in the inter-war years was far more common in independent Ireland's hospitals compared to Northern Ireland, or to many regional British cities. Notwithstanding such differences, interesting comparisons are evident between Dublin and London and suggest that fee-payment was more prominent in the respective capitals than in the regions. The majority of essays concentrate on individual regional case studies; however, their juxtaposition allows for insights into the mixed economy, voluntarism and the role of religion in health, which are not necessarily evident in local or national studies.

The volume is divided into four sections. The first contains the two historiographical essays that provide a contextual framework for the collection as a whole, and consider whether historical understandings of voluntarism and the relationship between the voluntary sector and the state can inform contemporary debates over the desirability of welfare pluralism. The second section offers a range of perspectives on voluntary hospital provision in British and Irish contexts, and provides an important addition to existing comparative and transnational case studies of hospitals and healthcare. The third section explores the mixed economy of welfare through a series of regional case studies, while the fourth and final section focuses on public health in local and regional context. The collection thus both exemplifies and illuminates the variety of voluntary and regional activity in health and social care in Ireland and Britain during the nineteenth and twentieth century.

I. Historiographical directions

I. 'Voluntarism' in English health and welfare: visions of history

Martin Gorsky

Introduction

In fact, the idea of an opposition between civil society and the state was formulated in a given context and in response to a precise intention: some liberal economists proposed it at the end of the eighteenth century to limit the sphere of action of the state, civil society being conceived of as the locus of an autonomous economic process. This was a quasi-polemical concept, opposed to administrative options of states of that era so that a certain kind of liberalism could flourish.

But something bothers me even more: the reference to this antagonistic pair is never exempt from a sort of Manicheism, afflicting the notion of the state with a pejorative connotation at the same time as it idealizes society as something good, lively and warm.

What I am attentive to is the fact that all human relationships are to a certain degree relationships of power. We evolve in a world of perpetual strategic relations. All power relations are not bad in and of themselves, but it is a fact that they always entail certain risks.

M. Foucault, 'The risks of security'¹

This essay presents some reflections on historical writing about voluntarism and healthcare in Britain, one of the themes of this book. It begins, though, with a lengthy extract from Foucault, uttered in an interview concerning the welfare state, for the challenge it poses the reader approaching voluntarism in history. Its date is 1983, just when the power of the Communist bloc was starting to fray before the defiance of the Polish Solidarity movement. Coinciding with the Western turn to neo-liberal thought, the moment marked a revival of interest in civil society, conceived as a realm of activity lying between state and market whose work was essential to a thriving democracy. Although Foucault did not live to see this discussion play out, his comment raises a salutary doubt. To what extent is this, and by implication cognate terms like 'voluntarism', 'third sector', 'philanthropy',

¹ M. Foucault, 'The risks of security', in M. Foucault, *Power*, ed. J. Faubion (Essential Works of Foucault 1954–84, iii, 2002), pp. 365–81, at p. 372.

a descriptor of a discernible social reality, and to what extent a figure of speech which conditions our perception of the world?

The contemporary deployment of such language as political instrument has recently been amply illustrated through the ‘Big Society’ slogan, marshalled by the U.K. Conservative Party during the 2010 general election. With a philosophical lineage in Burkean Toryism, the underlying idea represented a route out of the post-crash ideological dilemma.² If both the over-mighty state and hard-nosed Thatcherism had failed, then perhaps mobilizing the little platoons to rekindle civil society was a way forward? Although the ‘Big Society’ swiftly joined the pundits’ roll call of ‘big ideas that failed’, it was neither new nor transitory.³ Rather, the episode represented just the latest recrudescence of a political theme discernible since the nineteen-eighties. This was the period in which government first turned to the third sector to help it roll back the state, initially in areas like social housing and community job creation, then through establishing contractual and regulatory frameworks for the purchase of social services.⁴ The Blairite Third Way continued the process, plotting its rhetorical course between leaden bureaucracy and amoral markets. Now the voluntary sector’s hitherto supplementary role was formalized into one of partnership with the state, including an Office of the Third Sector within the Cabinet Office.⁵ Thus while ‘Big Society’ enthusiasms generated some distinctive policies the march towards welfare pluralism was long underway.⁶

Visions of history have played a part in the discourse accompanying these developments. Margaret Thatcher rooted her claim for voluntarism as ‘one of freedom’s greatest safeguards’ in a remembered past of small town Rotarians and the Women’s Royal Voluntary Service.⁷ Neo-liberal and leftist commentators alike invoked nineteenth-century friendly societies and co-operatives to demonstrate that individual self-interest was compatible with

² J. Norman, *The Big Society: the Anatomy of the New Politics* (Buckingham, 2010); P. Blond, *Red Tory* (2010).

³ T. Montgomerie, ‘Big ideas that failed to gain momentum’, *The Times*, 26 Nov. 2013.

⁴ N. Deakin, ‘The perils of partnership: the voluntary sector and the state, 1945–92’, in *An Introduction to the Voluntary Sector*, ed. J. Davis Smith, C. Rochester and R. Hedley (1995), pp. 40–65, at pp. 55–63.

⁵ P. Alcock, ‘Voluntary action, New Labour and the “third sector”’, in *The Ages of Voluntarism: how we got to the Big Society*, ed. M. Hilton and J. MacKay (Oxford, 2011).

⁶ E.g., S. Neville, ‘Social investment bank in £37m deals’, *Financial Times*, 13 Sept. 2012.

⁷ M. Thatcher, ‘Speech to Women’s Royal Voluntary Service national conference (“Facing the new challenge”’, 19 Jan. 1981 <<http://www.margaretthatcher.org/Speeches/displaydocument.asp?docid=104551anddoctype=1>> [accessed 28 March 2014]; the W.R.V.S. had in fact been created by government initiative (G. Finlayson, *Citizen, State and Social Welfare in Britain* (Oxford, 1994), p. 275).

collective goals.⁸ The nineteen-nineties briefly saw a 'stakeholder welfare' ideal, when a revived mutual aid movement was touted as the solution for low-income savers.⁹ Another bulwark of Victorian civic action, the voluntary hospital, was sometimes recalled in aid of the present, an appeal to pre-war achievement legitimizing the policy of trust status for N.H.S. hospitals.¹⁰ And recently 'Red' Tories and 'Blue' Labour alike have implicated the disappearance of working-class mutualism in today's welfare dependence and political passivity.¹¹

Alongside these co-options in policy discourse has been a substantial rethinking of British welfare history, driven by the desire to emancipate the subject area from what Finlayson dubbed a 'welfare state escalator' approach.¹² By this he intended an implicit teleology whereby pre-1945 social policies or institutions were interpreted in light of advance to the destination of state welfare. This particularly disadvantaged voluntary provision, which was understood through later perceptions of its failings rather than on its own terms.¹³ Histories badged as 'origins' or 'evolution' studies betrayed this mindset. Empirical comparisons of long-run issues like the social security of older people further problematized the notion of Attlee's welfare state as a critical juncture presaging improvement.¹⁴ Feminist thought provided another spur to revision, with women's philanthropy recovered from the condescension of patriarchy and revalued as a field of social action.¹⁵ What was needed was the replacement of linear narrative with notions of a 'mixed economy' of welfare, and a constantly 'moving frontier' between public, private and voluntary sectors.

New outline texts duly reacted to these critiques, though not without complaint that earlier authors' efforts had been caricatured: after all the

⁸ D. Green, *Reinventing Civil Society: the Rediscovery of Welfare without Politics* (1993); F. Field and others, *Stakeholder Welfare* (1996), pp. 38–40, 84–8; P. Hirst, *Associative Democracy* (Cambridge, 1993).

⁹ Field and others, *Stakeholder Welfare*.

¹⁰ H. Blears, *Communities in Control: Public Services and Local Socialism* (2003), pp. 43–7; D. Willets, 'A buccaneer nation dares to be different', *Sunday Times*, 25 Aug. 1996.

¹¹ Blond, *Red Tory*, pp. 13–15; M. Glasman, 'Labour as a radical tradition', *Soundings*, xlvii (2010), 31–41.

¹² Finlayson, *Citizen, State and Social Welfare*, p. 3.

¹³ F. Prochaska, *The Voluntary Impulse: Philanthropy in Modern Britain* (1988), pp. xiii–xiv; Finlayson, *Citizen, State and Social Welfare*, pp. 1–18.

¹⁴ P. Johnson, 'Risk, redistribution and social welfare in Britain from the Poor Law to Beveridge', in *Charity, Self-Interest and Welfare in the English Past*, ed. M. Daunton (1996), pp. 225–48; D. Thomson, 'Welfare and the historians', in *The World we have Gained*, ed. L. Bonfield, R. M. Smith and K. Wrightson (Oxford, 1986), pp. 355–78.

¹⁵ F. Prochaska, *Women and Philanthropy in 19th-Century England* (Oxford, 1980).

growth of the welfare state could hardly be ignored.¹⁶ Nonetheless today's student is expected to be as familiar with informal aid, friendly societies and medical charities as with factory acts and old age pensions.¹⁷ This commitment remains in place, as demonstrated by the response of academic entrepreneurs to the 'Big Society' agenda. Recent texts showcase the range of work the turn has stimulated, but also evince tensions in balancing the wish to inform with the need to correct historical misapprehensions, and without licence to challenge the organizing concept.¹⁸

So what exactly is the subject area? Readers will note that thus far descriptors like 'voluntarism' and 'civil society' have been blithely elided, it has been hinted that their historiography entwines with the political economy of welfare, and certain types of institution or association that may fall under the lens have been suggested. In what follows these themes will be developed further, beginning with a discussion of how 'voluntarism' and related terms emerged as categories of historical analysis. The essay will then consider trends in historical writing about British healthcare both outside and within the 'voluntarism' paradigm.

The idea of voluntary action

The effect of the new welfare history has been to carve out an area of historical research positioned in binary distinction to state services. 'Voluntarism' is also rather hard to define precisely. This catch-all word provides a widely used categorization, for example in survey texts – *The Voluntary Impulse* – and in scholarly vehicles for specialization – the Voluntary Action History Society, *The Non-Profit and Voluntary Sector Quarterly*, and so on. Yet it is also an expression whose currency among historical actors before the twentieth century is hard to gauge. A glance at Victorian representations in town directories or local newspapers yields terms like 'charities', 'benevolent institutions', 'benefit societies' or 'clubs'. Today's digital historian, if inclined to generate an n-gram of 'voluntarism' in Google Books' English-language corpus, will find early citations are to works of metaphysics and psychology. From whence, then, did our current practice come?

Finlayson, following Brian Harrison's reading of the *O.E.D.*, ascribed the earliest usages of 'voluntarism' to 1924 (as associational activity not determined by compulsion), and to 1957 (as a mode of social welfare).¹⁹

¹⁶ See 'Introduction', in P. Thane, *Foundations of the Welfare State* (2nd edn., 1996).

¹⁷ B. Harris, *The Origins of the British Welfare State: Social Welfare in England and Wales, 1800–1945* (Basingstoke, 2004).

¹⁸ Hilton and MacKay, *The Ages of Voluntarism. The Big Society Debate: a New Agenda for Social Welfare?*, ed. A. Ishkanian and S. Szreter (Cheltenham, 2012).

¹⁹ Finlayson, *Citizen, State and Social Welfare*, p. 6, n. 20: the reference goes to Brian

Harrison's first citation in fact derived from the American labour leader Samuel Gompers, and was made in the context of U.S. trade unionism, a sphere normally outside today's 'voluntary action' history.²⁰ A plausible British lineage is from 'voluntary' education, denoting day schools 'free from State control', to which the *O.E.D.* records references from 1745.²¹ Many of these were founded by charitable bodies whose objectives entwined education with religious inculcation, though by the nineteenth century their 'voluntary' funding combined philanthropy with fees and state subsidies.²² A political language of 'voluntary association' was current by the eighteenth-fifties, for example in counterpoint to state regulation of friendly societies.²³ Otherwise, 'voluntary' giving, denoting a free-will offering for some social or religious purpose, can be dated at least to 1682, and 'voluntaryist', which initially signified a supporter of congregational rather than state funding of the church, to 1842.²⁴

Finlayson also located the emergence of a 'language of sectors' in the mid twentieth century.²⁵ Several texts crystallized the connotations of voluntarism which foreshadow scholarly usage, with Elizabeth Macadam's *The New Philanthropy* (1934) an early example. This book sought to establish the changed basis of the relationship between state and 'voluntary social service', for the current confusion and overlapping of welfare agencies, both public and private, were failing to meet need.²⁶ What was required was some co-ordinating mechanism to yoke the power and compass of bureaucracy to the conscience and personal touch of philanthropy.²⁷ Macadam's choice of subject matter reflected this agenda. Friendly societies and voluntary hospitals were only fleetingly noted, the former now as effectively integrated with the state, and the latter perhaps soon to be: 'there appears to be nothing in this service which unfits it for State action'.²⁸ Instead the book dealt principally with areas supplementary to the social service state, and with

Harrison's citation of the *O.E.D.*, p. 2249.

²⁰ *O.E.D.*, p. 2249; Gompers famously opposed Progressive-era health insurance proposals for fear of undermining the appeal of trade union benefits.

²¹ *O.E.D.*, p. 2249.

²² M. Gorsky, *Patterns of Philanthropy: Charity and Society in 19th-Century Bristol* (Woodbridge, 1999), pp. 214–15.

²³ S. Cordery, *British Friendly Societies, 1750–1914* (Basingstoke, 2003), p. 65.

²⁴ *O.E.D.*, p. 2249.

²⁵ Finlayson, *Citizen, State and Social Welfare*, pp. 287–8.

²⁶ E. Macadam, *The New Philanthropy: a Study in the Relations Between the Statutory and Voluntary Social Services* (1934).

²⁷ M. B. Simey, *From Rhetoric to Reality: a Study of the Work of F. G. D'Aeth, Social Administrator* (Liverpool, 2005), pp. 125–8.

²⁸ Macadam, *The New Philanthropy*, pp. 29, 109, 133–4, 288.

advocacy outside it. It also offered a conceptual account of what voluntary activities could contribute, including their capacity for research and experimentation, for tackling stigmatizing or controversial issues and for individualized care, and their pressure group function.²⁹ But there was also critique of their weaknesses: the lack of co-ordination, the undemocratic nature of governing boards, the under-resourcing and amateurism of the labour force, the lack of leadership and their ineffectiveness in the political arena.³⁰

This notion of voluntarism as a realm with specific strengths and limitations relative to the state re-emerged in Constance Braithwaite's *The Voluntary Citizen* (1938). In her reading, 'voluntary' was synonymous with philanthropy, and her empirical content dealt with hospitals, district nursing associations and charities addressing poverty, impairment, orphans and so on. Frankly preferring the state as provider of health and social services, she argued that only government had the financial resources to support human development, and only it could fulfil the ideals of equality and interdependence.³¹ Charity, meanwhile, was financially inadequate, particularly for medical needs, and although giving had not been crowded out by public funding, its income was increasingly composed of receipts for services.³² Like Macadam, Braithwaite proposed that voluntary work could address inherent limitations of the state, either taking a supplementary role, pioneering new fields, or addressing controversial areas like birth control, pacifism and women's rights. Thus it was entirely compatible with the socialist state she favoured.³³

British socialist traditions also infused *Voluntary Social Services: their Place in the Modern State* (1945), edited by the medieval historian Anne Bourdillon and produced by the Nuffield College Social Reconstruction Survey Committee.³⁴ Although Bourdillon was the project's organizing secretary, the intellectual leadership came from G. D. H. Cole, who wrote a historical introduction and a chapter on mutual aid. While distinctive in thus bringing not just friendly societies but also trade unions and co-operatives within the subject's ambit, the text otherwise followed Macadam's focus in concentrating on organizations with a supplemental role in a welfare

²⁹ Macadam, *The New Philanthropy*, pp. 31–2, 136, 131–3, 287.

³⁰ Macadam, *The New Philanthropy*, pp. 33, 49, 113, 296–9.

³¹ C. Braithwaite, *The Voluntary Citizen: an Enquiry into the Place of Philanthropy in the Community* (1938), pp. 9–12.

³² See also H. Mess and C. Braithwaite, 'The finance of voluntary social services', in *Voluntary Social Services since 1918*, ed. H. Mess (1948), pp. 188–203.

³³ Braithwaite, *Voluntary Citizen*, pp. 21, 23, 29–43, 76–7.

³⁴ *Voluntary Social Services: their Place in the Modern State*, ed. A. F. C. Bourdillon (1945).

state. Bourdillon wrestled with the definitional tangle, first suggesting voluntary association was a timeless British 'habit', then observing that the meaning of 'voluntary' had only lately changed from 'unpaid' to denote a member-governed, but not statutory, social service organization.³⁵ For no very consistent reason this implied that churches, political parties and arts bodies should not be considered, nor the voluntary hospitals, despite their being the 'oldest and largest of the social services'.³⁶ Beyond this, the guiding assumption was that a 'natural process' occurred by which voluntary work identified and pioneered new fields, until 'majority opinion' insisted they became public services – and it was implicit that this was now the case with the hospitals.³⁷ Whether this meant that all voluntarism was inherently transitional or that there would always be a realm beyond the ambit of the state was left open.

Two further conceptual markers appeared in the Nuffield Report. First, Cole's text reified charity in history with terms like 'voluntaryism' and 'voluntarists', to denote a world-view specifically opposed to state incursions.³⁸ His historical survey traced the work of philanthropists from Hannah More to the Charity Organisation Society, treating theirs as class-based interventions distinct from the rights-based approach inherent in mutual aid. 'Voluntaryism', in other words, was a creed compliant with class hierarchies, and insistent upon self-help and charity as the solution to poverty, rather than 'demoralizing' public support.³⁹ It should be stressed that this derogatory sense was not the only one current. For example, the 1937 *Report* on social services by the right-of-centre advocacy group Political and Economic Planning (P.E.P.) defined 'voluntaryism' as a relationship to the public sector, either indicating the extent of contracting to voluntary organizations, or to mean unpaid volunteering for public bodies or official committees.⁴⁰ Nonetheless, both early usages differ strikingly from the contemporary sense. Second, it was Bourdillon who seems to have originated the 'moving frontier' trope, used to describe social initiatives that began as fields of 'public conscience' (voluntary) and later became 'recognized assumptions of civilized urban life' (statutory).⁴¹ Finlayson

³⁵ A. F. C. Bourdillon, 'Introductory', in Bourdillon, *Voluntary Social Services*, pp. 1–10, at pp. 1, 3, 4.

³⁶ Bourdillon, 'Introductory', p. 7.

³⁷ Bourdillon, 'Introductory', p. 2; G. D. H. Cole, 'A retrospect of the history of voluntary social service', in Bourdillon, *Voluntary Social Services*, pp. 11–30, at pp. 28–9; A. D. Lindsay, 'Conclusion', in Bourdillon, *Voluntary Social Services*, pp. 298–306.

³⁸ Cole, 'A retrospect', pp. 19, 21–2, 28.

³⁹ Cole, 'A retrospect', p. 19.

⁴⁰ P.E.P., *Report on the British Social Services* (1937), pp. 173, 175.

⁴¹ Bourdillon, 'Introductory', p. 2, n. 2; and see Cole, 'A retrospect', p. 22.

attributed his later appropriation to William Beveridge in a House of Lords debate of 1949, and it is ironic that he, like Beveridge, here corrupted the original sense of 'forward' state expansion to imply a permanently mutable relationship.⁴²

Shortly afterwards came Beveridge's *Voluntary Action* (1948), a study founded on a detailed empirical survey, the implications of which were then synthesized by committee.⁴³ Beveridge, though, was the main author and defined the field as 'private action ... for a public purpose – for social advance'; following Cole (though not Braithwaite and Macadam), he held this to signify both philanthropy and mutual aid.⁴⁴ Much of the report was duly devoted to the past and future prospects of friendly societies, trade unions and other mutuals. Here too the assumption of inherent strengths and limitations of state and voluntarism were discernible, though implicit. Voluntary inadequacy was demonstrated by the fact that National Health Insurance in 1911 had more than doubled the numbers covered by the mutuals. These pioneers had been naturally superseded, for only the state 'can ensure that at all times unsatisfied needs are clothed'.⁴⁵ And like his peers, Beveridge envisaged the role of voluntarism as supplementing the minimal state (in areas like community care of the old or physically impaired), aiding groups it stigmatized (unmarried mothers, prisoners), and experimenting with new service forms (citizens' advice bureaux, holiday camps).⁴⁶ The committee's patrician prejudices were sharply evident in passages imagining voluntary social clubs and holiday schemes to divert popular tastes away from the wireless, cinema and football pools.⁴⁷

Lineages of voluntar(y)ism

Thus far we have seen the idea of voluntarism as scholarly category emerging at a particular moment of growing state agency in welfare, promulgated by progressive thinkers at ease with this process, and seeking a language for discussing the boundaries to that growth. There was no theoretical consensus on what fell within the category, though in practice some common ground. Another linking theme was that both voluntarism and the state had certain

⁴² G. Finlayson, 'A moving frontier: voluntarism and the state in British social welfare 1911–49', *Twentieth Century British History*, i (1990), 183–206, at pp. 184, 190; Bourdillon, 'Introductory', p. 2.

⁴³ J. Harris, *William Beveridge: a Biography* (Oxford, 1997), pp. 453–61; *The Evidence for Voluntary Action*, ed. W. H. Beveridge and A. F. Wells (1949).

⁴⁴ W. H. Beveridge, *Voluntary Action: a Report on Methods of Social Advance* (1948), p. 8.

⁴⁵ Beveridge, *Voluntary Action*, pp. 76, 295, 319.

⁴⁶ Beveridge, *Voluntary Action*, pp. 227–64, 267, 277–87.

⁴⁷ Beveridge, *Voluntary Action*, pp. 268–72, 298–9.

limitations as a mode of delivery, though whether the latter's were inherent was undecided.

From where, then, did this organizing concept of state and voluntarism as complementary but mutually exclusive emerge? Braithwaite, Cole and Beveridge were, loosely, academic economists, though somewhat apart from the neo-classical grounding of the emergent discipline in Cambridge. Beveridge had qualified in mathematics, classics and law, and was 'self-taught' in economics; his directorship of the London School of Economics arose from his expertise in unemployment, sparked first by voluntary settlement work.⁴⁸ Cole began his academic career in economics, and by 1945 he was Oxford's Chichele professor of social and political theory. Best known as a left-wing labour economist, historian and political theorist, he had travelled from Fabianism, through Guild Socialism, to a rights-based social democracy that gave intellectual heft to the Attlee welfare state.⁴⁹ Braithwaite was based in the discipline's other early centre, the University of Birmingham, whose economics ('commerce') was more practically oriented and attentive to history than that of Cambridge or the L.S.E.⁵⁰ Though lesser known, we learn from biographies of others in her circle that she was a Quaker, feminist, conscientious objector and socialist.⁵¹

Given these backgrounds and locations it is likely that welfare economics was one inspiration, for by the nineteen-twenties this had provided theoretical legitimation for state intervention and established the notion of market failure in the social realm. Alfred Marshall, the founding force in the British profession, had delineated conditions in which Adam Smith's invisible hand (of the aggregate actions of utility maximizing individuals) might not advance social melioration. Not only was general equilibrium a chimera, but the distributional effects of markets could also prove inefficient and inequitable.⁵² Arthur Pigou, Marshall's successor, took forward the idea of sectors with attributable functions, developing his notion of market-

⁴⁸ R. Middleton, *Charlatans or Saviours? Economists and the British Economy from Marshall to Meade* (Cheltenham, 1998), pp. 86, 370

⁴⁹ L. P. Carpenter, *G. D. H. Cole: an Intellectual Biography* (Cambridge, 1973), pp. 119, 123, 203.

⁵⁰ Middleton, *Charlatans or Saviours?*, pp. 78, 110.

⁵¹ S. Harries, *Nikolaus Pevsner: the Life* (2013), p. 142; S. Games, *Pevsner: the Early Life. Germany and Art* (2010), p. 203; S. L. Roberts, 'Place, life histories and the politics of relief: episodes in the life of Francesca Wilson, humanitarian educator activist' (unpublished University of Birmingham Ph.D. thesis, 2010), pp. 150–2. Braithwaite helped the architectural historian Nikolaus Pevsner, then a Jewish refugee from Nazism, to secure a fellowship at Birmingham; his correspondence described her as 'A rather peculiar person, a masculine woman'.

⁵² Middleton, *Charlatans or Saviours?*, pp. 15–16, 112–17.

generated externalities, some good – thus meriting a broader base of payment; and some bad – thus legitimizing state intervention to mitigate their effect.⁵³

However these early interventions seem to have conceived of social welfare solely within a state/market framework, as contemporary economic histories testify. For example, J. H. Clapham (1926) foregrounded the Poor Law, public health and factory acts, ignoring hospitals and treating friendly societies briefly as ‘social insurance’ within discussion of financial institutions.⁵⁴ Cole’s own pre-war economic history did likewise, nodding cursorily to hospitals in a chapter on Georgian London, treating friendly societies in the context of trade unionism, and examining voluntary schooling as a vehicle for religious indoctrination that unhelpfully impeded the growth of state education.⁵⁵ Karl Polanyi, meanwhile, saw social legislation less as a correlate of class struggle and more as a functionalist adjustment to the ‘avalanche of social dislocation’ which industrial capitalism had wrought. Again, though, it was only the state that could ensure social reciprocity trumped individual utility.⁵⁶

Thus the early accounts of ‘voluntary action’ were at the margin of a welfare economics discourse primarily concerned with the balance of state and market. Was direct influence likely? Macadam’s intellectual home was social administration, not economics. Beveridge was apparently antipathetic towards economic theory, while Cole condemned its mathematical turn as ‘writing Choctaw’; economics was, anyway, rather marginal to the early framing of social policy.⁵⁷ Only Braithwaite explicitly described herself as an economist seeking to position philanthropy alongside markets and states, and it is in her work that concepts of voluntary inadequacy and of state ‘defects’ are most clearly presented.⁵⁸ Here, then, is an early sight of the ideas of voluntary failure and strengths that were eventually codified within welfare economics.⁵⁹ That said, Braithwaite was also frank about the

⁵³ S. Medema, ‘Pigou’s “prima facie case”: market failure in theory and practice’, in *No Wealth but Life: Welfare Economics and the Welfare State in Britain, 1880–1945*, ed. R. Backhouse and T. Nishizawa (Cambridge, 2010), pp. 42–61.

⁵⁴ J. H. Clapham, *An Economic History of Modern Britain* (Cambridge, 1926), pp. 294–8, 349–78, 588–91.

⁵⁵ G. D. H. Cole and R. Postgate, *The Common People 1746–1938* (1938), pp. 219, 227–8, 351–9.

⁵⁶ K. Polanyi, *The Great Transformation: the Political and Economic Origins of our Time* (Boston, Mass., 1944; 2nd edn., 2001), p. 42, ch. 4.

⁵⁷ Middleton, *Charlatans or Saviours?*, p. 161; Carpenter, *G. D. H. Cole*, p. 223.

⁵⁸ Braithwaite, *Voluntary Citizen*, pp. 7, 25.

⁵⁹ B. Weisbrod, ‘Towards a theory of the voluntary nonprofit sector in a three sector economy’, in *Altruism, Morality and Economic Theory*, ed. E. S. Phelps (1975), pp. 171–95; L.

'personal bias' underpinning her advocacy of voluntary citizenship within a socialist welfare state.⁶⁰ Although unstated, it is tempting to speculate about the influence of Quaker 'witness' on her position, and to note that debates over pacifism during the First World War had radicalized Quakerism through contact with socialist and idealist thought.⁶¹ Indeed, Braithwaite's bibliography included not only Pigou but also T. H. Green, the Oxford idealist philosopher, and Harold Laski, the Labour intellectual who blended Fabian socialism with advocacy of political pluralism.⁶²

Given the latter influence, it might seem plausible that a related political creed was important, the Guild Socialism championed by G. D. H. Cole in the nineteen-twenties. Enjoying a brief post-war popularity, Guild Socialism aimed to instil democracy at every level of economic organization, whether of producers or consumers, and it might seem that friendly societies or voluntary associations would have provided a useful model.⁶³ However, it was informed in its seminal texts by the models of trade unions and co-operatives, and Cole's proposals for decentralized health services involved Medical and Public Health Guilds and Collective Health Councils affiliated to local government.⁶⁴ So again it was within a state/market dualism that these utopian visions sought to resolve class struggle. Political pluralism therefore seems only a marginal influence.

Better attested is the impact of idealist thought on Beveridge, and this was arguably a shaping influence on *Voluntary Action*.⁶⁵ Idealism proposed the organic nature of society, in which the conscious development of the state could serve a moral purpose. By providing the wherewithal for good health, employment and freedom from want, government could create the circumstances in which an independent citizenry behaved as ethical and rational beings.⁶⁶ This thinking incorporated a range of positions on the extent and form of state benefits, and it also posited a boundary between

Salamon, *Partners in Public Service: Government-Non Profit Relations in the Modern Welfare State* (1995).

⁶⁰ Braithwaite, *Voluntary Citizen*, p. 2; N. Riddell, *Labour in Crisis: the Second Labour Government 1929-31* (Manchester, 1999), pp. 37-40.

⁶¹ A. D. Kerr-Wilson, 'The sword and the light: the evolution of the peace testimony of the British Society of Friends, 1914-18' (unpublished McMaster University M.A. dissertation, 1985).

⁶² Braithwaite, *Voluntary Citizen*, pp. 325-30.

⁶³ Carpenter, *G. D. H. Cole*, pp. 46-111; G. D. H. Cole, *Guild Socialism Re-Stated* (1920), pp. 42-95.

⁶⁴ Carpenter, *G. D. H. Cole*, pp. 71-111; Cole, *Guild Socialism Re-Stated*, pp. 101, 105-7.

⁶⁵ Harris, *William Beveridge*, pp. 77, 460.

⁶⁶ J. Harris, 'Political thought and the welfare state 1870-1940: an intellectual framework for British social policy', *Past & Present*, cxxxv (1992), 116-41.

state and voluntary action which this notional engaged citizen would inhabit. This is certainly the intellectual scenario of *Voluntary Action*, even if its empirical findings documented disengagement and preference for commercial leisure.

The cohering of certain realms of activity into an inconsistently defined 'voluntarism' therefore involved different intellectual strands. Above all, though, it was the creature of its time. Thus Elizabeth Macadam's agenda came directly from her experience in Liverpool, where she had led efforts to co-ordinate relief charities. Macadam, whose earlier work dealt with the training of social workers, was a pioneer in the academic professionalization of 'public administration'.⁶⁷ She was also the companion and 'political wife' of the prominent feminist and parliamentarian Eleanor Rathbone, who championed the economic empowerment of women through state family allowances.⁶⁸ Thus closely engaged with current welfare politics, Macadam's was a notion of modernity in which welfare as charitable dispensation must give way to an organized voluntary service that complemented the state.⁶⁹ A thread of feminism can also be discerned, for professional training would end the situation in which the 'ladies committee' was relegated to spheres of a 'womanly character'.⁷⁰

Voluntary Action, meanwhile, had been commissioned by the National Deposit Friendly Society, which sought advice on its future role in the era of National Insurance. Beveridge therefore needed both to elide voluntarism and mutualism, and to reassure his commissioners that the extension of social insurance, which his famous report of 1942 had instigated, would not extinguish welfare beyond the state.⁷¹ His biographer also stresses the highly contingent impact of the Second World War on shaping all three Beveridge reports. Hitherto his thought was marked by theoretical inconsistency and eclecticism, but the war had convinced him that shared values of

⁶⁷ R. A. Chapman, 'The origins of the Joint University Council and the background to public policy and administration: an interpretation', *Public Policy and Administration*, xxii (2007), 7–26; S. Pedersen, 'Macadam, Elizabeth (1871–1948)', *O.D.N.B.* (Oxford, 2004) <<http://www.oxforddnb.com/view/article/53582>> [accessed 20 June 2014]; E. Macadam, *The Equipment of the Social Worker* (1925).

⁶⁸ S. Pedersen, 'Rathbone, Eleanor Florence (1872–1946)', *O.D.N.B.* (Oxford, 2004; online edn. Jan. 2011) <<http://www.oxforddnb.com/view/article/35678>> [accessed 20 June 2014].

⁶⁹ Simey, *From Rhetoric to Reality*, pp. 87–8, 114, 125–6.

⁷⁰ Macadam, *The New Philanthropy*, p. 113; cf., for the feminization of early social work, K. Woodroffe, *From Charity to Social Work in England and the United States* (1962), pp. 207–27.

⁷¹ Harris, *William Beveridge*, pp. 453–4.

egalitarianism and trust in government were irreversibly established.⁷² The wartime moment, with its potential for radical reconstruction, also conditioned the perspective of Cole and the Nuffield team, who had provided research evidence for the main Beveridge Report on popular attitudes towards existing welfare, which some regarded (then and since) as highly partial.⁷³ On balance, then, these immediate factors seem as important as intellectual lineages in providing the platform on which stable concepts of state and voluntarism could emerge.

The idea of voluntarism, then, is not exactly an anachronism, deriving as it does from the established descriptor 'voluntary', long applied to schools, friendly societies and hospitals. However, it was also a time-bound construct, its contemporary sense emerging in the mid twentieth century as a language for political progressives whose sympathies lay with expansive state welfare to discuss its limits. It fused different strands of social, political and economic thought, and had no consistent content, but was practically oriented to the adaptation of charity and mutualism to the new dispensation. When Finlayson urged its revival in the nineteen-eighties, like Cole and P.E.P. he also reified it as a set of beliefs guiding behaviour, and ascribable to 'voluntarists'. For him the connotation was principally active citizenship, though he did acknowledge the class prejudices imputed by Cole.⁷⁴ From here it was a lesser step to elide 'voluntarism', now a synchronic 'impulse', with other timeless human attributes of 'voluntarists', like 'innovation, self-sacrifice ... love of one's fellow man'.⁷⁵ Yet what is striking in contemplating this genealogy is how contingent and questionable it is as a category of historical analysis.

A 'baggy monster' and its uses

Given these difficulties, might contemporary conceptual frameworks be of more help? Unfortunately these both acknowledge and compound the slipperiness of terms like voluntarism, civil society, charity, third sector, non-profit and N.G.O.⁷⁶ A much-cited reference point is Kendall and Knapp's 'loose and baggy monster' essay, which reviews the attendant typological

⁷² Harris, *William Beveridge*, pp. 478–95.

⁷³ J. Harris, 'Did British workers want the welfare state? G. D. H. Cole's survey of 1942', in *The Working Class in Modern British History: Essays in Honour of Henry Pelling*, ed. J. Winter (Cambridge, 1983), pp. 200–14; Carpenter, *G. D. H. Cole*, pp. 196–202.

⁷⁴ Finlayson, 'A moving frontier', pp. 185, 192, 197.

⁷⁵ Prochaska, *Voluntary Impulse*, pp. 6–7, where trade unions and friendly societies are excluded 'in the interests of managing the subject'.

⁷⁶ M. Hilton and others, *A Historical Guide to NGOs in Britain: Charities, Civil Society and the Voluntary Sector since 1945* (Basingstoke, 2012), pp. 1–11.

diversity and terminological inconsistency.⁷⁷ This points out that the voluntary sector has been variously defined according to social function (mutual aid, advocacy, service); to structure (non-profit, independent, volunteer-based); to motivation of participants (beneficence, solidarity); or to legal framings. Complexities deepen when international variants are considered, for while the British like to talk of 'voluntarism', the Americans prefer, and legally delineate, 'non-profit', the French perceive an *économie sociale* of solidaristic organizations, while German civil law recognizes *gemeinnützige* (public benefit) bodies, and so on.⁷⁸ Each is conceptually distinct and implies a different range of organizations, and thus emerges a tendency towards a broader purview than that staked out in mid twentieth-century Britain by Beveridge *et al.*

Anheier and Salamon's attempt to synthesize common components to permit cross-national comparison of 'Nonprofit Organizations' has duly resulted in a very capacious scheme. Grouping these within fields of activities, they include not only the charities, pressure groups and clubs familiar from the British literature, but many other organizations which reasonably meet criteria of independence, non-profit making and public benefit purpose. These encompass universities, trade unions, political parties and churches, but exclude co-operatives and friendly or building societies, which fall foul of a 'non-distribution' criterion.⁷⁹ Other challenges in applying this 'structural-operational' approach to British voluntarism abound. At what point does the extent of government funding and regulation negate 'independence'? Why exclude informal social care? Are fee-paying public schools really a public benefit?⁸⁰ In the face of all this Kendall and Knapp deploy their 'monster' metaphor, observing that 'the preferred approach will depend on the purpose for which the categorizations are required'⁸¹ – unless, presumably, we require a consensus over definition and content with which to evaluate impact in historical context.

The difficulty this imprecision presents for British historians, or at least their readers, is evident in the recent burst of writing on post-war non-governmental organizations. This term seems to have originated with the

⁷⁷ J. Kendall and M. Knapp, 'A loose and baggy monster: boundaries, definitions and typologies', in Davis Smith, Rochester and Hedley, *Introduction to the Voluntary Sector*, pp. 66–95.

⁷⁸ L. Salamon and H. Anheier, *Defining the Non-Profit Sector: a Cross-National Analysis* (Manchester, 1997), pp. 13–20; Beveridge included trade unions within *Voluntary Action*, observing that in 1939 almost half their spending went on 'friendly' benefits (principally sickness and superannuation).

⁷⁹ Salamon and Anheier, *Defining the Non-Profit Sector*, pp. 42, 70–4.

⁸⁰ Kendall and Knapp, 'Loose and baggy monster', pp. 86–8.

⁸¹ Kendall and Knapp, 'Loose and baggy monster', p. 66.

United Nations, whose founding charter used it to describe non-state actors eligible for consultative status with its Economic and Social Council, either because of their representativeness, special competence or technical expertise.⁸² Hilton and colleagues deploy it widely, eliding their usage with that of 'social action', 'charities' and 'voluntarism', but essentially defining N.G.O.s as bodies outside government or business intent on 'shaping the broader socio-political agenda'. Their larger argument is that with the decline of popular participation in conventional parties, political identification and expression has shifted to the voluntary sector.⁸³ Specifically, N.G.O.s were vehicles for the 'post-materialist' politics of the baby-boomers within mature welfare states, for whom the class struggle and social security had become irrelevant.⁸⁴ This classification (not obviously employed by actors themselves) helpfully sustains their call for a 'new historical paradigm' in reading post-war politics, which have now, they argue, migrated to the 'Big Society'.⁸⁵ Their case, then, builds on a rich mix drawn from traditional charities, user and consumer groups, and straightforward campaigning organizations, with themes like environmentalism, feminism, international aid and sexuality looming large.⁸⁶ Whether this is a legitimate 'preferred approach', or a partial selection of 'voluntary' organizations that validates a particular thesis, is for the reader to judge.

It also, of course, perpetuates the vagueness that has attended the concept of voluntarism since its consolidation in the nineteen-thirties. In face of this the health historian might conclude that it is not very useful and abandon it entirely, treating each organization on its own terms with no prior assumptions about function or motivation. Or she might cautiously accept it on grounds of its ubiquity, employing it as an umbrella for grouping discussion of the obviously salient fields, such as friendly society sickness insurance and voluntary hospital care before the N.H.S., and of user or

⁸² J. McKay and M. Hilton, 'Introduction', in *NGOs in Contemporary Britain: Non-State Actors in Society and Politics since 1945*, ed. N. Crowson, M. Hilton and J. McKay (Basingstoke, 2008), pp. 1–20, at p. 3; *Working with ECOSOC: an NGOs Guide to Consultative Status* (New York, 2011), pp. 1, 34–5.

⁸³ McKay and Hilton, 'Introduction', p. 5

⁸⁴ See R. Inglehart, *Modernization and Postmodernization: Cultural, Economic and Political Change in Forty-Three Societies* (Princeton, N.J., 1997); ironically Inglehart's later investigations show that degree of associational activity was not a factor in sustaining democratic politics (R. Inglehart and C. Welzel, *Modernization, Cultural Change, and Democracy: the Human Development Sequence* (Cambridge, 2008), tables II.2, II.3 *et seq.*).

⁸⁵ McKay and Hilton, 'Introduction', pp. 3–4; A. Mold, 'The changing role of NGOs in Britain: voluntary action and illegal drugs', in Crowson, Hilton and McKay, *NGOs in Contemporary Britain*, pp. 164–81, at p. 166; Hilton and McKay, *The Ages of Voluntarism*.

⁸⁶ Hilton and others, *A Historical Guide to NGOs*, pp. 79–265.

advocacy groups in the ensuing decades. With this in mind the remainder of this essay will briefly review historical writing in these areas, identifying periods in which the 'voluntarist' nature of these organizations has assumed prominence in the analysis, and finally considering whether today's N.G.O. paradigm provides a useful key for unlocking health politics.

Voluntarism and healthcare: historical trajectories

Friendly societies

G. D. H. Cole's reading was discernible in early post-war work on the friendly societies, which treated them as manifestations of a class society. The key studies were P. H. J. H. Gosden's, begun as doctoral work under the Marxist historian Eric Hobsbawm.⁸⁷ The principal actors were the skilled working class of industrial Britain, and the funds were epitomized as Victorian 'self-help', the Smilesian epithet distracting from their earlier origin in journeymen's guilds and their mutualist purpose. Sickness insurance was rather marginal to these accounts, and while Gosden charted the decline of friendly societies as vehicles for sociability, Bentley Gilbert depicted a financial system facing actuarial uncertainty prior to National Health Insurance (N.H.I.).⁸⁸ The Thompsonian turn in British social history focused further attention on their function as manifestations of the culture of the artisan elite, though proliferating local studies illustrated their presence among lower waged workers too.⁸⁹ Later overview texts retraced these paths, augmenting the central narrative with additional case studies and handsomely elaborating the cultural history.⁹⁰

A significant change occurred in the nineteen-eighties when welfare economic theory was applied to friendly society insurance activities. A founding concept of health economics was that markets failed in healthcare for two reasons. One was that consumers lacked the information to make

⁸⁷ E. Hobsbawm, 'Friendly societies', *The Amateur Historian*, iii (1957), 95–101; P. H. J. H. Gosden, *The Friendly Societies in England 1815–75* (Manchester, 1961), p. v; P. H. J. H. Gosden, *Self-Help: Voluntary Associations in the 19th Century* (1973).

⁸⁸ Gosden, *Friendly Societies*, pp. 138–49, 211–20; B. B. Gilbert, *The Evolution of National Insurance in Great Britain* (1966).

⁸⁹ G. Crossick, *An Artisan Elite in Victorian Society: Kentish London, 1840–80* (1978), ch. 9; H. Marland, *Medicine and Society in Wakefield and Huddersfield, 1780–1870* (Cambridge, 1987); D. Neave, *Mutual Aid in the Victorian Countryside: Friendly Societies in the Rural East Riding 1830–1914* (Hull, 1991).

⁹⁰ E. Hopkins, *Working-Class Self-Help in 19th-Century England* (1995); S. Cordery, *British Friendly Societies, 1750–1914* (Basingstoke, 2003); D. Weinbren, 'Beneath the all-seeing eye: fraternal order and friendly societies' banners', *Journal of Cultural History*, iii (2006); D. Weinbren, *The Oddfellows, 1810–2010: 200 Years of Making Friends and Helping People* (Lancaster, 2010).

informed choices and thus classic dynamics of supply and demand could not set prices. The second was that demand was inherently unpredictable, for the costs of ill health could be so catastrophic as to confound even the most prudent individual saver.⁹¹ David Green thus historicized the friendly societies' arrival as a grass-roots response to these trust and pricing failures; membership bonds obviated moral hazard and the professional monopolizers were held accountable to consumers.⁹² Developing his non-Marxist account of working-class action Green also drew on civil society theory to depict their procedures as nurseries of democracy and a building block of the liberal state.⁹³

The millennium was therefore a period of revisionism. Green's theme found parallels in the work of American economic historians arguing that non-governmental health insurance was the optimal form, because large, impersonal public funds encouraged moral hazard and hence higher costs.⁹⁴ It also appealed to political historians seeking alternative explanations for the mid-Victorian liberal consensus after 'social control' theory became discredited.⁹⁵ Further rethinking followed the insight that the funds' pre-N.H.I. financial status was more robust and flexible than earlier accounts had claimed.⁹⁶ All this played to the then fashionable neo-liberal agenda, with which Green was associated through the Institute of Economic Affairs, which suggested that a voluntary sector alternative to the welfare state had been viable before big government overwhelmed it.⁹⁷ Not only had the numbers covered by friendly society sick funds been similar to those initially insured under N.H.I., but popular opinion was by no means favourable to the state scheme.⁹⁸

Subsequent evaluations have reached more circumspect conclusions. Green's calculations of pre-N.H.I. coverage turned on some generous assumptions about the under-reporting of sickness insurance cover in unregistered or small funds.⁹⁹ Given this, the Beveridgean estimate of

⁹¹ See, e.g., A. Mills and K. Ransom, 'The design of health systems', in *International Public Health: Diseases, Programs, Systems, and Policies*, ed. M. Merson, R. Black and A. Mills (Gaithersburg, Md., 2006), pp. 513–47, at p. 521.

⁹² D. G. Green, *Working Class Patients and the Medical Establishment* (Aldershot, 1985).

⁹³ Green, *Re-inventing Civil Society*.

⁹⁴ J. E. Murray, 'Social insurance claims as morbidity data: sickness or absence?', *Soc. Hist. of Med.*, xvi (2003), 225–45.

⁹⁵ J. Garrard, *Democratisation in Britain: Elites, Civil Society and Reform since 1800* (Basingstoke, 2002).

⁹⁶ P. Johnson, *Saving and Spending: the Working-Class Economy in Britain 1870–1939* (Oxford, 1985).

⁹⁷ A. Seldon, *The Virtues of Capitalism* (Indianapolis, Ind., 2004), pp. 323–30.

⁹⁸ *Before Beveridge: Welfare before the Welfare State*, ed. D. Gladstone (1999).

⁹⁹ M. Gorsky, 'Friendly society health insurance in the 19th century', in *Financing Medicine: the British Experience since 1750*, ed. M. Gorsky and S. Sheard (2006), pp. 147–64.

‘voluntary inadequacy’ still seems reasonable.¹⁰⁰ Nor has debate over whether the working class wanted the welfare state substantiated the contention that it was fundamentally undemocratic. Rather labour seems to have moved gradually from suspicion to acceptance as the conceptual horizon of reform possibilities widened.¹⁰¹ Similarly the rank and file of friendly society members acquiesced in state old age pensions when the prospectus became clear.¹⁰² Beyond this, popular views probably ranged from apathy to misunderstanding to enthusiastic support for N.H.I.¹⁰³ Meanwhile the ‘labour mobilization’ approach in comparative histories of welfare states shows no sign of receding.¹⁰⁴ A classic case is New Zealand, where recent studies of this ideal-typical ‘world without welfare’ revealed that it was the failure of mutualism to provide for ageing populations which explains welfarism’s early arrival.¹⁰⁵

Current English friendly society historiography is similarly refocused on the pressures bearing on funds before N.H.I., now from the perspective of morbidity. Analysing claim data to derive patterns of sickness, James Riley showed a striking rise in morbidity coinciding with the mortality decline since 1870, both within the ageing population, and across age groups.¹⁰⁶ Debate has turned on whether this was a real biological phenomenon or a ‘cultural inflation of morbidity’, driven either by shifting norms of the sick role, or by the funds’ economic capacity to sustain time off, or by the pension needs of unemployed older people, which were legitimized as sickness benefit.¹⁰⁷ Recent contributions argue that even allowing for some

¹⁰⁰ P. Johnson, *Saving and Spending: the Working-Class Economy in Britain 1870–1939* (Oxford, 1985), p. 57; B. Harris, *The Origins of the British Welfare State: Social Welfare in England and Wales, 1800–1945* (Basingstoke, 2004), pp. 81–4.

¹⁰¹ P. Thane, ‘The working class and state “welfare” in Britain, 1880–1914’, repr. in Gladstone, *Before Beveridge*, pp. 86–112.

¹⁰² J. H. Treble, ‘The attitudes of friendly societies towards the movement in Great Britain for state pensions, 1878–1908’, *International Review of Social History*, xv (1970), 266–99; Cordery, *British Friendly Societies*, pp. 159–64.

¹⁰³ Harris, ‘British workers’.

¹⁰⁴ F. G. Castles and D. Mitchell, ‘Worlds of welfare and families of nations’, in *Families of Nations: Patterns of Public Policy in Western Democracies*, ed. F. G. Castles (Aldershot, 1993), pp. 93–128.

¹⁰⁵ F. Castles, *The Working Class and Welfare, Reflections on the Political Development of the Welfare State in Australia and New Zealand, 1890–1980* (Wellington, 1985); D. Thomson, *A World Without Welfare: New Zealand’s Colonial Experiment* (Auckland, 1998).

¹⁰⁶ J. C. Riley, *Sick not Dead: the Health of British Workingmen during the Mortality Decline* (1997).

¹⁰⁷ S. Ryan Johansson, ‘The health transition: the cultural inflation of morbidity during the decline of mortality’, *Health Transition Review*, i (1991), 39–65; Murray, ‘Social insurance claims’; J. Macnicol, *The Politics of Retirement in Britain, 1878–1948* (Cambridge, 1998).

influence from these factors, there was a clear rise in sickness prevalence as life expectation rose.¹⁰⁸ We need not embrace demographic determinism to suspect that this dynamic mattered to the (‘forward’) moving frontier, as it did across other welfare states.¹⁰⁹

Voluntary hospitals

By contrast, the post-war literature on voluntary hospitals emanated from social administration, not social history. First Richard Titmuss’s official history of wartime social policy suggested a worsening crisis of hospital underfunding and uneven provision in the late nineteen-thirties, and like its companion volumes treated the Emergency Medical Service as the model for a new and better service.¹¹⁰ Further accounts of pre-war failings appeared in American studies analysing the coming of ‘socialized medicine’ for domestic consumption.¹¹¹ The classic work, though, was by Titmuss’s protégé, the economist Brian Abel-Smith, whose history of English and Welsh hospitals from 1800 still dominates the field.¹¹²

Subtitled a ‘study in social administration’, this text came after Abel-Smith cut his teeth as researcher for the Guillebaud Committee, which endorsed the financial viability of the N.H.S.¹¹³ It also coincided with his work for the World Health Organization on developing comparative quantitative indicators of health system activity, and it was part-funded by an American foundation, through the offices of the pioneer health systems scholar, Odin Anderson.¹¹⁴ Though not overtly whiggish, there were intimations of the progressive assumptions that might be expected of a Fabian socialist author, like a description of the 1920 Dawson Report as a ‘lost opportunity’ for

¹⁰⁸ B. Harris, M. Gorsky, A. Guntapali and A. Hinde, ‘Long-term changes in sickness and health: further evidence from the Hampshire Friendly Society’, *Econ. Hist. Rev.*, lxxv (2012), 719–45; M. Gorsky, A. Guntapali, B. Harris and A. Hinde, ‘The “cultural inflation of morbidity” during the English mortality decline: a new look’, *Social Science Medicine*, lxxii (2011), 1775–83.

¹⁰⁹ H. Wilensky, *Welfare State and Equality: Structural and Ideological Roots of Public Expenditures* (Berkeley, Calif., 1975), pp. 24–7, 47–8.

¹¹⁰ R. M. Titmuss, *Problems of Social Policy* (1950); C. L. Dunn, *The Emergency Medical Services*, i: *England and Wales* (1952).

¹¹¹ H. Eckstein, *The English Health Service: its Origins, Structure, and Achievements* (Cambridge, Mass., 1964).

¹¹² B. Abel-Smith, *The Hospitals 1800–1948: a Study in Social Administration in England and Wales* (Cambridge, 1964).

¹¹³ S. Sheard, *The Passionate Economist: how Brian Abel-Smith Shaped Global Health and Social Welfare* (Bristol, 2013).

¹¹⁴ O. Anderson, *The Evolution of Health Services Research: Personal Reflections on Applied Social Science* (Oxford, 1991), pp. 147–8.

reform.¹¹⁵ However, it was rather through his periodization, from the birth of the industrial revolution to that of the welfare state, his twin-tracked account of public and voluntary hospitals, and his time series of hospital statistics that he set the parameters of subsequent British hospital history.¹¹⁶

Much of what followed has had the same rather empirical tone. Foucault's near-contemporary rendering of the hospital as site of a depersonalizing clinical gaze had little initial purchase, and when historians of science entered the field the 'voluntary' nature of the hospital was not much at issue.¹¹⁷ A flurry of works in the nineteen-seventies responded to the 'gateways to death' caricature associated with historical demographer Thomas McKeown, effectively overturning it.¹¹⁸ The nature of subscriber philanthropy attracted interest as an aspect of class relations, with key studies of classic industrializing regions and beyond.¹¹⁹ Fascination with charities as a nexus of middle-class identity formation briefly held sway, unravelling the hospital's social role in respect of class, sect and party; in this literature 'voluntarism' did become salient, for it was free association within a public sphere which separated the new urban bourgeoisie from early modern corporate power structures.¹²⁰

As with friendly societies, a more specifically 'voluntarist' literature emerged from the nineteen-nineties, though not as an aspect of neo-liberal critique. It did, however, respond to the Finlayson agenda, in that it set aside assumptions of progressive inevitability in favour of revised empirical

¹¹⁵ Abel-Smith, *The Hospitals*, p. 284.

¹¹⁶ Abel-Smith, *The Hospitals*, 16; R. Pinker, *English Hospital Statistics 1861–1938* (1966).

¹¹⁷ L. S. Jacyna, 'The laboratory and the clinic: the impact of pathology on surgical diagnosis in the Glasgow Western Infirmary, 1875–1910', *Bulletin of the History of Medicine*, lxii (1988), 384–406; S. Sturdy and R. Cooter, 'Science, scientific management and the transformation of medicine in Britain, 1870–1950', *History of Science*, xxxvi (1998), 421–66.

¹¹⁸ J. Woodward, *To do the Sick no Harm: a Study of the Voluntary Hospital System to 1875* (1974); S. Cherry, 'The hospitals and population growth: the voluntary general hospitals, mortality and local populations in the English provinces in the 18th and 19th centuries', *Population Studies*, pt. 1, xxxiv (1980), 59–75, pt. 2, xxxv (1980), 251–65.

¹¹⁹ C. Webster, 'The crisis of hospitals during the industrial revolution', in *Human Implications of Scientific Advance*, ed. E. G. Forbes (Edinburgh, 1977), pp. 214–22; H. Marland, *Medicine and Society in Wakefield and Huddersfield, 1780–1870* (Cambridge, 1987); J. V. Pickstone, *Medicine and Industrial Society* (Manchester, 1985); M. Fissell, *Patients, Power, and the Poor in 18th Century Bristol* (Cambridge, 1991).

¹²⁰ R. Porter, 'The gift relation: philanthropy and provincial hospitals in 18th-century England', in *The Hospital in History*, ed. L. Granshaw and R. Porter (1989), pp. 149–78; A. Wilson, 'Conflict, consensus and charity: politics and the provincial voluntary hospitals in the 18th century', *Eng. Hist. Rev.*, cxi (1996), 599–619; A. Borsay, "'Persons of honour and reputation': the voluntary hospital in an age of corruption", *Medical History*, xxxv (1991), 281–94; Gorsky, *Patterns of Philanthropy*; cf. R. J. Morris, *Class, Sect and Party. The Making of the British Middle Class: Leeds, 1820–50* (Manchester, 1990).

scrutiny.¹²¹ Its interest in local decision-making before the N.H.S. was also timely in light of public choice debates about provider capture and democratic deficit.¹²² Abel-Smith and Pinker's depiction of a transition from charitable funding to mass contributory schemes received particular attention, with their crude sample years and spatial breakdown augmented by fuller time series and finer geographical variations. Implications for control by worker-governors were also explored.¹²³ Several investigations adopted a welfare economics approach, exploring voluntary sector performance with respect to: spatial distribution, which showed considerable diversity at city and county level in rates of provision, utilization, income, income sources and expenditure, with some suggestion of an inverse correlation with need; financial adequacy, which modified the conventional view of general crisis though essentially supported the 'transition' account; and its relationship to the municipal sector, which suggested that public hospitals met gaps in voluntary provision.¹²⁴

The implication that such 'voluntary failure' was a causal factor in the creation of the N.H.S. was critically interrogated, and attention directed instead to changing public and professional attitudes towards voluntary hospitals, and their place in the interest politics of 1942–6.¹²⁵ This augmented

¹²¹ S. Cherry, 'Beyond National Health Insurance: the voluntary hospitals and hospital contributory schemes – a regional study', *Soc. Hist. of Med.*, v (1992), 455–82; K. Waddington, *Charity and the London Hospitals, 1850–98* (Woodbridge, 2000).

¹²² S. Cherry, 'Accountability, entitlement and control issues and voluntary hospital funding c.1860–1939', *Soc. Hist. of Med.*, ix (1996), 215–33; S. Thompson, 'To relieve the sufferings of humanity, irrespective of party, politics or creed? Conflict, consensus and voluntary hospital provision in Edwardian South Wales', *Soc. Hist. of Med.*, xvi (2003), 247–62; K. Waddington, 'Subscribing to a democracy? Management and the voluntary ideology of the London hospitals, 1850–1900', *Eng. Hist. Rev.*, cxii (2003), 357–79.

¹²³ S. Cherry, 'Before the National Health Service: financing the voluntary hospitals, 1900–39', *Econ. Hist. Rev.*, l (1997), 305–26; M. Gorsky, J. Mohan and M. Powell, 'The financial health of voluntary hospitals in interwar Britain', *Econ. Hist. Rev.*, lv (2002), 533–57; M. Gorsky and J. Mohan, with T. Willis, *Mutualism and Health Care: British Hospital Contributory Schemes in the 20th Century* (Manchester, 2006).

¹²⁴ J. Hollingsworth and E. Hollingsworth, 'Differences between voluntary and public organizations: the behavior of hospitals in England and Wales', *Journal of Health Policy, Politics and Law*, x (1985), 371–97; M. Powell, 'Hospital provision before the NHS: a geographic study of the 1945 hospital survey', *Soc. Hist. of Med.*, v (1992), 483–504; M. Gorsky, J. Mohan and M. Powell, 'British voluntary hospitals, 1871–1938: the geography of provision and utilization', *Journal of Historical Geography*, xxv (1999), 463–82; Gorsky, Mohan and Powell, 'Financial health'; J. Mohan, "'The caprice of charity": geographical variations in the finances of British voluntary hospital services before the NHS', in Gorsky and Sheard, *Financing Medicine*, pp. 77–92.

¹²⁵ P. Bridgen, 'Voluntary failure, the middle classes, and the nationalisation of the British voluntary hospitals, 1900–46', in *Charity and Mutual Aid in Europe and North America since 1800*, ed. B. Harris and P. Bridgen (2007), pp. 212–34.

established theorizing on the N.H.S. reform, which has explored the degree of prior consensus, the extent to which the labour movement opposed voluntarism and the importance of bureaucratic and ideological momentum from inside the state.¹²⁶ Findings drawn from case studies and opinion poll data argue that despite some oppositional municipal socialism, the public was generally supportive of charity and provider pluralism, at least until the mid nineteen-forties.¹²⁷ The unabashed usage of the first-person nominative pronoun in the title ‘Did we really want a National Health Service? Hospitals, patients and public opinions before 1948’, makes explicit the current political intent.¹²⁸ As in the nineteen-fifties and sixties, history speaks to social policymaking, though now in the context of a reversion to pluralism and integration of private medicine.

Health, voluntarism and N.G.O.s since 1948

Moving beyond 1948, a preliminary point to make is that voluntarism is rather peripheral to the historical or policy literature on the N.H.S. because until recently it did not deliver curative services. In the major survey texts it is therefore absent, although organizations concerned with mental health and older people have small walk-on parts.¹²⁹ This began to change when policy permitted outside contracting by N.H.S. trusts, to which this essay will return below. Thus it is possible to claim as ‘civil society’ the G.P. mutuals created within the internal market structures, as does the National Council for Voluntary Organisations.¹³⁰ There are

¹²⁶ C. Webster, ‘Conflict and consensus: explaining the British health service’, *Twentieth Century British History*, i (1990), 115–51; J. S. Hacker, ‘The historical logic of National Health Insurance: structure and sequence in the development of British, Canadian, and U.S. medical policy’, *Studies in American Political Development*, xxii (1998), 57–130; L. R. Jacobs, ‘Institutions and culture: health policy and public opinion in the U.S. and Britain’, *World Politics*, xlv (1992), 179–209.

¹²⁷ B. Doyle, ‘Labour and hospitals in urban Yorkshire: Middlesbrough, Leeds and Sheffield, 1919–38’, *Soc. Hist. of Med.*, xxiii (2010), 374–92; N. Hayes and B. M. Doyle, ‘Eggs, rags and whist drives: popular munificence and the development of provincial medical voluntarism between the wars’, *Historical Research*, lxxxvi (2013), 712–40; N. Hayes, ‘Our hospitals? Voluntary provision, community and civic consciousness in Nottingham before the NHS’, *Midland History*, xxxvii (2012), 84–105; N. Hayes, ‘Did we really want a National Health Service? Hospitals, patients and public opinions before 1948’, *Eng. Hist. Rev.*, cxxvii (2012), 625–61.

¹²⁸ Cf. N. Hayes, ‘Health reforms, opinion polls and surveys: myths and realities’ <<http://www.historyandpolicy.org/papers/policy-paper-149.html>> [accessed 9 May 2014].

¹²⁹ R. Klein, *The New Politics of the NHS: from Creation to Reinvention* (1983; Oxford, 2006), p. 60; C. Webster, *The Health Services since the War*, ii: *Government and Health Care – the National Health Service 1958–79* (1996), pp. 406–7, 649–50.

¹³⁰ National Council for Voluntary Organisations, ‘What is civil society?’, *NCVO UK Civil Society Almanac* <<http://data.ncvo.org.uk/a/almanac14/what-is-civil-society-2>> [accessed 9

clearly limits here: such bodies are monitored by regulation, responsible to the secretary of state, and still funded ultimately by general taxation, the receipts of which enter the system through a rationing process (dubbed 'resource allocation') still anchored in nineteen-seventies technocratic planning.¹³¹

Thus the first historiographical point to make is that where 'voluntary' health services are concerned the N.H.S.-era literature is small. A few works have dealt with the fate of charitable funds in the service, noting the gradual loosening of constraints as to their application.¹³² Hospital contributory scheme scholarship has explored those organizations' post-1948 transition into health cash plans, where the story is of a gradual loss of mutualist trappings and of mimetic tendencies casting them as low-cost private medical insurance.¹³³ In this respect their experience parallels the hollowing out since the nineteen-eighties of residual 'self-help', through state-sanctioned demutualization of building and friendly societies. The economic historian's verdict on this is downbeat: the windfalls that enticed modest savers to abandon mutualism were soon recouped in raised fees by the privatized societies, now marching headlong towards the fatal credit boom.¹³⁴ As for surviving friendly societies, sporadic efforts to resuscitate them through vehicles such as friendly society bonds have been overwhelmed by commercial tax-exempt savings.¹³⁵ The limited post-1948 history is therefore one of falling membership, reorientation towards family and older people's sociability, and failure in financial services markets, not least for sickness and health insurance.¹³⁶

Beyond this, several studies have considered the community health councils created in 1974, tangentially relevant for their voluntary

May 2014]; by 2010 these had about 1,700 employees and a turnover of c. £120 million (see *Britain: Made Mutual. Mutuals Yearbook 2010* (Borehamwood, 2010), p. 35).

¹³¹ J. Welshman, 'Inequalities, regions and hospitals: the Resource Allocation Working Party', in Gorsky and Sheard, *Financing Medicine*, pp. 221–41; A. Maynard, 'Health care rationing: doing it better in public and private health care systems', *Journal of Health Politics, Policy and Law*, xxxviii (2013), 1103–27.

¹³² L. Fitzherbert, *Charity and the National Health* (1992); M. Lattimer, *The Gift of Health* (1996); M. Gorsky and J. Mohan, *Don't Look Back? Voluntary and Charitable Finance of Hospitals in Britain, Past and Present* (2001).

¹³³ M. Gorsky, J. Mohan and T. Willis, 'From hospital contributory schemes to health cash plans: mutualism in British health care after 1948', *Journal of Social Policy*, xxxiv (2005), 447–67.

¹³⁴ A. Offer, 'British manual workers: from producers to consumers, c.1950–2000', *Contemporary British History*, xxii (2008), 537–71, at p. 550.

¹³⁵ A. Coombs, M.P., 'Friendly societies', Hansard, *Parliamentary debates*, 6th ser., cl, cols. 167–74, at col. 167, 4 Apr. 1989.

¹³⁶ Weinbren, *The Oddfellows*, pp. 230, 259–60, 276–83, 289–96.

representation alongside public and professional participants.¹³⁷ The picture is of a modest channel for local democracy unjustly muzzled when the market reforms began. Subsequent work on ‘patient and public involvement’ is more concerned with localism and grass-roots democracy than voluntarism *per se*.¹³⁸ Early sightings of the ‘patient-consumer’ have also been made, and problematized.¹³⁹ Again, though, the marginal importance of these developments needs emphasizing. As the latest enquiry into gross medical neglect in the N.H.S. observed, the ‘small, virtually self-selected volunteer groups’ created under ‘patient and public involvement’ mechanisms proved an abject failure, providing ‘no effective voice’.¹⁴⁰

Perhaps, then, a more promising arena in which to explore post-war voluntarism is public health. As indicated above, the N.G.O. paradigm developed by Hilton and colleagues now frames the discussion. Their position is that ‘the essence of voluntary sector power changed from being primarily applied, to primarily discursive’, increasingly concentrated on advocacy, agenda setting and reframing the political language in which issues were articulated.¹⁴¹ The claim is grounded in the University of Birmingham’s Database of Archives of Non-Government Organisations (D.A.N.G.O.) project, which captures 1,978 N.G.O.s active in the U.K., 1945–97. Its classification scheme records 309 (16 per cent) of these concerned with ‘ill-health, medicine, counselling and rehabilitation’.¹⁴²

In principle the historiography of English public health provides an apt testing ground for such claims about voluntarism and post-ideological politics. The scholarly narrative has articulated a decline and fall of the public health function within the state. This saw the dismantling of the local government empires of medical officers of health by the nineteen-seventies and a concomitant failure to develop a new vision of social medicine,

¹³⁷ R. Klein and J. Lewis, *The Politics of Consumer Representation: a Study of Community Health Councils* (1976); C. Hogg, *Citizens, Consumers and the NHS: Capturing Voices* (Basingstoke, 2008).

¹³⁸ T. Milewa, J. Valentine and M. Calnan, ‘Managerialism and active citizenship in Britain’s reformed health service: power and community in an era of decentralisation’, *Social Science Medicine*, xlvii (1998), 507–17; T. Milewa, J. Valentine and M. Calnan, ‘Community participation and citizenship in British health care planning: narratives of power and involvement in the changing welfare state’, *Sociology of Health and Illness*, xxi (1999), 445–65.

¹³⁹ Hilton and others, *A Historical Guide to NGOs*, pp. 35–6; A. Mold, ‘Patient groups and the construction of the patient-consumer in Britain: an historical overview’, *Journal of Social Policy*, xxxix (2010), 505–21.

¹⁴⁰ R. Francis, Q.C., *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Executive Summary* (2013), pp. 46–7.

¹⁴¹ McKay and Hilton, ‘Introduction’, p. 9.

¹⁴² Database of Archives of Non-Governmental Organisations <<http://www.dango.bham.ac.uk/index.htm>> [accessed 13 Jan. 2014].

appropriate to an age of chronic diseases and lifestyle risk factors.¹⁴³ So was this an open field for 'voluntary sector power'? Broadly the emergent historiography has augmented but complicated the picture of new-style N.G.O.s flourishing outside the state since the nineteen-sixties. We can consider this through recent work on smoking, illicit drugs and disability.

Tobacco historians have sought to explain the process by which the concern about the smoking/lung cancer link translated into policy. In the U.K. epidemiological insights dated from 1950, and were endorsed by the Royal College of Physicians in 1962, though only from the mid nineteen-seventies did lung cancer deaths and female smoking rates start to decline.¹⁴⁴ The formation in 1971 of the group Action on Smoking and Health (A.S.H.) has therefore been of interest, its dynamic impact contrasting with officialdom's ineffectiveness. However, investigation has shown that from the outset it was essentially a small insider pressure group that channelled academic expertise; it was supported by the chief medical officer, co-ordinated strategy with politicians, and was heavily funded by government, to the tune of 90 per cent by 1978.¹⁴⁵

Establishing causation in smoking cessation has been like 'unravelling gossamer with boxing gloves', so voluntarism's importance is hard to calibrate.¹⁴⁶ Judicious interpretation therefore situates A.S.H.'s role alongside that of academia, organized medicine and media in effecting a broadly based cultural shift.¹⁴⁷ However, comparative analysis also suggests that the fiscal lever has been the decisive factor in bringing down consumption.¹⁴⁸ U.K. tobacco taxes had increased in 1947 to raise revenue, from when male consumption fell, and were then tightened for health purposes from the late nineteen-seventies. Further evidence that smoking politics has been essentially 'government versus the market' comes from the proliferating studies of tobacco companies and their history of malpractice. These follow

¹⁴³ J. Lewis, *What Price Community Medicine? The Philosophy, Practice and Politics of Public Health since 1919* (Brighton, 1986); W. Holland and S. Stewart, *Public Health: the Vision and the Challenge* (1998).

¹⁴⁴ V. Berridge, *Marketing Health: Smoking and the Discourse of Public Health in Britain, 1945–2000* (Oxford, 2007).

¹⁴⁵ V. Berridge and A. Mold, 'Professionalisation, new social movements and voluntary action in the nineteen-sixties and nineteen-seventies', in Hilton and McKay, *The Ages of Voluntarism*, pp. 114–34.

¹⁴⁶ S. Chapman, 'Unravelling gossamer with boxing gloves: problems in explaining the decline in smoking', *B.M.J.*, cccvii (1993), 429–32.

¹⁴⁷ Berridge, *Marketing Health*.

¹⁴⁸ D. T. Levy, F. Chaloupka and J. Gitchell, 'The effects of tobacco control policies on smoking rates: a tobacco control scorecard', *Journal of Public Health Management Practice*, x (2004), 338–53.

litigation that enforced access to company archives, a dramatic development sparked by industry whistle-blowing, not voluntary agitation.¹⁴⁹

Histories of N.G.O.s concerned with recreational drugs similarly reveal entanglement with the state and uncertainty over political impact. Work on organizations in the nineteen-sixties and nineteen-seventies offering legal aid, advice and services, sometimes from a counter-cultural position, shows again that state funding quickly became central.¹⁵⁰ It also depicts drugs voluntarism as a characteristic beneficiary of welfare pluralism from the nineteen-eighties, as innovative responses to a surge in heroin use encouraged low-budget service contracting.¹⁵¹ Only in the nineteen-nineties did activities extend to user engagement and a discourse of rights, though again within the ambit of state-sponsorship.¹⁵² These studies signal a low level of political impact, principally in the realm of treatment policy; by contrast, their advocacy for more tolerant drug laws led nowhere.¹⁵³ Instead the gradual normalization of soft drug use is understood in light of deeper attitudinal changes, expressed within a discourse of pleasure antithetical to the language of public health.¹⁵⁴ As to the politics of heroin, voluntarism has, unsurprisingly, had no discernible influence on the geopolitics of underdevelopment and instability that determined supply, nor the poverty and inequality which, in the U.K., underpinned demand.¹⁵⁵

Political impact is more obvious in the case of disability voluntarism, though once again this cannot be reduced to the ideal typical N.G.O., independent and user-led. Advocacy organizations in this arena were initially discussed in the literatures of pressure group politics and of disability studies, the latter a radical academic project that itself encouraged disabled

¹⁴⁹ S. M. Carter, 'Tobacco document research reporting', *Tobacco Control*, xiv (2005), 368–76; R. D. Hurt and others, 'Open doorway to truth: legacy of the Minnesota tobacco trial', *Mayo Clinic Proceedings*, lxxxv (2009), 446–56, at p. 454.

¹⁵⁰ Mold, 'The changing role of NGOs', pp. 164–9; A. Mold, "'The welfare branch of the alternative society?' The work of drug voluntary organization release 1967–78', *Twentieth Century British History*, xvii (2006), 50–73, at pp. 68–9.

¹⁵¹ Mold, 'The changing role of NGOs', pp. 169–73.

¹⁵² Mold, 'The changing role of NGOs', pp. 173–7.

¹⁵³ Mold, "'The welfare branch of the alternative society?'".

¹⁵⁴ H. Parker, L. Williams and J. Aldridge, 'The normalization of "sensible" recreational drug use: further evidence from the North West England Longitudinal Study', *Sociology*, xxxvi (2002), 941–64; P. O'Malley and M. Valverde, 'Pleasure, freedom and drugs: the uses of "pleasure" in liberal governance of drug and alcohol consumption', *Sociology*, xxxviii (2004), 25–42.

¹⁵⁵ P.-A. Chouvy, 'Afghanistan's opium production in perspective', *China and Eurasia Forum Quarterly*, iv (2006), 21–4; H. Parker, 'Heroin epidemics and social exclusion in the UK, 1980–2000', in *Heroin Addiction and the British System*, ii: *Treatment and Policy Responses*, ed. M. Gossop and J. Strang (2005), pp. 80–90.

voluntarism.¹⁵⁶ Such works traced the comparatively small organizations emerging within a ‘poverty lobby’ in the nineteen-sixties and nineteen-seventies, and the coming, from the nineteen-eighties, of broader social movements oriented to civil rights. Recent doctoral studies have explored the interplay between such voluntary groups and the state, showing how the ‘lobby’ blended activism, expertise and insider influence to achieve recognition of impairment as a distinct category of welfare need.¹⁵⁷ They also show a familiar process of state funding and co-option in policy execution. As in the smoking case, it is difficult to gauge the precise contribution of voluntarism when set against other factors, such as the media impact of the thalidomide scandal. It is also clear that conventional politics were not dislodged; the language of voluntary advocates had to resonate with ideological positions, bureaucratic dynamics mattered and economic policy set the limits of the possible.

Thus in public health, these histories suggest voluntary action conformed closely to the expectations of Macadam and Braithwaite. It arose in circumstances of state failure, where policy was inhibited either by cultural norms and industry power, or because voiceless target groups suffered popular prejudice or neglect. Bourdillon’s supposition that it would be partially subsumed by the state as values shifted is also borne out, though she did not foresee the extent to which her ‘moving frontier’ would edge backwards as service contracting took hold. That said, the case of health more broadly suggests that excessive claims for a new politics driven by N.G.O.s need to be tempered. Where curative services are concerned, the political economy of the N.H.S. seems to have been driven by the state as agent of financing and the medical profession as provider of care, with the citizen’s interest often falling between the two.

Conclusion

Long before postmodern anxieties asserted themselves theorists cautioned that all history bears ‘the character of “contemporary history”’.¹⁵⁸ For how can it be other than ongoing dialogue between past and present? ‘The historian is of his own age, and is bound to it by the conditions of human existence.

¹⁵⁶ P. Whiteley and S. Winyard. *Pressure for the Poor: the Poverty Lobby and Policy Making* (New York, 1987); M. Oliver, *The Politics of Disablement* (1990); M. Oliver, ‘The disability movement is a new social movement’, *Community Development Journal*, xxxii (1997), 244–51.

¹⁵⁷ J. Hampton, ‘Disabled people and the classic welfare state, 1948–75: changes in perception, developments in policy’ (unpublished University of Bristol Ph.D. thesis, 2011); G Millward, ‘Invalid definitions, invalid responses: disability and the welfare state, 1965–95’ (unpublished University of London Ph.D. thesis, 2014).

¹⁵⁸ B. Croce, *History as the Story of Liberty*, trans. S. Sprigge (1938; 1941), p. 19.

The very words which he uses have current connotations from which he cannot divorce them.¹⁵⁹ This essay has reflected on words deployed since the nineteen-eighties when historicizing health and welfare, particularly 'voluntary', 'voluntarism' and related terms. It has barely glanced at the issue of how historical actors articulated their own involvement in these areas. Instead it followed Finlayson in identifying the nineteen-thirties and nineteen-forties as a transitional moment in thinking about the roles of state and non-state organizations. Though thoroughly inconsistent in definitions and content, and often applied in quite different ways to those their originators intended, the concepts of voluntar(y)ism have nonetheless exerted considerable power.

To close, though, we might glance beyond Britain to situate this discussion within the broader literature on health systems. Here there has been remarkably little interest in placing the 'third sector' within conceptual schema concerned overwhelmingly with states and markets. The founding texts invoked a public/private spectrum, or state/market typologies, or a binary distinction between societies which did or did not treat health as a 'collective responsibility'.¹⁶⁰ The latter framework was Brian Abel-Smith's, one of the first scholars in the field of comparative health systems, and it is significant that despite his historical expertise, and his own activism, he minimized the distinctiveness of voluntarism.¹⁶¹ Rather, it had fostered a popular expectation that hospital services should be available to all free at the point of use, an ideal now enshrined in government policy.¹⁶²

Strategic planning for health system development in low-income countries has also been couched principally within the language of governments and markets. When international organizations turned in the nineteen-seventies to strengthening primary healthcare it was state provision that seemed to promise the most rapid results.¹⁶³ Then, from the nineteen-eighties, when the debt crisis and the 'Washington consensus' undermined this approach,

¹⁵⁹ E. H. Carr, *What is History?* (1961; Harmondsworth, 2nd edn., 1987), pp. 24–5.

¹⁶⁰ O. W. Anderson, 'Medical care: its social and organizational aspects. Health-service systems in the United States and other countries – critical comparisons', *New England Journal of Medicine*, cclxix (1963), 839–43; M. I. Roemer, *The Organisation of Medical Care under Social Security: a Study Based on the Experience of Eight Countries* (Geneva, 1969); B. Abel-Smith, 'The major pattern of financing and organisation of medical services that have emerged in other countries', *Medical Care*, iii (1965), 33–40.

¹⁶¹ Sheard, *Passionate Economist*, notes his roles in the Child Poverty Action Group and in London hospital governance.

¹⁶² Abel-Smith, 'Major pattern of financing', pp. 33–5.

¹⁶³ World Bank, *Financing Health Services in Developing Countries: an Agenda for Reform* (Washington, D.C., 1987), p. 1; N. Cherev, *The World Health Organization between North and South* (Ithaca, N.Y., 2012).

priorities switched to encouraging user payment, whether within public, private or mission contexts.¹⁶⁴ Where this involved establishing ‘community based health insurance’, the issue was not cultivating a ‘voluntary impulse’, but how to implement a Bismarckian model with appropriate incentives and rewards for low-income settings.¹⁶⁵ Today, where global policy discourse plays out as ideological debate, the principal cleavage remains that between proponents of markets and states.¹⁶⁶ For the former, who treat individual freedom as the greater good, private provision responding to patient demand is the optimal arrangement. For the latter, committed to equity and security for all, the state as regulator, provider and agent of the patient seems the best guarantor of health rights. To the extent that voluntarism intrudes, it is through discussion of charity, which appeals to the individualist as alleviating humanitarian conscience without undermining personal responsibility, and to the collectivist, reluctantly, as a transitional phase.¹⁶⁷ Such issues, though, are rarely central to health systems argumentation.

Closing the discussion with states and markets, not voluntarism, prompts final reflections on how histories speak to the present. If the voluntarist turn has accompanied a policy trajectory of welfare pluralism, is it still suited to our needs? In the case of Britain’s health services, the answer is probably not. The current juncture has seen the protracted introduction of the internal market finally completed and N.H.S. structures reconstituted as quasi-independent trusts engaged with each other in commissioning relationships. Official rhetoric raised hopes that the ‘the key players’ would be ‘social enterprise ... alongside charities and voluntary groups’.¹⁶⁸ However, the latest data suggest this is far from the case. In the five years since 2007 the percentage spending by primary care commissioners directed to voluntary organizations stayed at about 1 per cent, while the private sector share increased from about 4 per cent to 8 per cent (£2.09 bn. to £5.22 bn.).¹⁶⁹ Unofficial scrutiny for 2013 reveals that of fifty-seven new contracts issued for clinical services, only one was won by a charity, one by a joint N.H.S./private arrangement, fifteen

¹⁶⁴ World Bank, *Financing Health Services*; R. Yates, ‘Universal health care and the removal of user fees’, *The Lancet*, ccclxxiii (2009), 2078–81.

¹⁶⁵ T. Barnighausen and R. Sauerborn, ‘One hundred and eighteen years of the German health insurance system: are there any lessons for middle- and low-income countries?’, *Social Science and Medicine*, liv (2002), 1559–87.

¹⁶⁶ D. Callahan and A. Wasuna, *Medicine and the Market: Equity vs. Choice* (Baltimore, Md., 2006).

¹⁶⁷ Maynard, ‘Health care rationing’, pp. 1106–7.

¹⁶⁸ A. Lansley, speech 30 March 2012, cited in L. Reynolds and M. McKee, “‘Any qualified provider’ in NHS reforms: but who will qualify?’, *The Lancet*, ccclxxix (2012), 1083–4

¹⁶⁹ S. Arora, A. Charlesworth, E. Kelly and G. Stoye, *Public Payment and Private Provision: the Changing Landscape of Health Care in the 2000s* (2013), pp. 14–15.

Healthcare in Ireland and Britain from 1850

by N.H.S. bodies and thirty-nine by the private sector.¹⁷⁰ Popular political discourse has duly begun, belatedly, to centre on the 'privatization' issue. Yet historians so far seem ill equipped to react to this resurgence of markets in healthcare, preoccupied as they are by voluntarist pasts.

¹⁷⁰ N.H.S. Support Federation, *Contract Alert April–Dec. 2013* <<http://www.nhscampaign.org/news-and-views.html>> [accessed 19 Jan. 2014].

2. Healthcare systems in Britain and Ireland in the nineteenth and twentieth centuries: the national, international and sub-national contexts

John Stewart

Introduction

In a paper given in 2012 the present author argued that taking a Scottish perspective on recent reforms to the National Health Service in England was illuminating in a number of respects.¹ First, the English reforms further highlighted the fact that Scotland has always had, even before political devolution in the late nineteen-nineties, a relatively autonomous healthcare system.² Second, perceived problems about healthcare organization and outcomes were among the drivers within Scotland for political devolution in the nineteen-nineties. The Scots were, for example, resistant to the introduction of internal markets in the N.H.S. and so consequently, in the slogan of the time, there should be Scottish solutions to Scottish problems. Third, with political devolution there were further policy divergences between Scotland and England, and indeed between England and Wales.³ Fourth, the present English reforms have been explicitly rejected as a model for Scotland by the Scottish government and public. It was thus suggested that it was possible, given that Scotland was to have an independence referendum in 2014 and that welfare provision would feature heavily in the debates leading up to this event, that health policy would have been crucial

¹ J. Stewart, 'Reform of the British National Health Service: lessons from history', paper given to the School of Population Health, University of Auckland, 13 March 2012 (copy available from author).

² The best account of the notion of relative autonomy and its historic origins remains L. Paterson, *The Autonomy of Modern Scotland* (Edinburgh, 1994).

³ On health policy pre- and immediately post-devolution, see J. Stewart, *Taking Stock: Scottish Social Welfare after Devolution* (Bristol, 2004). For Wales in the same era, see P. Chaney and M. Drakeford, 'The primacy of ideology: social policy and the first term of the National Assembly for Wales', in *Social Policy Review* 16, ed. N. Ellison, L. Bauld and M. Powell (Bristol, 2004), pp. 121–43. For more recent developments, a starting point is K. Smith and M. Hellowell, 'Beyond rhetorical differences: a cohesive account of post-devolution developments in UK health policy', *Social Policy and Administration*, xlvii (2012), 178–98.

not only in advancing political devolution but also in bringing about the demise of the United Kingdom.⁴

This particular example illustrates a number of points which are enlarged upon in this essay. First, we have a purportedly unitary state, the United Kingdom, in which different forms of healthcare provision co-exist. Second, from a slightly different perspective, we have one nation, Scotland, learning, albeit negatively, from another, England. Policy knowledge, in other words, crosses the English/Scottish border. Third, is it really the case that Scotland and Wales are diverging from England? We could look at it another way by arguing that two of the smaller nations of the United Kingdom have, in fact, much in common in health policy terms and have remained faithful to the founding principles of the N.H.S. of the mid nineteen-forties – in contrast to England. All this might tell us something about, inter alia, the way health and social policy is enacted in smaller political entities. Fourth, it is a reminder that healthcare policy is highly contentious, as President Obama discovered. In passing, it is worth noting the problems federal governments have in introducing nationwide health policies and how widely individual states may differ in their own provision and in their willingness to accept central direction – for every Massachusetts with proto-Obamacare there are southern states like Alabama.⁵ But, as we have already noted and shall see further below, this is not a case of American exceptionalism – other, purportedly more unified, nations have sub-national differences too.

So in what follows we first briefly examine the national context of health policy formation. Next we move on to the international context, before finishing with some observations about the sub-national dimension. For the most part these analyses are illustrated by cases from Britain and Ireland, although particularly in the section on the international context examples from further afield are also drawn upon. The overarching aim is to provoke further thought and debate about historical treatments of healthcare provision and how national histories can be supplemented or expanded with insights from international and sub-national comparisons and contexts.

⁴ For an account of the role played by health issues in political devolution, see C. Nottingham, 'The politics of health after devolution', in *The NHS in Scotland: the Legacy of the Past and the Prospect of the Future*, ed. C. Nottingham (Aldershot, 2000).

⁵ For an illuminating comparative study of American and French healthcare, see P. V. Dutton, *Differential Diagnoses: a Comparative History of Health Care Problems and Solutions in the United States and France* (Ithaca, N.Y., 2007). Some sense of what those proposing healthcare reform in the United States are up against can be found in A. Offer, 'A warrant for pain: caveat emptor versus the duty of care in American medicine, c.1970–2010', *Real World Economics Review*, lxi (2012), 85–99.

The national context

Much writing on the history of social policy, whether with respect to Britain or elsewhere, takes the nation-state as the defining political entity and space in which that social policy is enacted and implemented. This is perfectly understandable. It is, after all, nation-states, or national governments, which legislate for and carry out state-sponsored social policy. They may, of course, delegate some of this to local government or to voluntary or even for-profit bodies, but the essential point remains – social welfare such as healthcare takes place within national boundaries and much contemporary debate about welfare ‘tourism’ clearly buys into this idea.

And again the United Kingdom’s N.H.S. provides an illuminating case study. There were, in fact, three National Health Service Acts in the nineteen-forties – for England and Wales (although Wales also had, historically, a limited degree of autonomy), for Ulster (and unsurprisingly attended by religious controversy) and for Scotland.⁶ The Northern Irish and Scottish laws were important both in recognizing legal and historical precedents and, in the much longer term, facilitating the political devolution of healthcare in the late nineteen-nineties. And there were important differences between the three acts. The three systems were, nonetheless, virtually identical triplets; the English and Welsh and the Scottish acts were passed by the only U.K. mainland parliament of the time, that in Westminster; and ultimately all three systems were primarily funded by the Treasury out of general taxation. From a patient’s viewpoint, no difference in diagnosis, treatment and care should have been discernible whether an individual fell ill in London or in Edinburgh, just as there should have been no difference between, say, Cardiff, Belfast or Sheffield. This overarching situation prevailed until relatively recently, although as we shall see in practice the situation was rather more complicated.

So it might be argued that here we find a solid case for stressing the primary role of the nation-state. There is also another dimension worth considering. Central to the creation of the N.H.S. was that it was to be universal, comprehensive and free at the point of consumption. The ‘universal’ aspect of the service meant that it could be accessed by anyone

⁶ On Wales, see P. Michael, ‘An overview of the history of health and medicine in Wales’ and C. Webster, ‘Devolution and the health service in Wales, 1919–69’, both in *Health and Society in 20th Century Wales*, ed. P. Michael and C. Webster (Cardiff, 2006), pp. 1–59, 240–69. For the Scottish act, see J. Stewart, ‘The National Health Service in Scotland, 1947–74: Scottish or British?’, *Historical Research*, lxxvi (2003), 389–410. And for Northern Ireland, see J. Privilege, ‘The Northern Ireland government and the welfare state, 1942–8: the case of health provision’, *Irish Hist. Stud.* (forthcoming 2015). The author is grateful to Dr. Privilege for an advance copy of this article.

with U.K. citizenship. The N.H.S. was, of course, also a key component of post-war reconstruction in Britain and, for the ruling Labour Party, the creation of the New Jerusalem. It thus had a central role in creating a particular form of British identity and citizenship, as well as being one of the main planks of the supposed post-war consensus which lasted down to the nineteen-seventies. It is thus revealing that opinion poll evidence shows that one of the things that makes people most proud to be British – not English, or Irish, or Scottish or Welsh, but British – is the National Health Service. The polling organization Ipsos M.O.R.I., for instance, found in its survey of ‘the state of the nation’ for 2013 that when a sample of Britons was asked what made them most proud to be British the N.H.S. came top with 45 per cent of the vote, ahead of other national institutions such as the armed forces and the royal family. Similarly, when asked which anniversary occurring in 2013 made them most proud to be British, that recording sixty-five years of the N.H.S. easily came top, with 54 per cent.⁷ The remark by former Conservative chancellor Nigel Lawson that the N.H.S. ‘is the closest thing the English have to a religion’ is thus wrong in attributing this sentiment solely to England, but right in identifying it in the first place.⁸

So when analysing healthcare in a national context, we might want to think not just of policy enactment and application but also what that tells us about the broader society and how it might contribute to notions of national identity and social solidarity. A recent work on the history of the Irish Hospitals Sweepstake argues that, the scheme’s problems notwithstanding, it could be seen as a cohesive force in Irish society and a central component of the recently founded Irish Free State.⁹ Similarly, examination of the Scandinavian countries shows that here too health and welfare provision is seen as central to the various national identities and something to be protected against supra-national intervention, for example by the European Union.¹⁰

⁷ ‘State of the nation 2013’ <<http://www.ipsos-mori.com/researchpublications/researcharchive/3111/State-of-the-Nation-2013.aspx>> [accessed 26 June 2013].

⁸ Cited in N. Timmins, *The Five Giants: a Biography of the Welfare State* (2nd edn., 2001), p. 451.

⁹ M. Coleman, *The Irish Sweep: a History of the Irish Hospitals Sweepstake, 1930–87* (Dublin, 2009).

¹⁰ For a recent discussion of the Scandinavian welfare states, and guide to the literature, see *The Nordic Model of Welfare: a Historical Reappraisal*, ed. N. F. Christiansen, K. Petersen, N. Edling and P. Haave (Copenhagen, 2006). An early, and still important, account of what these countries were trying to achieve is G. Esping-Andersen, *Politics against Markets: the Social Democratic Road to Power* (Princeton, N.J., 1985).

The international context

Nonetheless, seeing the history of healthcare and welfare through the lens of the nation-state is, it is now argued, to gain only a partial picture. This is an issue with significant contemporary resonances given European integration and its implications for social policy in both Britain and Ireland.¹¹ We now turn, therefore, to some of the international contexts in which British and Irish healthcare provision operated in the nineteenth and twentieth centuries. Of course, it would be misleading to suggest that no historians put social policy development in an international framework – the works of E. P. Hennock and Glen O’Hara are useful correctives to such a view.¹² Nonetheless most histories of social welfare do operate within the framework of the nation-state, for the reasons suggested above.

However, those from other disciplines such as sociology, social policy and political science have been more willing to adopt a transnational approach, and not least because of purported ‘globalization’.¹³ One famous attempt to classify late twentieth-century welfare states was that of Gøsta Esping-Andersen in his *Three Worlds of Welfare Capitalism*.¹⁴ Esping-Andersen’s welfare regimes were the social democratic, with high levels of state social provision and taxation and associated high levels of social solidarity; the corporatist, with high levels of social provision but with responsibilities often delegated to bodies such as the Catholic Church, although again in the name of social solidarity; and the liberal, with only residualist state services reserved for the poorest in society and an emphasis on individual and market solutions to social problems. Esping-Andersen has been much criticized but at least in some respects can help us to think critically and historically about healthcare provision.¹⁵

So, for example, the British welfare state can be characterized, common perception to the contrary, as largely liberal or residualist, with strong

¹¹ For an introduction to some of these issues, see M. Ferrera, *The Boundaries of Welfare: European Integration and the New Spatial Politics of Social Protection* (Oxford, 2005); and M. Cousins, *European Welfare States: Comparative Perspectives* (2005).

¹² E. P. Hennock, *The Origin of the Welfare State in England and Germany, 1850–1914: Social Policies Compared* (Cambridge, 2007); G. O’Hara, “Applied socialism of a fairly moderate kind”: Scandinavia, British policy makers and the post-war housing market’, *Scandinavian Journal of History*, xxxiii (2008), 1–25.

¹³ See, e.g., E. S. Einhorn and J. Logue, *Modern Welfare States: Scandinavian Politics and Policy in the Global Age* (Westport, Conn., 2003).

¹⁴ G. Esping-Andersen, *The Three Worlds of Welfare Capitalism* (Oxford, 1990).

¹⁵ Critics have, e.g., qualified Esping-Andersen’s treatment of Southern European nations and of Australasia (see F. Castles, ‘Welfare state development in Southern Europe’, *West European Politics*, xviii (1995), 291–313; and F. Castles and D. Mitchell, ‘Identifying welfare state regimes: the links between politics, instruments and outcomes’, *Governance*, v (1992), 1–26).

elements of continuity from the preceding welfare system. Pat Thane, for instance, remarks that the post-1945 social security system ‘was closer to the spirit and practice of its deeply rooted Poor Law tradition’ than many have realized, at the time or subsequently.¹⁶ Jose Harris similarly observes that the rhetoric of ‘universal’ benefits, free from any ‘moral’ discretion, which surrounded the social insurance debates of the nineteen-forties, fails to bear close scrutiny.¹⁷ The exception, at least until recently in the English case, was the N.H.S., which tied in very closely with the social democratic model and thus with the Scandinavian welfare states. One way of looking at the history of post-war healthcare provision in Britain, therefore, is as a social democratic project in an otherwise liberal welfare system. We revisit this issue below. To return to Esping-Andersen and specifically to the problem of his typologies, it is undoubtedly the case that there is a debate among Irish historians and social scientists about how, if at all, Ireland fits in with his analytical framework.¹⁸ Nonetheless, and in very general terms, the attention paid by Esping-Andersen to the role of religious bodies in welfare provision across national boundaries is at least to some degree pertinent to the Irish situation, and thereby gives commonalities with other nations. It is certainly noticeable how many essays in the present collection touch on religious themes.¹⁹

More recently, Steven King and the present author edited a volume on welfare provision in peripheral European nations, including Scotland, Ireland and Wales. Part of our argument was that such nations – or, in certain cases, territories which saw themselves as nations but had not yet achieved nationhood – were relatively homogeneous, were relatively solidaristic, were often heavily influenced by organized religion, and frequently had difficult geographical terrain and thinly spread populations. We then suggested that this could lead to similar forms of health and welfare provision across these nations around the edge of Northern Europe. There were thus, so we

¹⁶ P. Thane, ‘Labour and welfare’, in *Labour’s First Century*, ed. D. Tanner, P. Thane and N. Tiratsoo (Cambridge, 2000), p. 100.

¹⁷ J. Harris, “Contract” and “citizenship”, in *The Ideas that Shaped Post-War Britain*, ed. D. Marquand and A. Seldon (1996), pp. 122ff.

¹⁸ See, as a starting point, the discussion in S. Carey, *Social Security in Ireland, 1939–52: the Limits to Solidarity* (Dublin, 2007).

¹⁹ On religion and social welfare, see also *Religion, Class Coalitions, and Welfare States*, ed. K. van Kersbergen and P. Manow (Cambridge, 2009). Revealingly, this collection has no chapters specifically on either Ireland or the United Kingdom, although see the contribution by S. Kahl, ‘Religious doctrines and poor relief: a different causal pathway’, pp. 267–95, and her earlier ‘The religious roots of modern poverty policy: Catholic, Lutheran and Reformed Protestant traditions compared’, *European Journal of Sociology*, xlvii (2005), 91–126. The author is grateful to Dr. Seán Lucey for alerting him to the latter publication.

argued and in an analytical tool taken from economic history, ‘core’ and ‘peripheral’ Northern European nations in terms of welfare regimes.²⁰ Such an analysis was, with the benefit of hindsight, problematic, as was Esping-Andersen’s, albeit for very different reasons.

But perhaps both approaches can still be mined for certain insights when considering the history of healthcare. The role of religion has already been noted. The part played by shared geographical characteristics in certain societies is also worthy of attention. So, for instance, in the Highlands and Islands of Scotland formal healthcare provision was virtually non-existent under the Poor Law and the region’s problems led to the introduction, as a result of the Dewar Commission set up around 100 years ago, of the Highlands and Islands Medical Service. This was a form of quasi-socialized medical service and a further marker, before the N.H.S., of Scottish difference (although, as noted below, it can also be seen in a sub-national context).²¹ In rural nineteenth-century Wales, meanwhile, access to even the scant medical services of the Poor Law could be problematic, and here physical remoteness too played its part.²² A similar situation unsurprisingly prevailed in early nineteenth-century Ireland.²³ Also in Ireland, Lindsay Earner-Byrne has noted that the development of maternity services in the twentieth century was shaped by ‘a curious mixture of religion and geography’ with, for a long period, only certain major urban centres providing any sort of service.²⁴ The more general point, though, is that seeing national health and welfare systems as part of wider health and welfare regimes or families is at the very least illuminating for comparative purposes but might also tell us how those health and welfare systems come into being in the first place and develop subsequently.

But we now move on to more concrete examples of the ways in which the international context and overseas influences contributed, positively or

²⁰ S. King and J. Stewart, ‘Welfare peripheries in modern Europe’, in *Welfare Peripheries: the Development of Welfare States in 19th and 20th Century Europe*, ed. S. King and J. Stewart (Bern, 2007), pp. 9–38.

²¹ The best account of the Highlands and Islands Medical Service is P. Whatley, ‘The development of medical services of the Highlands and Islands of Scotland, 1843–1936’ (unpublished University of Dundee Ph.D. thesis, 2014).

²² J. Stewart and S. King, ‘Death in Llantrisant: Henry Williams and the New Poor Law in Wales’, *Rural History*, xv (2004), 69–87.

²³ G. O’Brien, ‘State intervention and the medical relief of the Irish poor, 1787–1850’, in *Medicine, Disease and the State in Ireland, 1650–1940*, ed. E. Malcolm and G. Jones (Cork, 1999), pp. 195–207.

²⁴ L. Earner-Byrne, ‘“Twixt God and geography”: the development of maternity services in 20th century Ireland’, in *Western Maternity and Medicine, 1880–1990*, ed. J. Greenlees and L. Bryder (2013), pp. 99–112.

negatively, to health and welfare development in nineteenth- and twentieth-century Britain and Ireland. This is a seriously under-researched field, but one that nonetheless needs to be addressed. So we know, for example, that when school meals and medical services were introduced in Edwardian Britain this was part of a broader international trend, with developments in other European countries and further afield being closely monitored by interested parties in Britain.²⁵

And it was suggested above that it is possible to see the N.H.S. as according more with the social democratic model of welfare provision than other parts of the British welfare state. It is noteworthy, then, that the leader of the Socialist Medical Association (S.M.A.), an organization which had a powerful influence on Labour Party health policy down to the mid nineteen-forties, went to social democratic Sweden in the nineteen-thirties – the time at which that nation was beginning to construct one of the archetypes of the social democratic welfare state – and on his return declared its hospital system to be ‘the best in the world’. Consequently, the journal associated with the S.M.A., *Medicine Today and Tomorrow*, ran a series of articles on the Swedish healthcare system.²⁶ And in the post-war era the Labour intellectual Tony Crosland, in his seminal *The Future of Socialism*, noted that in contrast to Britain very few people in Sweden used private health or education services. This was partly because the Swedish services were of such a high standard as a result of the considerable resources allocated to them.²⁷ It is no coincidence that Crosland’s work was published around the time the Guillebaud Report was showing the N.H.S. to be underfunded.²⁸

If we return to the founding of the N.H.S., another incident illustrates the point about international context, although in fact in the end nothing much came of it. Nonetheless, it is a rather telling episode with a long shelf-life. In early 1949 the newspaper the *Chicago Tribune* ran a story headlined ‘British socialism runs on United States money’. This was in response to a speech to the United Nations by a Labour government minister which emphasized, among other things, his administration’s commitment to ‘a

²⁵ B. Harris, *The Health of the Schoolchild: a History of the School Medical Service in England and Wales* (Buckingham, 1995), chs. 2, 3.

²⁶ Cited in J. Stewart, *The Battle for Health: a Political History of the Socialist Medical Association, 1930–51* (Aldershot, 1999), pp. 58–9.

²⁷ C. A. R. Crosland, *The Future of Socialism* (abridged and revised edn., 1964), p. 85.

²⁸ One of the architects of the Guillebaud Report was Brian Abel-Smith, a Fabian academic with a strong interest in healthcare systems both in Britain and abroad (see S. Sheard, *The Passionate Economist: how Brian Abel-Smith Shaped Global Health and Social Welfare* (Bristol, 2013)).

complete national health service'. The backdrop here is that many Americans were appalled that monies supplied under the Marshall Plan should be used to ends of which they fundamentally disapproved, including socialized healthcare.²⁹ There are distant echoes of this in contemporary right-wing American political discourse – the claim that Obama's healthcare scheme is both socialist and European (the elision being of 'socialized medicine' with 'socialism'). Equally, while the British may be justifiably proud of their N.H.S. it is worth reflecting on the contribution made to it by the proceeds of American capitalism.

Other forms of American capitalism also helped to shape healthcare provision in both Britain and Ireland, not least in the form of the great philanthropic bodies which, especially after the First World War, channelled much of their resources into health and welfare projects abroad. While it would be misleading to argue that American philanthropy dictated the policy and practice agenda in Britain and Ireland, its views were nonetheless clearly expressed and locally understood. So, for instance and as Greta Jones has shown, the Rockefeller Foundation, despite its evident frustrations with the country, put resources into public health and medical education in the newly independent Ireland.³⁰ Similarly, Christopher Lawrence, in his study of the medical school at the University of Edinburgh and its support from the Rockefeller Foundation, sees in the inter-war era a crucial transformation in medical science, underpinned by funding and the 'flow of medical practices' from the United States.³¹ The Commonwealth Fund of New York, meanwhile, poured considerable money into British mental health services for young people, which were eventually to be embedded in the post-war welfare state.³² To return briefly to our earlier point with respect to religion, Tom Feeney has shown how the introduction of similar services for young people in post-war Ireland derived from a complicated interaction between church and state as well as influences from Britain and America.³³ This in turn is a reminder that the Catholic Church itself is an international body. Catholic Action, a global movement one of whose aims was greater Catholic engagement with social issues, promoted mental health

²⁹ Cited in D. M. Fox, 'The administration of the Marshall Plan and British health policy', *Journal of Policy History*, xvi (2004), 199.

³⁰ G. Jones, 'The Rockefeller Foundation and medical education in Ireland in the 1920s', *Irish Hist. Stud.*, xxx (1997), 564–80.

³¹ C. Lawrence, *Rockefeller Money, the Laboratory, and Medicine in Edinburgh, 1919–30* (Rochester, N.Y., 2005), pp. 17, 26.

³² J. Stewart, *Child Guidance in Britain, 1918–55: the Dangerous Age of Childhood* (2013).

³³ T. Feeney, 'Church, state, and family: the advent of child guidance clinics in independent Ireland', *Soc. Hist. of Med.*, xxv (2012), 484–62.

services for children in Scotland and a particular form of motherhood and maternity care in Argentina, while the Sisters of Mercy ran the Auckland Mater Hospital in New Zealand.³⁴

And equally in this international context we find the proliferation of international health bodies, official and voluntary, from the late nineteenth century onwards which encouraged the international of exchange of ideas. Britain was, for example, active in the establishment of the League of Nations Health Organization, a body which bridged the era between the international health conferences of the nineteenth century and the creation, after the Second World War, of the World Health Organization.³⁵ So, as the American historian Daniel Rodgers puts it, proposals for social reform were central to ‘movements of politics and ideas throughout the North Atlantic’. In consequence such social politics had their origins ‘not in ... nation-state containers, not in a hypothesized “Europe” nor an equally imagined “America”, but in the world between them’. Rodgers’s ‘Atlantic’, it should be emphasized, embraces not just those countries of the northern hemisphere but also Britain’s Dominions in the South Pacific.³⁶

And this in turn leads us to an international structure very firmly rooted in Britain, and of which Ireland was until the nineteen-forties a part, the empire. If there was a general international flow of people and ideas about welfare, then this was even more the case between Britain, her colonies and her Dominions. So, for instance, we know that Britain and New Zealand exchanged ideas and practitioners in the field of child health, mental and physical. As Linda Bryder has shown, a leading figure here was Dr. Frederic Truby King, a New Zealander trained in medicine at Edinburgh University and one of the key organizers of the Babies of the Empire Society, a body which sought to promote mothercraft and infant welfare in Britain and further afield.³⁷ It has also recently been shown that the institution, by the Dominion’s first Labour government, of a socialized healthcare system in New Zealand in the late nineteen-thirties had a significant impact,

³⁴ Stewart, *Child Guidance*, ch. 3; Y. Eraso, *Representing Argentinian Mothers: Medicine, Ideas and Culture in the Modern Era, 1900–46* (Amsterdam, 2013); M. Tennant, *The Fabric of Welfare: Voluntary Organisations, Government and Welfare in New Zealand, 1840–2005* (Wellington, 2007), p. 91.

³⁵ I. Borowy, *Coming to Terms with World Health: the League of Nations Health Organisation, 1921–46* (Frankfurt, 2009).

³⁶ D. T. Rodgers, *Atlantic Crossings: Social Politics in a Progressive Age* (Cambridge, Mass., 1998), p. 5.

³⁷ L. Bryder, “Babies of the Empire”: the evolution of infant welfare services in New Zealand and Britain in the first half of the 20th century’, in *The Practice of Reform in Health, Medicine, and Science, 1500–2000: Essays for Charles Webster*, ed. M. Pelling and S. Mandelbrote (Aldershot, 2005), 247–62.

positively and negatively, on the British labour movement and the British medical profession respectively.³⁸ Moving closer to the present day, market-based approaches to social welfare, including in healthcare, have been an international phenomenon and New Zealand, initially under a Labour government, was in the vanguard of such developments. As one New Zealand historian remarks, this ‘reforming zeal’ was shared with other countries such as Britain, Australia and the United States, and was partly internally generated but also international in scope. So, just as at the turn of the century, New Zealand became ‘a social laboratory’ but this time as ‘part of a transnational set of experiments that now drew upon Anglo-American neo-liberal orthodoxy’.³⁹

We also know that Scottish medical schools trained a disproportionate number of doctors from the mid nineteenth century onwards, with students drawn from the U.K. and abroad, and then exported huge numbers of them to the empire, Truby King being a case in point. This was important not just in terms of personnel but also in spreading ideas and practice, such as that of Joseph Lister on antiseptis.⁴⁰ Similarly, Karly Kehoe has shown how posts such as naval surgeon were crucial to the Irish Catholic middle class in the middle of the nineteenth century in gaining access both to the medical profession and to the empire.⁴¹ Ideas flowed between Britain and the colonies and Dominions, hence the influence of Truby King on British child-rearing and the setting up of schools of tropical medicine in Liverpool and London. The latter came into being within months of each other at the end of the nineteenth century and with the active support of important political figures such as the colonial secretary, Joseph Chamberlain. Helen Power remarks that these schools ‘trained the Medical Officers of the Colonial Medical Service’ and that, more generally, their influence was felt on the ‘development of healthcare in the tropical colonies’. The London school, further bearing out a point made earlier, received a significant financial boost in the nineteen-twenties by way of funding from the Rockefeller Foundation. Indeed, Donald Fisher argues, the foundation

³⁸ L. Bryder and J. Stewart, ‘“Some abstract socialistic principle or ideal”: British reactions to New Zealand’s 1938 Social Security Act’, in *Britain and the World* (forthcoming, 2015).

³⁹ B. Labrum, ‘A social laboratory? The changing meanings and practices of welfare, 1840s–1990s’, in *The New Oxford History of New Zealand*, ed. G. Byrnes (Melbourne, 2009), p. 419.

⁴⁰ M. A. Crowther and M. W. Dupree, *Medical Lives in the Age of Surgical Revolution* (Cambridge, 2007), especially ch. 9.

⁴¹ K. Kehoe, ‘Accessing empire: Irish surgeons and the Royal Navy, 1840–80’, *Soc. Hist. of Med.*, xxvi (2013), 204–24.

saw its donation as a means of spreading its own influence throughout the empire.⁴²

The Irish case is particularly instructive in the imperial context. Virginia Crossman has argued that the Irish Poor Law developed in a particular, and largely unexpected, way. It certainly paralleled the English and Scottish Poor Laws in specializing in areas such as care of the sick. But Ireland also took a different path in areas such as public health and in the provision of dispensaries. There were also close links between state-provided welfare services and those of the Catholic Church, something hardly likely to exist in Scotland, England or Wales – at least in that form. All this, she suggests, heightened a sense of Irish difference. So, while not an exact historical parallel, we nonetheless have here a not dissimilar situation to that described at the outset with regard to contemporary Scotland: health and welfare policy as a contributory factor to a movement for political separation and possibly divorce.⁴³ And the work of scholars such as Sophia Carey and Mel Cousins suggests that post-independence Irish social policy continued to be shaped by both colonial legacy and the influence of the Catholic Church.⁴⁴ So the empire, as an international phenomenon, was important in health and welfare policy and practice, but in a complicated way full of unintended consequences. As one imperial historian correctly observes, though, ‘more work remains to be done’ to unpick the connections between welfare policy formation in Britain and her colonies and Dominions.⁴⁵

The sub-national context

So it has been argued that we need to think of the history of healthcare provision in both national and international contexts – a demanding challenge. To make it even more demanding, we need also to take the sub-national dimension into account. Although, of course, again raising the issue of what we mean by the ‘nation’, Pamela Michael has shown that while mental healthcare in Wales developed in the same legislative context as in England, nonetheless Welsh provision had its own distinctive characteristics.⁴⁶ Raising similar issues and similar definitional problems,

⁴² H. J. Power, *Tropical Medicine in the 20th Century: a History of the Liverpool School of Tropical Medicine, 1898–1990* (1999), pp. 12, 3; D. Fisher, ‘Rockefeller philanthropy and the British empire: the creation of the London School of Hygiene and Tropical Medicine’, *History of Education*, vii (1978), 129 and *passim*.

⁴³ V. Crossman, *Politics, Power and Pauperism in Late 19th Century Ireland* (Manchester, 2006).

⁴⁴ Carey, *Social Security in Ireland*; M. Cousins, *The Birth of Social Welfare in Ireland, 1922–52* (Dublin, 2003).

⁴⁵ A. Thompson, ‘Introduction’, in *Britain’s Experience of Empire in the 20th Century*, ed. A. Thompson (Oxford, 2012), p. 28.

⁴⁶ P. Michael, *Care and Treatment of the Mentally Ill in North Wales, 1800–2000* (Cardiff, 2003).

albeit for very different reasons, Oonagh Walsh has argued that in the nineteenth century the 'Irish asylum system ... differed from the English model', not least in its administrative structures.⁴⁷ From a rather different perspective, the notion of 'core' and 'periphery' can be employed within nations as well as in a European context. The already-encountered Highlands and Islands Medical Service, for instance, was unique not only within the United Kingdom but also within Scotland itself. It was created precisely because the region was distinctive (or at least was perceived as distinctive) from its Lowland neighbour not only in terms of healthcare needs but also, for example, demography.⁴⁸ Such phenomena are not confined to Scotland. As a recent collection of essays on the remote and rural north has shown, peripheral areas of countries such as Sweden and Canada have certain characteristics in common – the international dimension again – while differing from the 'core' areas of their own nations.⁴⁹

A further way into the idea of the sub-national is to consider the role of municipal health services in England and Wales. The word 'municipal' is a reminder that while the Ministry of Health had been set up at the end of the First World War, nonetheless public sector health services such as hospitals remained in the hands of local authorities or local committees, and even after the coming of the N.H.S. certain health services continued to be a local government responsibility. While municipal services had a long history, the 1929 Local Government Act was especially important in the first half of the twentieth century. The act allowed certain types of local authorities to take over, most notably, the Poor Law hospitals. In part, this was an attempt to remove the stigma associated with the Poor Law from medical services and to replace what had been a highly disaggregated and diverse system with one with a greater degree of uniformity. As it turned out, not all local authorities availed themselves of this opportunity – already, then, a source of divergence within the municipal sector as well as a sign of weakness on the part of the central authority which was generally unable to force local bodies to adopt policies they found unsympathetic. And while expenditure on hospitals and other medical services rose fairly consistently over the course of the nineteen-thirties, there were significant variations at local level. These can be partly explained through differences in local politics, but while this was important it was far from the whole picture.

⁴⁷ O. Walsh, 'Lunatic and criminal alliances in 19th century Ireland', in *Outside the Walls of the Asylum: the History of Care in the Community, 1750–2000*, ed. P. Bartlett and D. Wright (1999), 132–52.

⁴⁸ Whatley, 'The development of medical services in the Highlands and Islands', *passim*.

⁴⁹ *Medicine in the Remote and Rural North, 1800–2000*, ed. J. T. H. Connor and S. Curtis (2011).

So, for example, the county boroughs of Newport and Bradford both had a fairly consistent Labour Party presence but behaved very differently in terms of provision. Another county borough, West Hartlepool, had a consistently right-wing administration and very poor hospital and health services, at least as judged by expenditure.⁵⁰ But we also know that the London County Council (L.C.C.) took immediate advantage of the 1929 act and pursued a vigorous hospital policy. It did so, at least up until 1934 when Labour took over, under enthusiastic and committed Conservative leadership.⁵¹

In short, there was huge diversity across the municipal sector, the intentions of the 1929 act notwithstanding. Politics certainly had a role to play here but so too did the role of individual medical officers of health and the interaction of the public sector with other forms of healthcare provision, and in particular voluntary hospitals and other types of third sector activity.⁵² The case study of Aberdeen by Martin Gorsky illustrates a number of these points, and not least the activities of three successive medical officers of health.⁵³ Such interactions, although with a different cast of actors and different outcomes, can also be found in inter-war Ireland, as has been shown by Mary Daly and, more recently, Seán Lucey. The latter, for example, reveals how, after independence, the Free State sought to remove the stigma of the Poor Law from public sector hospitals, the first serious attempt to break up the Poor Law so forcefully advocated by the Webbs. However, this was only partially successful and diversity of provision continued to characterize the Irish hospital system.⁵⁴ Although still an under-researched, and contentious, area there can be little doubt

⁵⁰ This paragraph draws on research undertaken by Alys Levene, Martin Powell, John Stewart and Becky Taylor and funded by a Wellcome Trust project grant. Its findings are brought together in A. Levene, M. Powell, J. Stewart and B. Taylor, *Cradle to Grave: Municipal Medicine in Interwar England and Wales* (Bern, 2011). The point about the weakness of the central authority is further elaborated upon in B. Taylor, J. Stewart and M. Powell, 'Central and local government and the provision of municipal medicine, 1919–39', *Eng. Hist. Rev.*, cxxii (2007), 397–426.

⁵¹ J. Stewart, "'The finest municipal hospital service in the world'? Contemporary perceptions of the London County Council's hospital provision, 1929–39', *Urban History*, xxxii (2005), 327–44.

⁵² On local public health services and the role of the medical officer of health, see J. Welshman, *Municipal Medicine: Public Health in 20th Century Britain* (Bern, 2000).

⁵³ M. Gorsky, "'Threshold of a new era': the development of an integrated hospital system in northeast Scotland, 1900–39', *Soc. Hist. of Med.*, xvii (2004), 247–67.

⁵⁴ M. E. Daly, "'An atmosphere of sturdy independence': the state and the Dublin hospitals in the 1930s', in Malcolm and Jones, *Medicine, Disease and the State in Ireland*, pp. 234–52; D. S. Lucey, "'These schemes will win for themselves the confidence of the people': Irish independence, Poor Law reform and hospital provision', *Medical History*, lviii (2014), 46–66.

about the pre-N.H.S. significance and diversity of the municipal sector, as is further witnessed by the work of historians such as Martin Gorsky, Julia Neville and Barry Doyle.⁵⁵

But to return briefly to the L.C.C., by the late nineteen-thirties it was under Labour rule and claiming to be the largest single provider of hospital beds in the world. As such, it was seen by many on the political left – especially by the S.M.A., encountered above – as the basis of a more widely applicable model for socialized medicine. Indeed the Labour Party, up until the appointment of Aneurin Bevan as minister of health in 1945, was committed to any new health service being based in local authorities, and it is significant that among the critics of Bevan’s ultimate plan for the N.H.S. were the L.C.C. itself and those, Conservative and Labour, who had served on it – most notably among the latter Bevan’s Cabinet colleague, Herbert Morrison. But Bevan was hostile to local provision, arguing not only that it was inefficient but that there was too much divergence across the sector. If it was to live up to the ‘universal’ dimension of ‘universal, comprehensive and free’ then any new service had to operate in more or less the same way everywhere.⁵⁶

But in reality the N.H.S. was never a monolithic, command and control institution, the claims of New Labour notwithstanding – on the contrary, its various components were all to some degree disaggregated. As we have already seen, different legislation covered different polities within the United Kingdom. But even if we do treat it as a single entity it remains the case that from its foundation the N.H.S. had a tripartite structure consisting of, to put it simply, hospital services, primary care, and those aspects of healthcare which remained in local authority hands and, until 1974, under the control of that very nineteenth-century creation, the medical officer of health. Local authorities were, for example, charged with patrolling the 1956 Clean Air Act, one of the decade’s major public health initiatives.⁵⁷ Similarly, services such as school medical inspection and some forms of

⁵⁵ M. Gorsky, ‘Local government health services in interwar England: problems of quantification and interpretation’, *Bulletin of the History of Medicine*, lxxxv (2011), 384–412; M. Gorsky, ‘The Gloucestershire Extension of Medical Services Scheme: an experiment in the integration of health services in Britain before the NHS’, *Medical History*, l (2006), 491–512; J. Neville, ‘Explaining local authority choices on public hospital provision in the 1930s: a public policy hypothesis’, *Medical History*, lvi (2012), 48–71; B. Doyle, ‘Competition and cooperation in hospital provision in Middlesbrough, 1918–48’, *Medical History*, li (2007), 337–66. For a comparative study of municipal health policies, see M. Niemi, *Public Health and Municipal Policy Making: Britain and Sweden, 1900–40* (Aldershot, 2007).

⁵⁶ Stewart, ‘*The Battle for Health*’, *passim*.

⁵⁷ C. Mills, ‘Coal, clean air, and the regulation of the domestic hearth in post-war Britain’, in *Health and the Modern Home*, ed. M. Jackson (2007), 224–43.

treatment remained the remit of local bodies, in this particular case local education authorities.⁵⁸ The organizational structures of the N.H.S. were highly problematic in that they meant it was not a fully integrated service, and this had detrimental consequences for co-ordination and co-operation between its three components.⁵⁹ Attempts to reorganize the N.H.S. since 1974 have met with limited success and, in different national contexts, have had different outcomes.⁶⁰

Such diversity and disaggregation can be illustrated by the case of the hospital service in Britain. Here we focus on the question of regionalism in the period from the nineteen-thirties through to the nineteen-seventies.⁶¹ If the municipal hospital sector was diverse in the inter-war period then this was even more the case, and virtually by definition, in the voluntary sector.⁶² Nearby voluntary hospitals might, for instance, have separate ambulance facilities while providing similar services for a similar population. Clearly this was, apart from anything else, inefficient. By the late nineteen-thirties, and the Sankey Report of 1937 was crucial here, there were proposals for greater co-ordination between voluntary hospitals, and indeed with the municipal sector on a regional basis.

The war intervened and what we then have is the Emergency Hospitals Service, later the Emergency Medical Service, organized from the centre but operating with a regional administrative structure. In broad terms, it was this framework which formed the basis of the new N.H.S.'s Regional Hospital Boards, created in the late nineteen-forties and surviving through to the early nineteen-seventies. But allocating resources to these boards

⁵⁸ Harris, *The Health of the Schoolchild*, ch. 9.

⁵⁹ The best one-volume account of the post-war N.H.S. prior to political devolution remains C. Webster, *The National Health Service: a Political History* (Oxford, 2nd edn., 2002).

⁶⁰ On the 'national' issue, see Stewart, 'The National Health Service in Scotland'; Stewart, *Taking Stock*. On post-1974 re-organization in England and, up to 1997, Wales, see R. Klein, *The New Politics of the NHS: from Creation to Reinvention* (Oxford, 2010).

⁶¹ For further detail, see C. Webster, *The Health Services since the War*, i: *Problems of Health Care* (1988), ch. 8. A comparative discussion of regionalism can be found in D. Fox, *Health Policies, Health Politics: the British and American Experience, 1911–65* (Princeton, N.J., 1986).

⁶² For the historiography of voluntarism and healthcare, see the essay in this volume by Martin Gorsky. Variations in voluntary hospital provision are discussed in S. Cherry, 'Regional comparators in the funding and organization of the voluntary hospital system, c.1860–1939' and J. Mohan, "'The caprice of charity': geographical variations in the finances of British voluntary hospitals before the NHS', both in *Financing Medicine: the British Experience since 1750*, ed. M. Gorsky and S. Sheard (2006), pp. 77–92. For a major source of income for voluntary hospitals, and one which was often highly localized, see M. Gorsky and J. Mohan, with T. Willis, *Mutualism and Health Care: British Hospital Contributory Schemes in the 20th Century* (Manchester, 2006).

proved highly problematic. As John Welshman has shown, the Sheffield Regional Hospital Board was always at or near the foot of the table in terms of funding received. This was known, but not acknowledged as a problem, until the late nineteen-sixties and the creation, in 1975, of the Resource Allocation Working Party. What this meant in practice was that, particularly when compared with affluent areas such as Oxford, the Sheffield region had, for instance, fewer consultants as well as a shortage of junior doctors.⁶³

We noted earlier that from a patient's perspective healthcare under the N.H.S. should have been delivered equally irrespective of where any given individual lived but we now have to qualify this on account of these sub-national differences. These also raise important questions about how to deal with resource allocation at these levels. Should it simply be on the basis of population, or should factors such as socio-economic profile, age profile, morbidity and mortality rates, or even geography be factored in? On this last point, and to return to the Scots, the latter have always argued that higher per capita health expenditure, supplied by the U.K. Treasury, is justified in Scotland on the grounds of the cost and difficulty of providing health services to remote, thinly populated regions with difficult weather and travel conditions – the Highlands and Islands issue again.⁶⁴ More generally, though, examining healthcare at a sub-national level throws up issues and features which can be easily missed when simply looking at the 'national' picture and generalizing official documents.

Conclusion

Students of earlier generations were introduced to the history of the welfare state through texts such as Maurice Bruce's *The Coming of the Welfare State* and Derek Fraser's *The Evolution of the British Welfare State*.⁶⁵ Admirable works in their times, they were nonetheless very much products of those times (as, of course, are all pieces of historical writing). They were whiggish in tone, seeing the creation and development of social welfare provision as linear; as increasingly the provenance of the central state and within a national political context; as benign and well intentioned; as promoting a

⁶³ J. Welshman, 'Hospital provision, resource allocation, and the early National Health Service: the Sheffield Regional Hospital Board, 1947–74', in Pelling and Mandelbrote, *The Practice of Reform*, pp. 279–302; J. Welshman, 'Inequalities, regions and hospitals: the Resource Allocation Working Party', in *Financing Medicine*, pp. 221–41.

⁶⁴ This is discussed in Stewart, *Taking Stock*; J. Stewart, 'Sickness and health', in *The History of Everyday Life in 20th Century Scotland*, ed. L. Abrams and C. Brown (Edinburgh, 2010), pp. 228–53.

⁶⁵ M. Bruce, *The Coming of the Welfare State* (1961) – there have been three subsequent editions; D. Fraser, *The Evolution of the British Welfare State* (1973) – there have been three subsequent editions.

degree of social equality; and as thereby solving some of the more obvious social problems engendered by industrial society. To put it another way, they were in the spirit of the post-war consensus and the writings of thinkers such as T. H. Marshall and, perhaps more problematically, Richard Titmuss.⁶⁶ They also, of course, pre-dated the economic and political upheavals of the last quarter of the twentieth century and beyond.

We now have a more nuanced historical picture of welfare provision in that, for instance, we have come to recognize the significance of the mixed economy of welfare; that motivations for welfare provision are complex; that continuities as well as change are important; and that modes of funding are about more than simply the choice between social insurance and general taxation – our earlier example of the Irish Hospitals Sweepstake throws this into sharp relief as, more recently, do the various experiments under New Labour and its successor in introducing market forces into the N.H.S., especially in England. But there is still a need to pay more attention to the international and sub-national contexts and frameworks in which healthcare has been historically formulated. In fact, a fair amount is now known about sub-national provision but there remains ample scope for further critical examination of, for instance, historic patterns of diversity and the role of particular individuals in particular local circumstances.

The international context of health policy formation and implementation is rather less well developed, at least by historians. This is ironic in that we also know that policymakers, social reformers and medical doctors frequently look to other societies for models or examples of practice. As we have seen, British observers were aware of what was happening with respect to the reform of New Zealand's healthcare system in the late nineteen-thirties, while welfare reform from the nineteen-seventies onwards was part of a broader international phenomenon, the rise of neo-liberalism. The relationship between Britain and its empire, and particularly the Dominions (of which Ireland was one until the nineteen-forties), in terms of the sharing of knowledge and practice in healthcare may thus prove to be a particularly valuable and fruitful field of research. But the central point is that historians need to move beyond the nation-state as the sole reference point when discussing the development of healthcare systems. Although a demanding challenge, more account needs to be taken of both international and sub-national contexts.

⁶⁶ T. H. Marshall, *Citizenship and Social Policy* (Cambridge, 1950); R. Titmuss, *Commitment to Welfare* (1968).

II. Voluntary hospital provision

3. Paying for health: comparative perspectives on patient payment and contributions for hospital provision in Ireland

Donnacha Seán Lucey and George Campbell Gosling

This essay concentrates on the place of fee-payment and contribution schemes in inter-war healthcare. It primarily examines developments on both sides of the Irish border post-partition. It is also comparative in focus, examining Irish developments within a British context and providing an exploration of the dynamics that underpinned patient payment in health in local, national and transnational contexts. This comparative focus represents a new approach to the historiography of contribution schemes and patient payment which to date has concentrated mostly on British examples, and offers insights into the differing trajectories in health policy that emerged across inter-war Britain and Ireland. This essay is divided into two sections which concentrate on Ireland after partition in 1921 – Northern Ireland remained in the U.K. and the Irish Free State became independent. The first section examines contribution schemes and the role of patient fee-payment in inter-war Belfast and post-partition Northern Ireland; the Belfast experience is contextualized within the recently developed literature on British contribution schemes. The second section focuses on developments south of the border where patient fee-payment was more prominent and ultimately led to a two-tiered private/public hospital system.

Contribution schemes in Irish healthcare: the case of Belfast

This section of the essay examines workers' contribution schemes in voluntary healthcare. Recent historiographical attention on British contribution schemes has demonstrated that such funding represented the largest single source of finance for British voluntary hospitals and staved off potential financial catastrophe during an era of spiralling costs and decreasing charitable donations.¹ Contribution schemes have also been credited with heralding the end of 'medical charity'. It has been contended that they represented a new era of mutualism, self-help and quasi-insurance that undermined

¹ S. Cherry, 'Beyond National Insurance. The voluntary hospitals and hospital contributory schemes: a regional study', *Soc. Hist. of Med.*, v (1992), 455–82.

older philanthropic terms of entitlement, which were based on reciprocity and notions of the deserving and undeserving poor.² Notwithstanding these works, it has been noted that knowledge of contribution schemes' social, cultural and political make-up, operation on a day-to-day level and extent of politicization remains limited.³ Furthermore, work on Bristol has concluded that they represented a less radical evolution of charity and voluntarism and cannot be viewed as insurance schemes or medical commercialization.⁴ Doyle and Hayes have since argued that in the East Midlands the change was largely a transfer from elite philanthropic to cross-class mutual income, with voluntary action remaining a vital part of the funding and life of inter-war voluntary hospitals.⁵ Contribution schemes in an Irish context – north or south – have received little attention. This section addresses this gap in the literature, and particularly explores the Belfast context. It examines the role of fee-payment, the challenges to the place of medical charity by these schemes, and their relationship with fee-payment in medical care.

In Ireland, fee-payment in the hospitals of the newly established Irish Free State grew significantly in the inter-war years. This was partly facilitated by the emergence of private wings in some hospitals. Contribution schemes, however, were practically non-existent and mutualism was weak. Much of the Irish population lived in rural farming communities that were not conducive to mutualism, and labour politics were not as strong as in Britain. The crisis of funding in Irish voluntary hospitals was as severe as in Britain, but was staved off by the Irish Sweepstakes which generated large sums for the Irish Free State's beleaguered voluntary hospitals.⁶ Irish welfare was influenced by Catholic social thought, which emphasized charity's purpose of uplifting the poor morally while resisting state encroachment.⁷ In contrast to Britain, contribution schemes never emerged as a significant feature of voluntary healthcare in the Irish Free State.

² S. Cherry, 'Accountability, entitlement and control issues and voluntary hospital funding, c.1860–1939', *Soc. Hist. of Med.*, ix (1996), 215–33.

³ Among the rare exceptions is B. M. Doyle, 'The economics, culture, and politics of hospital contributory schemes: the case of inter-war Leeds', *Labour History Review*, lxxvi (2012), 289–315, at p. 292.

⁴ G. Campbell Gosling, "'Open the other eye": payment, civic duty and hospital contributory schemes in Bristol, c.1927–48', *Medical History*, liv (2010), 475–94.

⁵ N. Hayes and B. M. Doyle, 'Eggs, rags and whist drives: popular munificence and the development of provincial medical voluntarism between the wars', *Historical Research*, lxxxvi (2013), 712–40.

⁶ M. Coleman, *The Irish Sweep: a History of the Irish Hospitals Sweepstakes, 1930–87* (Dublin, 2009).

⁷ L. Earner-Byrne, *Mother and Child: Maternity and Child Welfare in Ireland, 1920s–60s* (Manchester, 2007), p. 59.

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Patient contributions and payment were, however, prominent in Irish voluntary hospitals. Mostly patients contributed according to their means – often making part-payment – and fee-payment was not a condition of access. This echoes what has been termed ‘economic reciprocalism’ in the British case, where deservingness was demonstrated through the willingness to make some financial contribution.⁸ Such concepts were apparent in the early Irish Free State reform of Poor Law hospitals; the introduction of private wards in public hospitals was justified on the grounds that those who contributed through taxation and hospital fees were entitled to preferential treatment.⁹ Despite claims that poorer patients had limited accessibility, voluntary hospitals continued to care for non-paying or part-paying patients, indicating that traditional forms of medical charity remained prominent in southern Irish voluntary hospitals.¹⁰

In Britain contribution schemes acted as a significant vehicle for voluntarism and provided new avenues of user participation in hospital governance, particularly among the working classes.¹¹ Similar developments did not emerge in the Irish Free State, dampened by the lack of substantial contribution schemes and the prevalence of Catholic religious authorities. The semi-voluntary Irish hospitals – a type of hospital not in existence in Britain – did receive local authority grants, and locally elected politicians sat on the boards of management.

Contribution schemes did not emerge in Irish Free State cities, which failed to undergo industrialization in the nineteenth century. Belfast, however, was the most industrialized part of the island and economically more akin to a heavily industrialized British city, with a high proportion of skilled labourers in shipbuilding and the linen industry. This had an impact on hospital funding, and contribution schemes in Belfast developed more closely in line with the wider British experience. The city had a well-established voluntary hospital system which was larger than in many similar British cities such as Liverpool and Glasgow (see Table 3.1). Irish cities generally had more voluntary beds than their British counterparts. This

⁸ G. C. Gosling, “Open the other eye”, pp. 487–94; G. C. Gosling, *Payment and Philanthropy in British Healthcare, 1918–48* (forthcoming, 2015).

⁹ D. S. Lucey, “‘These schemes will win for themselves the confidence of the people’: Irish independence, Poor Law reform and hospital provision”, *Medical History*, lviii (2014), 46–66; D. S. Lucey, *From Poor Law to Free State: Poverty, Welfare and Healthcare in Revolutionary and Independent Ireland, 1918–39* (forthcoming, 2015).

¹⁰ M. E. Daly, “‘An atmosphere of sturdy independence’: the state and the Dublin hospitals in the 1930s”, in *Medicine, Disease and the State in Ireland, 1640–1940*, ed. E. Malcolm and G. Jones (Cork, 1999), pp. 235–40.

¹¹ M. Gorsky, J. Mohan and T. Willis, *Mutualism and Healthcare: British Hospital Contributory Schemes in the 20th Century* (Manchester, 2006), p. 2.

was most clearly demonstrated in Dublin, where the growth of Catholic voluntary hospitals and the large number of medical schools led to one of the most extensive voluntary systems in Britain or Ireland.

Table 3.1 Beds per 1,000 of population in Irish and British cities, 1911 and 1940

	1911	1940
Belfast	2.31	3.27
Dublin	5.85	4.56
Glasgow	2.01	3.2
Liverpool	1.54	2.49
Sheffield	1.36	2.31

Source: Voluntary Hospitals Database <<http://www.hospitalsdatabase.lshtm.ac.uk>> [accessed 20 June 2014]; B. R. Mitchell, *British Historical Statistics* (Cambridge, 1988).

In Britain, voluntary hospitals often embodied co-operation and consensus that characterized the efforts of employers and workers to provide communities with hospital facilities, such as in Edwardian South Wales where social tensions were often overcome.¹² This was apparent in Belfast, where the leading voluntary hospital – the Royal Victoria Hospital – received support from the upper and working classes, albeit within a different political context than in Britain. The political, social and commercial unionist elite were centrally involved in the hospital. In the early nineteen-twenties the leading industrialist William Pirrie – chairman of Harland and Wolff Shipbuilders and the First Viscount Pirrie – was its patron. Throughout the period the hospital received significant support from the region’s aristocracy and in 1926 the marquess of Dufferin and Ava became the institution’s chairman.¹³ Its annual meetings were important civic events and were frequently addressed by figures such as the Northern Irish prime minister, James Craig. The involvement of the social and political elite in charitable healthcare represented a continuation of traditional philanthropy. Although the voluntary hospital sector’s reliance on upper-class benevolence had greatly waned during the inter-war period throughout Britain and Ireland,

¹² S. Thompson, ‘To relieve the sufferings of humanity, irrespective of party, politics or creed: conflict, consensus and voluntary hospital provision in Edwardian South Wales’, *Soc. Hist. of Med.*, xli (2003), 247–62; S. Thompson, ‘Varieties of voluntarism in the South Wales coalfield, c.1880–1914’, in *Understanding the Roots of Voluntary Action: Historical Perspectives on Current Social Policy*, ed. C. Rochester, G. C. Gosling, A. Penn and M. Zimbeck (Sussex, 2011), pp. 82–94.

¹³ *Annual Report of the Belfast Royal Victoria Hospital: 134th, for the Year Ending 31st December 1926* (Belfast, 1927), p. 15.

bequests still formed an important source of capital expenditure. This was evident in the R.V.H., where general subscriptions dropped from £8,681 in 1921 to £6,542 in 1939, but bequests partly funded the hospital's expansion.¹⁴ The elite also played a vital role in heading public appeals for funds, such as in 1927 when the duchess of Abercorn led a fundraising campaign for the new Royal Maternity Hospital.¹⁵

In many British industrial cities, social collegiality between the working and upper classes was a feature of voluntary healthcare.¹⁶ While the political and social elite of unionism supported the hospital, working-class Protestant support was also apparent. In 1932 the Loyal Orange Lodge in the Sandy Row district of Belfast, for example, donated £500 to the R.V.H., for which the lodge received two life governorships in the hospital and a named bed.¹⁷ The largely working-class lodge organized the collection over two years and received support from the Women's District Lodge, indicating the prevalence of grass-roots fundraising for the voluntary hospital. Working- and upper-class co-operation was aided by the pan-class nature of Ulster unionism, although such social collegiality was a feature of inter-war voluntary hospital funding and management in Britain too.

The R.V.H. also witnessed the emergence of contribution schemes as a major source of funding. Such funding increased from £2,602 in 1900 to £19,067 in 1926; by 1941 the scheme provided £41,877 of the hospital's total income of £90,624, and was by far the largest form of income. This reflected developments in Britain, where worker contribution schemes and patient full- or part-payment became the financial linchpin of voluntary hospitals. In Belfast's R.V.H., however, such funding was of greater importance and in 1936 constituted 45.3 per cent of its income; this was higher than the 34.4 per cent average of sixty-three similar teaching voluntary hospitals in

¹⁴ For the demise of charity in voluntary hospital finance, see M. Gorsky, J. Mohan and M. Powell, 'The financial health of voluntary hospitals in interwar Britain', *Econ. Hist. Rev.*, lv (2002), 533–57. In Belfast Henry Musgrave bequeathed £50,000 in the early 1920s, which helped to fund capital projects including the building of the Royal Maternity Hospital and the Musgrave Hospitals (see *Annual Report of the Belfast Royal Victoria Hospital: 132nd, for the Year Ending 31st December 1924* (Belfast, 1925), p. 18).

¹⁵ *Annual Report of the Belfast Royal Victoria Hospital: 136th, for the Year Ending 31st December 1928* (Belfast, 1929), p. 17.

¹⁶ See Doyle, 'The economics, culture, and politics of hospital contributory schemes', pp. 289–315; B. Doyle, 'Labour and hospitals in three Yorkshire towns: Middlesbrough, Leeds, Sheffield, 1919–38', *Soc. Hist. of Med.*, xxiii (2010), 374–92; B. Doyle, 'Power and accountability in the voluntary hospitals of Middlesbrough 1900–48', in *Medicine, Charity and Mutual Aid: the Consumption of Health and Welfare in Britain, c.1550–1950*, ed. A. Borsay and P. Shapely (Ashgate, 2007), pp. 207–24.

¹⁷ *Northern Whig*, 22 Feb. 1932.

England, Scotland and Wales.¹⁸ Workers' contribution schemes also made up much of the income in Belfast's other general voluntary hospital – the Catholic Mater Hospital – accounting for 33.7 per cent of its total income in 1944. Conversely, the proportion of fee-paying patients (part or full fees) was lower than the wider British or Irish experience: in 1936 4.8 per cent of the R.V.H.'s income came from patients' fees, compared to 14.5 per cent in the British hospital sample. In the Irish Free State, the lack of contribution schemes and the establishment of private wards and wings by public voluntary hospitals led to a far greater reliance on direct patient payments: in 1933, out of a total of £262,916 ordinary income for all general voluntary hospitals, £149,283 (56.7 per cent) came directly from patients' pockets.¹⁹ This demonstrated contrasting experiences across Ireland and Britain.

Although it is difficult to determine the social composition of these workers' contribution schemes, there is evidence that they transcended the political and religious divide. The Catholic voluntary Mater Hospital received contributions from all the major employers in the city, and workers in the Harland and Wolff Shipyard – long considered a Protestant place of employment – contributed £4,503 out of a total of £19,540 for the hospital's workman's collection in 1942.²⁰ While the Mater was run by the Catholic Sisters of Mercy, many Protestants received attention, particularly as out-patients. Similarly, the R.V.H. was closely tied to the unionist and Protestant medical, political and social establishment, and traditionally received collections from Protestant churches, but the institution's commitment to the general poor, and its geographical location by the predominately Catholic region of West Belfast, ensured that Catholics had access to the hospital.

Belfast's schemes were based on workplace contributions organized by each hospital, as opposed to city-wide collections into a common fund; this was similar to other cities in Britain where individual hospital collection was the common type of scheme. Such arrangements existed for the two general voluntary hospitals and the Mater Infirmorum, although they were absent from many of the smaller specialist hospitals in the city. The Victoria Hospital's Working Men's Committee (V.H.W.M.C.), the largest in Belfast, organized workplace collections from employees throughout the city. Strong support for the scheme was evident from employers; firms facilitated collections and often organized automatic deductions from weekly pay packs. The V.H.W.M.C. propaganda emphasized that the hospital was beneficial to both workers and employers, and sufferers of workplace

¹⁸ Gorsky, Mohan and Powell, 'The financial health of voluntary hospitals', p. 549.

¹⁹ *The Hospitals Commission First General Report, 1933-4* (Dublin, 1936), p. 125.

²⁰ Down & Connor Diocesan Archives, Mater Infirmorum Hospital, *Annual Report for 1942* (Belfast, 1943).

accidents received 'prompt and skilful attention' which reduced bouts of unemployment. Subscribers and their families received free intern and extern medical treatment in the hospital. The V.H.W.M.C. promoted these 'advantages' and highlighted that subscription secured 'ample surgical and medical care' for workers prone to industrial accidents.²¹ It also highlighted the charitable nature of the hospital and that it would not be able to function without the working-class contributions.²² Unsurprisingly skilled workers in the shipyards were the largest contributors; in 1919 workers from Harland and Wolff and the Workman Clark Shipyard provided 35.5 per cent of the £12,541 collected. Contributions also emanated from the city's linen mills, which had much smaller workforces than the shipyards but were more numerous; workers from smaller businesses and organizations also contributed.

Workers from each firm were entitled to a representative on the committee, whose officers in turn sat on the hospital's committees and were involved in its day-to-day management. As already noted, similar developments in Britain have been viewed as significant vehicles for voluntarism and the democratization of voluntary hospital management.²³ The V.H.W.M.C. also resonated with mutualistic approaches to social provision through the pooling of workers' resources, also evident in the co-operative, trade union and friendly societies movements. Doyle has argued that the contribution scheme in Leeds – one of the most successful in Britain – was representative of mutualism, and from the nineteen-thirties an insurance scheme, rather than voluntarism.²⁴ However, the extent of mutualism in the V.H.W.M.C. needs to be moderated. If 'economic reciprocalism' motivated membership of schemes in Bristol, similar dynamics were evident in Belfast. This was evident when the lord chief justice, Sir Denis Henry, stated during the hospital's annual meeting in 1923: 'they [subscribers] did not want to be treated as paupers; they were honest, hard-working men, who were prepared, God helping them, to pay their way'.²⁵ In the eyes of the hospital's leadership, contribution demonstrated deservingness of medical relief.

Recent work on contribution schemes in Britain has concentrated on the potential democratizing effect on hospital management. The rise of the financial importance of contribution schemes led to greater patient participation in hospital governance – Gorsky and others have highlighted

²¹ *Annual Report of the Belfast Royal Victoria Hospital: 127th, for the Year Ending 31st December 1919* (Belfast, 1920), p. 6.

²² *Report of the RVHWMC, 1919* (Belfast, 1920), p. 4.

²³ Gorsky, Mohan and Willis, *Mutualism*, p. 2.

²⁴ Doyle, 'The economics, culture, and politics of hospital contributory schemes', pp. 302, 313.

²⁵ R.V.H., *Annual Report for 1923* (Belfast, 1924), p. 16.

that such influence could be marginal, although Doyle has demonstrated a far greater degree of worker influence in Labour Party strongholds in Yorkshire cities.²⁶ In Belfast, the vast majority of subscribers had little if any involvement in the running of the scheme beyond paying their dues.²⁷ Charles Payne, a shipyard manager in Harland and Wolff, outlined how new employees filled out a subscriber's slip on appointment, indicating that membership was largely functional.²⁸ The importance of the hospital in meeting working-class sickness was often articulated; this represented a continuation of the nineteenth-century place of voluntary hospitals, which were favoured by industrialists for the efficient preservation of human capital.²⁹ Furthermore, the V.H.W.M.C. leadership remained static, indicating the lack of involvement of many of the subscribers.³⁰ It was not engaged in working-class culture, often a characteristic of mutualistic activity, to the same extent as similar schemes in English cities such as Leeds, where charity football matches and gala events were common.³¹ In Belfast the scheme remained somewhat traditional, reflective of employer patronage, and did not represent a major form of working-class identity or mutualism. Such mutualism was apparent in other forms of hospital funding, such as when local lodges of the Orange Order became life governors of the R.V.H. While such funding was enmeshed with political and religious outlooks in a politically, religiously and ethnically divided city, it paled in comparison to the V.H.W.M.C., which by and large was not outwardly associated with either political viewpoint.

The scheme's democratization of the R.V.H.'s management was limited; the V.H.W.M.C. held a single seat on the hospital's boards of finance and admission. Power and control in the hospital remained in the hands of the medical and social elite. The limited impact on its traditional hierarchy ensured a continuation of the hospital's charitable ethos and that 'continuity over change' in medical voluntarism was evident.³² Entitlement and access to the R.V.H. were not predicated on membership of the scheme; patients in 'necessitous circumstances' were admitted free in a continuation of the

²⁶ Gorsky, Mohan and Willis, *Mutualism*, p. 138; B. Doyle, 'Power and accountability in the voluntary hospitals'; Doyle, 'Labour and hospitals in three Yorkshire towns'.

²⁷ Gorsky, Mohan and Willis, *Mutualism*, pp. 106–14.

²⁸ R.V.H., *Annual Report for 1923*, p. 17.

²⁹ Gorsky, Mohan and Willis, *Mutualism*, p. 19.

³⁰ William Carson remained chairman of the V.H.W.M.C. for over 15 years until his death in 1936 (*Report of the RVHWMC, 1936* (Belfast, 1937), p. 4).

³¹ Doyle, 'The economics, culture, and politics of hospital contributory schemes'; Hayes and Doyle, 'Eggs, rags and whist drives'.

³² G. C. Gosling, 'Charity and change in the mixed economy of healthcare in Bristol, 1918–48' (unpublished Oxford Brookes University Ph.D. thesis, 2011)

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charitable ethos of the hospital.³³ Contributors were entitled to preference for intern treatment, except in urgent cases and those nominated by subscribers who supported beds.³⁴ However, limitations on entitlement existed. In 1926 the V.H.W.M.C. complained to the hospital's management that subscribers had difficulty accessing care, and that paying patients received preferential treatment.³⁵ In 1930 the V.H.W.M.C. again complained that subscribers were kept on waiting lists for a considerable time. On this occasion the medical staff regretted the 'unavoidable delay' and instructed the house surgeons to facilitate such patients 'as far as possible'.³⁶ Although membership of the V.H.W.M.C. did ensure that subscribers' interests were presented to the hospital's management, it did not lead to automatic entitlement to the hospital, and the medical staff made final decisions on patient access.

Advances in medical science made hospitals more attractive to the middle classes who traditionally received private attention. The R.V.H.'s medical staff, however, resisted this development and highlighted that such patients were not entitled to the hospital's medical relief. In 1928 the hospital informed all Northern Irish general practitioners – whom it believed were sending better-off patients to the R.V.H. – that the institution was primarily for those in 'necessitous circumstances' and V.H.W.M.C. subscribers.³⁷ Although by 1928 some 400 patients annually paid towards their upkeep, the hospital's authorities stressed that payments were not for medical and surgical treatment – provided on a charitable basis by the honorary medical staff – and that the hospital did not offer private pay beds.³⁸ Similar to the Bristol case, payment was not viewed by the medical staff and management in a commercial sense, but rather as an individual contribution at an appropriate level to support a fundamentally philanthropic hospital.³⁹

The hospital's management was slow to introduce commercialized medical care and develop a separate private wing. In 1927 the hospital authorities opted to develop the Royal Maternity Hospital rather than build a 'pay block'.⁴⁰ However, suspicion that 'hospital abuse' was prevalent

³³ *Annual Report of the Belfast Royal Victoria Hospital: 131st, for the Year Ending 31st December 1923* (Belfast, 1924), p. 12.

³⁴ *Annual Report of the Belfast Royal Victoria Hospital, 1923*, p. 12.

³⁵ P.R.O.N.I., R.V.H. Board of Management Committee minute book, MIC 514/1/23, 17 March 1926, p. 116.

³⁶ P.R.O.N.I., R.V.H. staff minute book, MIC 514/1/23, 31 Oct. 1930.

³⁷ P.R.O.N.I., R.V.H. staff minute book, MIC 514/1/23, 'Copy of letter from R.V.H., Belfast', Feb. 1928.

³⁸ P.R.O.N.I., R.V.H. Management Committee, MIC/514/1/1/22, 28 March 1928.

³⁹ Gosling makes a similar argument (see Gosling, *Payment and Philanthropy*).

⁴⁰ P.R.O.N.I., R.V.H. staff minute book, MIC/514/1/23, 5 July 1927.

among patients who were not entitled to medical relief in the general ward meant that plans were agreed in 1928 to build a new fee-paying wing. Entitlement was restricted to those who could not afford the full cost of medical and surgical fees and a nursing home.⁴¹ Potential patients in 'better circumstances' with an annual income over £600 were deemed ineligible for treatment in the 'pay block'. Such limitations were considered necessary in order to conform to the charitable bequest that was to fund the development, but also protected medical practitioners' private practice.⁴² The fee-paying wing of the hospital – named the Musgrave Hospital – was not opened until 1938.

Contributions from the V.H.W.M.C. significantly increased. This was partly brought about by limited economic revival and wage inflation from the mid nineteen-thirties. In 1936 Harland and Wolff workers contributed £4,648 to the hospital compared to £1,083 in 1932 – the worst year of the economic depression.⁴³ Increased contributions were also evident in other sectors, including local and central government – for example, subscriptions from Belfast City Council employees rose from £172 in 1919 to £2,464 in 1936; contributions from post office workers doubled from £469 in 1931 to £943 in 1936; and central government employees' contributions increased from £251 to £479 over the corresponding period.⁴⁴ This reflected workforce fluctuations and increased numbers employed in administration.

Support for the opening of the hospital to new types of workers was evident among its leadership. In 1928 Colonel Crawford – a member of the board of management – highlighted the need to provide for groups that traditionally did not come 'under working men's schemes', including 'clerks and people of that sort'.⁴⁵ However, much ambiguity existed regarding entitlement as the opening up of the hospital to new groups threatened its traditional role. The medical staff refused to allow some government employees to contribute under the V.H.W.M.C. scheme, including the Royal Ulster Constabulary (R.U.C.). In 1932 they considered the treatment of 'government servants in a voluntary hospital' as a 'dangerous precedent'.⁴⁶ Despite repeated calls to include R.U.C. members, it was emphasized that the 'honorary' medical staff gave their services freely on the understanding that the hospital was a charity, and R.U.C. members were not considered 'charitable patients'.⁴⁷

⁴¹ P.R.O.N.I., R.V.H. Management Committee, MIC/514/1/1/22, 28 March 1928.

⁴² P.R.O.N.I., R.V.H. staff minute book, MIC/514/1/23, 22 March 1928.

⁴³ *Report of the RVHWMC, 1936* (Belfast, 1937).

⁴⁴ *Report of the RVHWMC, 1936*.

⁴⁵ P.R.O.N.I., R.V.H. Management Committee, MIC/514/1/1/22, 28 March 1928.

⁴⁶ P.R.O.N.I., R.V.H. staff minute book, MIC/514/1/23, 17 May 1932.

⁴⁷ P.R.O.N.I., R.V.H. staff minute book, MIC/514/1/23, 18 Oct. 1932.

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The attempt by the R.U.C. members to join the V.H.W.M.C. demonstrated the hospital's attractiveness to groups beyond the traditional recipients of charitable healthcare. It also demonstrated that membership of the scheme was viewed as a means of securing access to the hospital. This was worsened by longer waiting lists, which bestowed further benefits to subscribers. A 1934 medical staff report recommended that patients without a 'special claim on the hospital' – that is, non-subscribers – should not be admitted or placed on the waiting list.⁴⁸ However, tensions existed regarding the terms of entitlement of subscribers. As already highlighted, access to the hospital was not automatic and subscribers were frequently placed on waiting lists. The medical staff insisted that membership of the scheme represented nothing other than a charitable contribution. In 1937 controversy arose when a woman was denied admission to the hospital as a 'subscriber' when it emerged that her husband – an official in the Department of Education – had a wage of £800 per annum.⁴⁹ The hospital authorities believed the case was a 'flagrant violation of the scheme', although not an isolated one.⁵⁰ Subsequently, a committee was established to examine the definition of 'subscriber'. The report rejected the automatic entitlement of subscribers and claimed that the weekly subscriptions of 2s were not financially comparable to the requirements of an insurance scheme. The medical staff deemed the contributions to be 'purely voluntary subscriptions' and that visiting medics acted on a 'purely voluntary' basis and did not derive any remuneration.⁵¹ The committee viewed the contribution scheme within a traditional charitable context.

Paradoxically, contribution schemes provided the financial lifeline for the R.V.H. yet simultaneously undermined its charitable reputation. During an era of increased demand on hospital services, it is apparent from this case study that many joined the scheme to gain entitlement to the institution. While this represented a significant transformation in the character of the contribution scheme, there was much opposition to change. In particular, the medical staff highlighted that they gave their services on a charitable basis, and that the small weekly subscriptions could not be considered as payment for health or insurance schemes. The belated development of private provision exacerbated pressure on resources; without recourse to private beds middle-class patients joined the contribution scheme in the hope of gaining access. Similar tensions over change and continuity were evident throughout inter-war Britain, and have been explored in the

⁴⁸ P.R.O.N.I., R.V.H. staff minute book, MIC/514/1/23, 13 Nov. 1932.

⁴⁹ P.R.O.N.I., R.V.H. staff minute book, MIC 514/1/23, 6 July 1937.

⁵⁰ P.R.O.N.I., R.V.H. staff minute book, MIC 514/1/23, 18 March 1938.

⁵¹ P.R.O.N.I., R.V.H. staff minute book, MIC 514/1/23, 18 March 1938.

historiography. It is also apparent that there was much variety across British and Irish cities; to varying degrees contribution schemes were underpinned by mutualism, and led both to user participation in hospital management and contributor entitlement.

Private and paying patients: the case of Dublin

The move from the philanthropic premise of the voluntary hospital system to commercial medicine was more straightforward in the case of private wards for the middle classes. This new category of patient would be accommodated not in the usual dormitory-style wards, but in a separate one- or occasionally two-bed room, domestic in style. These private wards typically – as in Belfast – would be physically separate, sometimes in entirely different buildings. Charges for such rooms were not the voluntary contributions towards the cost of maintenance discussed above, but rather compulsory fees set at a rate to cover at least the full cost of treatment. Consequently, where patients in the general wards might pay up to one guinea per week, those in private wards could pay up to ten guineas per week, in addition to which they would have to negotiate with the doctor a fee for his services.⁵² The King's Fund categorized these private beds according to the rate at which they were charged. A small proportion were priced at up to three guineas per week and said to be for patients of 'limited means', the vast majority at between four and seven guineas for those of 'moderate means', while only rarely at eight to ten guineas for the 'well-to-do'.⁵³ This is the only area of the pre-N.H.S. hospital system where we genuinely see private healthcare operating on a commercial basis.

Given the reputation of the larger voluntary hospitals as the elite and the contrasting perception of Poor Law infirmaries as institutions of last resort, the emergence of such provisions might be seen as a logical development.⁵⁴ Indeed, this was the view of Charles Rosenberg in identifying a 'private patient revolution' in American hospitals at the turn of the century.⁵⁵ However, as Paul Bridgen has argued for London, the British voluntary hospitals ultimately failed to become the provider of hospital services for

⁵² L.M.A., A/KE/185, King's Fund, Voluntary Hospitals (Paying Patients) Bill (hereafter V.H.P.P.B.), Draft Statement for the Information of the Promoters (confidential), revised draft, 27 March 1935.

⁵³ L.M.A., A/KE/185, King's Fund, V.H.P.P.B., Information for Promoters (confidential), 27 March 1935.

⁵⁴ For a discussion of how these factors led to the diversification of hospital funding, see Gorsky, Mohan and Powell, 'The financial health of voluntary hospitals in interwar Britain'.

⁵⁵ C. E. Rosenberg, *The Care of Strangers: the Rise of America's Hospital System* (New York, 1987), pp. 237–61.

the middle classes. He suggests that a ‘voluntary hospital insufficiency’ in middle-class provision left the middle classes with ‘little to lose’ from nationalization in the N.H.S.⁵⁶ This can be seen both from private care within voluntary hospitals, which was institutionally marginal, and from the very small number of entirely private hospitals.⁵⁷ When the Musgrave Hospital opened in Belfast in 1938, as the private partner of the Royal Victoria Hospital, there were only eighteen such institutions across all of England (see Table 3.2). Eight of these were general hospitals, including London’s Royal Masonic Hospital in Ravenscourt Park, which was noticeably the largest such institution, with 200 beds – no other hospital had more than seventy-five. Bath had a similar arrangement to Belfast, with the seventy-four-bed Forbes Fraser Private Hospital effectively an extension of the Bath General Infirmary. Combined, solely private hospitals provided just 583 beds across England in 1938, only 0.7 per cent of the voluntary hospital bed total.

By contrast, Ireland had long been seen as more favourable to private hospital medicine than Britain. Sir Henry Charles Burdett, who would go on to found the King’s Fund in 1897, wrote a book in 1879 surveying equivalent systems across the Western world. As early as this he noted that ‘the Irish capital [had] done more to give the pay system a trial than any other town in the United Kingdom’.⁵⁸ However, ‘The increased accommodation in General hospitals for that section of the community in a position to pay for it’ was described by the Irish Hospitals Commission in 1936 as ‘a development of comparatively recent times’.⁵⁹ Certainly it was only in the early twentieth century that there were significant developments in private provision, with the Catholic voluntary sector leading the way in parallel with America.⁶⁰ The Bon Secours, a Catholic religious order, established a

⁵⁶ P. Bridgen, ‘Voluntary failure, the middle classes, and the nationalisation of the British voluntary hospitals, 1900–46’, in *Charity and Mutual Aid in Europe and North America since 1800*, ed. B. Harris and P. Bridgen (2007), pp. 216, 228. Given its focus on the King’s Fund, this sits well alongside F. Prochaska’s, *Philanthropy and the Hospitals of London: the King’s Fund, 1897–1990* (Oxford, 1992). R. Lewis, R. Nixon and B. Doyle, *Health Services in Middlesbrough: North Ormesby Hospital 1900–48* (Middlesbrough, 1999) offers some local analysis, although the existing literature provides little context for such an investigation.

⁵⁷ The distinction between a hospital and a nursing home used here is whether or not there were resident medical staff – although many of each took the name of the other. There were a far greater number of private nursing homes.

⁵⁸ H. C. Burdett, *Pay Hospitals and Paying Wards throughout the World: Facts in Support of a Re-arrangement of the English System of Medical Relief* (1879).

⁵⁹ *Hospitals Commission First Report*, p. 68.

⁶⁰ B. Mann Wall, *Unlikely Entrepreneurs: Catholic Sisters and the Hospital Marketplace, 1865–1925* (Columbus, Ohio, 2005), p. 103.

105-bed private hospital in Cork in 1915 and another in Tralee in 1921. Some of the larger general voluntary hospitals in Dublin had established private homes by the early nineteen-twenties, including a 100-bed development at St. Vincent's and a smaller establishment at the Mater Hospital.⁶¹ The Mercy Hospital in Cork had also established a private wing by the early nineteen-thirties. Prior to independence there had been no local authority funding for the Irish Catholic voluntary hospitals, nor the Anglo-Irish charitable donations from which the Protestants benefited. This was a significant factor in their nursing congregations becoming 'unlikely entrepreneurs' and catering for a middle-class grouping who were able to pay full medical fees and were increasingly turning to hospitals for the most advanced medical care.

Table 3.2 Solely private hospitals in England in 1938

Hospital	Type	Area	Beds
Royal Masonic Hospital, Ravenscourt Park	General	London	200
Forbes Fraser Private Hospital	General	Bath	74
The Fielding Johnson	General	Leicester	43
Queen Victoria Nursing Institution	General	Wolverhampton	42
Bromhead Nursing and Maternity Home	General	Lincoln	34
St. Mary's Convalescent Home	Special	Somerset	34
Leazes House Sanatorium, Wolsingham (TB)	Special	Durham	33
The John Faire	General	Leicester	30
St. Saviour's for Ladies of Limited Means (women and children)	General	London	21
Rosehill Private Sanatorium, Penzance	Special	Cornwall	20
Ellerslie House	Special	Nottingham	18
Burton-on-Trent Nursing Institution and Maternity Home	Special	Burton-on-Trent	15
Merthyr Guest Memorial Hospital	General	Somerset	12
Duchess of Connaught Memorial Hospital, Bagshot (maternity)	Special	Surrey	7

Sources: *The Hospitals Year-Books* (1933–47); Ministry of Health, *Regional Hospital Services Survey Reports* (1945).

⁶¹ *Hospitals Commission First Report*, pp. 16, 122.

Unlike Britain, the gradual expansion of the private hospital sector in the inter-war years was remoulded in the nineteen-thirties by the arrival of the Irish Hospitals Sweepstake. The Irish Hospitals Commission laid down 'guiding rules' on the balance between patients paying at different rates for those institutions wanting to receive funds from the sweepstake. This was set at 25 per cent of beds reserved for free patients – those who could not afford to pay at any level; and 20 per cent for those private patients who could afford to pay above the cost of their treatment and maintenance. This left 55 per cent for those paying the cost of treatment and maintenance either in full or in part. Meanwhile, the commission stated in its first report that these guidelines should not be implemented too rigidly, 'as to cause an implication that the provision, promptly, of facilities for all those who are unable to pay is not the over-riding obligation'.⁶² We can therefore see this as an attempt to protect hospital provision for the poorest. However, the possibility that this policy may have had unintended consequences must be considered, since the other categories are more problematic.

There appears to have been a gap between voluntary hospital practices and the understanding of them that underpinned the guidelines drawn up by the Hospitals Commission. In both Britain and Ireland, contributions from patients in the ordinary wards went only towards the cost of maintenance, while the doctors continued to offer their services gratuitously. Moreover, these contributions fell far short of covering the full cost of maintenance, let alone that of treatment. Attention was drawn to this shortfall by the Royal City of Dublin Hospital, in an appeal for donations that stated 'the actual cost of running the Hospital for the year 1929 was £16,623 19s. 11d., and the amount received from patients in the ordinary wards was only £3,476 10s. 9d.'⁶³ Therefore, the ordinary ward patient paying at the full rate was still receiving heavily subsidized care. The hope that this could continue to be funded at least in part by charitable donations was apparent from the hospital's collecting box, which read: 'Three pennies will keep a Patient for one Hour: Won't you Help?'⁶⁴ Furthermore, the guidelines excluded 'patients paying 10s. per week or less' from this category, including them instead among 'free patients'.⁶⁵ In contrast, work on Britain would suggest that 25 per cent of patients being admitted and treated entirely free would be far from exceptional.⁶⁶ Consequently, the Hospitals Commission's guidelines actually opened

⁶² *Hospitals Commission First Report*, p. 69.

⁶³ *Annual Report of the Royal City of Dublin Hospital for 1929* (Dublin, 1930), p. 7.

⁶⁴ *Annual Report of the Royal City of Dublin Hospital for 1928* (Dublin, 1929), p. 15.

⁶⁵ *Hospitals Commission First Report*, p. 69.

⁶⁶ See Gosling, *Payment and Philanthropy*.

the door for a far greater expansion of working-class patient payments in Ireland's hospitals than was probably intended.

Turning to the final of the Hospitals Commission's categories, the guidelines allowed for 20 per cent of hospital beds to be set aside exclusively for private patients. By cross-referencing contemporary sources,⁶⁷ we can piece together figures for the number of private beds in England before N.H.S. voluntary hospitals.⁶⁸ The figure is dramatically lower than that set by the Irish Hospitals Commission. Between 1933 and 1938, the proportion of voluntary hospital beds across England set aside for private patients rose from a little over 6 per cent to nearly 9 per cent. Moreover, this private provision was heavily concentrated in the south of England, especially in and around London. At no time before the introduction of the N.H.S. did private hospital beds across all of provincial England reach the number to be found in the capital.⁶⁹

This raises the question of whether the different patterns of private hospital provision we can identify are really between Britain and Ireland, or between capitals and provinces. Table 3.3 shows that, in two of the major voluntary hospitals in Dublin in the year the Hospitals Commission was established, patients appear to have been divided between those paying nothing at all and those paying a significant commercial rate, in line with the British hospitals' private wards. Twenty-four of those free patients were listed for the Mater's private wards.⁷⁰

Table 3.3 Free and paying patients at Dublin's Mater and St. Vincent's hospitals, 1933

Fees per week	Free	1<10s	10s<£2 2s	£2 2s<
Mater	1,910	70	888	1,523
St. Vincent's	1,555	28	1,195	1,529

Source: *The Hospitals Commission First General Report, 1933-4* (Dublin, 1936), p. 122.

The rules and regulations of the Royal City of Dublin Hospital stated that the resident medical officer (the resident surgeon until 1899) 'shall not engage in private practice, nor in teaching (clinical or otherwise), nor hold any other appointment; and shall be required to devote his entire time to the care of the inmates of the Hospital, and to the superintendence of

⁶⁷ These are the regional hospital surveys conducted during the Second World War by the Ministry of Health and the Nuffield Provincial Hospitals Trust to inform reconstruction efforts, and the annual Hospital Year Books of the Central Bureau for Hospital Information that succeeded *Burdett's Charities* from 1933.

⁶⁸ Figures were recorded differently for hospitals in Scotland and in South Wales.

⁶⁹ For an in-depth analysis see Gosling, *Payment and Philanthropy*.

⁷⁰ *The Hospitals Commission First Report*, p. 122.

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the Extern Departments, under the direction of the Medical Staff.⁷¹ This did not mean there was no income derived directly from patients or from charging for services. Income from ‘pay patients’ reached over £100 for the first time in 1899, rising from less than 1 per cent of total income to 4 or 5 per cent in the decade that followed. These first years of the twentieth century also saw increased income from private and home nursing fees. Combined, these two sources provided between 10 and 15 per cent of total income each year.⁷²

However, it was only in 1926 that a dedicated private ward was opened, using three rooms made available by the extension of the nurses’ home. The hospital’s directors viewed this development as ‘supplying a long-felt want’ by catering for those ‘who for financial reasons are unable to use the Private Nursing Homes of the city’.⁷³ The high weekly charge of £4 4s covered maintenance, ordinary medicines, dressings, nursing and the use of the operating theatre. A year later, with use of the new ‘deep therapy’ department included, these private wards were said to ‘have proved a boon to persons of limited means’.⁷⁴ Over the following decade, income from the private wards would amount to between 10 and 14 per cent of total ordinary income.⁷⁵

While contribution schemes were well established in Belfast by the late nineteen-thirties, when they were joined by middle-class private institutions such as the Musgrave Hospital, the reverse is true for Dublin. The Employees’ Hospital Fund was set up in the mid nineteen-thirties on the principle of ‘You help us when you are well and we will help you when you are ill’.⁷⁶ It would take a decade for contributory sources to account for 10 per cent of the institution’s total ordinary income.⁷⁷ Certainly the direction of travel was away from free provision for the poor, as demonstrated by the political controversy over the poor’s access to voluntary hospitals in Dublin and Cork in the early nineteen-thirties.⁷⁸ By the eve of Establishment Day (6 November) in 1961 – following the passing of the 1961 Hospital Federation and Amalgamation Bill – only 271 of 60,486 bed days ‘were attributable to patients who paid nothing or less than [the] standard capitation rate’.⁷⁹ The

⁷¹ N.A.I., 2006/98, box 52, Royal City of Dublin Hospital, rules and regulations, 1896, p. 3 (stated again in the 1903 version, p. 7).

⁷² *Annual Reports of the Royal City of Dublin Hospital for 1877–1917*.

⁷³ *Annual Report of the Royal City of Dublin Hospital for 1926* (Dublin, 1927), pp. 10–11.

⁷⁴ *Annual Report of the Royal City of Dublin Hospital for 1927* (Dublin, 1928), pp. 9, 15.

⁷⁵ *Annual Reports of the Royal City of Dublin Hospital for 1927–37*.

⁷⁶ *Annual Report of the Royal City of Dublin Hospital for 1936* (Dublin, 1937), p. 14.

⁷⁷ *Annual Reports of the Royal City of Dublin Hospital for 1944–8*.

⁷⁸ For Dublin, see Daly, “An atmosphere of sturdy independence”; for Cork, see Lucey, “These schemes will win for themselves the confidence of the people”, p. 62.

⁷⁹ *Annual Report of the Royal City of Dublin Hospital for 1961* (Dublin, 1962), p. 8.

scale of charges by then stood at £12 12s 0d per week for private rooms and £10 10s 6d per week for private cubicles.⁸⁰

The situation was somewhat different in Dublin's Coombe Lying-in Hospital. In the late nineteen-thirties, 72 per cent of its patients were 'free' (by the Hospitals Commission's definition), accounting for 40.29 of the average 53.4 patients resident in the institution. This was said to illustrate that their work was 'to deal with a large number of the very poor of the metropolis within the wards of the Hospital'.⁸¹ Despite this, there is mention in the hospital's financial abstracts of 'pay patients' as early as 1864, when the sum of £1 was recorded.⁸² The turn of the century saw a notable increase in income from pay patients, although still only accounting for around 3 per cent of the total ordinary income.⁸³ This figure was significantly higher in the inter-war years when, despite failing to keep up with rising overall income in the mid nineteen-thirties, income from this source typically accounted for around a quarter of the hospital's total ordinary income. This grew further still in the nineteen-forties, and in 1950 for the first time provided the majority.⁸⁴

Over this period of growth in income from paying patients at the Coombe Lying-in Hospital, the almoner recorded the number of patients paying at each level. It was the task of the almoner both to administer the social work department of the hospital and the patient payment schemes. When in 1895 Miss Mary Stewart was appointed as the first hospital almoner at the Royal Free Hospital in London, she was given three duties: to prevent the 'abuse' of admission being given to 'persons able to pay for medical treatment'; to refer the 'destitute' to the Poor Law; and to encourage those between the two to join 'Provident Dispensaries' whenever financially possible.⁸⁵ As the social work side of the role developed, approaching the patient holistically became seen as the best way to ensure that a fair price was set upon admission.⁸⁶ From her figures, presented in Table 3.4, it is evident that the significant increases in income from patient payments at the Coombe Lying-in Hospital did not come from reducing the numbers

⁸⁰ *Annual Report of the Royal City of Dublin Hospital for 1961*, p. 13.

⁸¹ *Annual Report of the Coombe Lying-in Hospital for 1937* (Dublin, 1938), p. 6 and *Annual Report of the Coombe Lying-in Hospital for 1936* (Dublin, 1937), p. 7.

⁸² *Annual Report of the Coombe Lying-in Hospital for 1864* (Dublin, 1865), p. 16.

⁸³ *Annual Reports of the Coombe Lying-in Hospital for 1864–1906*.

⁸⁴ *Annual Reports of the Coombe Lying-in Hospital for 1923–51*.

⁸⁵ L. Cullen, "'The first lady almoner': the appointment, position, and findings of Miss Mary Stewart at the Royal Free Hospital, 1895–9", *Journal of the History of Medicine and Allied Sciences*, lxxvii (2013), 551–82.

⁸⁶ See Gosling, *Payment and Philanthropy* and B. Doyle *The Politics of Hospital Provision in Early 20th-Century Britain* (2014).

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receiving treatment free or at a heavily subsidised rate. Rather, the latter years of this period see a notable increase in the number of patients paying a higher rate, particularly an increase at the very top, suggesting that the hospital moved into providing elite services for the well-to-do in addition to its traditional role of caring for the city's poorest.

Table 3.4 Paying patients at the Coombe Lying-in Hospital, 1944–51

Per week	1944	1945	1946	1947	1948	1949	1950	1951
<i>Up to 10s</i>	1,126	979	1,090	1,142	973	886	1,066	1,045
<i>Up to 42s</i>	347	450	518	504	595	504	612	633
<i>42 to 63s</i>	141	279	346	359	448	537	307	227
<i>63s</i>	79	57	49	94	78	98	286	527
<i>84s</i>							9	21
<i>105s</i>							37	79
<i>Local authorities/ National Health</i>	144	91	124	70	94	106	83	129
<i>Paid for by army</i>	551	393	204	155	165	140	155	147
<i>Total</i>	2,388	2,249	2,331	2,324	2,353	2,271	2,555	2,818
<i>Up to 10s</i>	1,126	979	1,090	1,142	973	886	1,066	1,045

Source: N.A.I., BR/DUN 55 J/1–4, annual reports of the Coombe Lying-in Hospital, 1944–51.

Conclusion

The Irish and British experiences differed in a number of respects. In the Irish Free State, contribution schemes failed to emerge as significant forms of voluntarism. Patient payment was derived partly from the early commercialization of medicine, which was particularly evident in Catholic voluntary hospitals. However, this was combined with a continued commitment to traditional philanthropic healthcare, and the majority of patients in voluntary hospitals received free care or only partially contributed to it. Voluntary hospitals in the Free State were not vehicles for voluntary action or avenues for greater democratization. A contrasting picture is presented in Belfast where, similar to the British experience, contribution schemes emerged as vital to the finances of the two general voluntary hospitals. The case study of the Belfast V.H.W.M.C., however, demonstrates that the scheme lacked the mutualistic, quasi-insurance or democratizing features that have been identified in schemes in Britain. Similar to recent findings on Bristol, many associated with the Belfast

scheme considered it and the hospital to be charitable in nature; something frequently highlighted by the honorary medical staff. The entitlement of subscribers, however, was ambiguous and many joined in anticipation of gaining access to the increasingly sophisticated medical facilities in the institution.

We might characterize the most significant differences, however, as being those between capitals – Dublin and London – and the provinces. In which case we should keep in mind the differences of how the mixed economies of healthcare were governed in Britain and Ireland. Although a tradition of ‘sturdy independence’ has been identified among the voluntary hospitals of Dublin which resisted the government’s attempts at the re-organization of hospital services, we should acknowledge the lack of interference by the state in inter-war Britain.⁸⁷ After the 1929 Local Government Act, municipal authorities appropriating Poor Law infirmaries gave the Ministry of Health some involvement in encouraging the co-operation of public and voluntary hospitals. However, outside war and before the N.H.S, the sums of money flowing from government to the voluntary sector were simply never substantial enough to give the state any real influence in determining who could receive hospital treatment or on what basis. The sweepstake ensured that this was not the case in the Irish Free State.

Daly has described the way in which ‘the large sums of money available prevented reform’ by supporting an otherwise unsustainable network of small hospitals in Dublin.⁸⁸ Similarly, if the guidelines laid down by the Hospitals Commission for receiving funds from the sweepstake were followed, then we must ask whether the first Fianna Fáil government inadvertently embedded a two-tier hospital system in Ireland. Equally, the lack of contribution schemes in the Irish Free State and the different expectations for ordinary ward payment need to be considered. Therefore, the guidelines of the Hospitals Commission appear to have embedded a system whereby there was a greater proportion of hospital services devoted to the middle classes and under which working-class patients were asked to pay at a significantly higher rate than was the case in Britain.

⁸⁷ Daly, “An atmosphere of sturdy independence”.

⁸⁸ Daly, ‘The curse of the Irish Hospitals’ Sweepstake: a hospital system, not a health system’, *History Hub: Working Papers in History and Policy*, ii (2012), 9–11.

4. ‘Why have a Catholic Hospital at all?’ The Mater Infirmorum Hospital Belfast and the state 1883–1972*

Peter Martin

The Mater Infirmorum Hospital sits in the middle of North Belfast, on the Crumlin Road. The area is mixed, with a large Protestant population, but this is indisputably a Catholic hospital. Despite being historically the main general hospital in the area, serving both communities, it existed outside the N.H.S. from 1948 to 1973 due to a dispute with the government. Its history offers insights into Catholic identity in Northern Ireland and the relationship between healthcare and the political divide in the region.

The Mater was established as a voluntary hospital by the Sisters of Mercy with the assistance of Bishop Dorrian of Down and Connor. It was formally opened in 1883 with a mandate to provide for all the people of the area without regard to creed or class. However, there were distinctive aspects to this story that explain what a Catholic hospital meant in late nineteenth-century Belfast. The foundation myth of the hospital was somewhat unusual: instead of being a response by its founders to personal revelation or the plight of an ignored community, the Mater was conceived, according to Marie Duddy’s history of the Sisters of Mercy, after sisters visiting Catholic patients in Frederick Street Hospital faced a hostile reception from the matron. The Mater, in this account, was not intended to cater solely for Catholic patients but to provide a Catholic style of pastoral care to all.¹ This places it firmly among the Catholic endeavours of the era: the setting up of schools and universities, the building of churches and cathedrals, and the increased self-awareness of Catholic professionals, all amounting to something like a shadow state. Belfast in this period was a largely Protestant city into which a growing Catholic population had migrated in search of work. Effectively excluded from civic government, they were, like many

* Research for this article was carried out during the author’s time as a research fellow at the Institute of Irish Studies, Q.U.B.

¹ M. Duddy, *The Call of the North: a History of the Sisters of Mercy, Down and Connor Diocese* (Belfast, 2010), p. 115.

migrant populations around the world, concerned simultaneously with demonstrating their distinctiveness while demanding equality.

The original Mater was a small hospital, essentially a large house with an adjoining row of terraces. Its prospectus emphasized egalitarianism rather than Catholicism. It was dedicated to 'the relief of the sick WITHOUT DISTINCTION OF CREED' (original emphasis), all clergymen were to have free access to their flocks and – perhaps in a rebuke to freemasonry – there was the 'password to all wards – sickness'.² The early buildings had been bought with diocesan funds but the construction of the hospital the sisters wanted would require £30,000. In 1893 the superioress appealed to a range of companies, going far beyond the traditional Catholic networks. In doing so she found herself in competition with the Victoria Hospital in the south of the city.

Despite the positive image presented by the Mater, it proved difficult to balance the twin objectives of being open to all while being a Catholic institution. Although there were never any problems over the treatment of Protestant patients, the unionist establishment was often ambivalent about the hospital. On the one hand, Lord Pirrie, the lord mayor of Belfast, subscribed to the Mater's 1897 building programme, but on the other, the three main railway companies (Belfast & Co. Down, Belfast & Northern and Great Northern) refused to do so and instead subscribed a combined £4,000 to the Royal Victoria Hospital. The matter was controversial even with Protestant shareholders and was raised at half-yearly meetings. In the case of the Northern Counties railroad the opposition stemmed from one shareholder who threatened to veto the Royal's grant if the Mater was included. Although the epithet 'sectarian' was used in these discussions they were generally civilized and it seems the term meant different things to the two sides. Protestant opponents of the Mater meant that it was 'intended only for one particular denomination' and would be staffed and managed by Catholics; Fr. Dempsey of Carrickfergus argued that 'sectarian as a word of sense did not apply to Catholic institutions'. Certainly the Catholic supporters of the Mater were careful also to support the Royal Victoria.³

What remains interesting about these discussions is the fact that they reveal how problematic even contemporaries found the idea of a Catholic hospital. It was open to all patients but was a Catholic institution. Was it then a full part of civic society or (like schools or churches) part of the shadow society that Catholics had developed in parallel to the British state? On the Catholic side it was seen as a reasonable counter to the de facto

² Duddy, p. 121.

³ D.C.D.A., MH.1, 'The railways and hospital'.

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Protestantism of the official hospitals. Most importantly it consolidated the Catholic narrative that the Mater had been built almost exclusively with the support of their community and was firmly theirs. Despite this problematic position, the Mater was accepted by parts of the establishment. The new hospital was built in 1900 and it became a full teaching hospital for Q.U.B., demonstrating its acceptance by the medical profession at least.

These problems of identity were made even clearer after the establishment of Northern Ireland in 1921. For the new regional government Catholicism was synonymous with disloyalty and little effort was made to separate constitutional and revolutionary methods of opposition to partition. This attitude was especially prevalent in the Ministry of Home Affairs which had responsibility for health. Such views were clearly evident in a dispute in 1925 over the Mater’s desire to acquire land from an adjoining prison. The hospital’s application noted its care of soldiers during the First World War and promised that the land would allow for new facilities to be built providing work for local people. Prime Minister James Craig was favourably disposed but his minister for home affairs, Richard Dawson Bates, and the prison authorities were not. In particular the governor of the prison, A. W. Long, warned that ‘it must be remembered that soon we shall have significant S[in]n F[é]in prisoners, who are doing long sentences. The sympathies of the nurses and students will be with these prisoners’.⁴ Antrim County Council also refused to approve the development.⁵

Despite this setback the Mater expanded significantly in the years after partition along similar lines to other voluntary hospitals. A radiographic department was set up in 1929 and extended in 1936 and 1941, and its existing buildings were redeveloped. Our Lady’s Hospital was established in Beechmount in 1935 to care for elderly and chronic cases. In 1941 the Mater Hospital treated some 52,761 patients of whom only 2,925 were in-patients. Nearly 35,000 were out-patients and almost 15,000 were accident cases.⁶ A maternity unit was added in 1945. This was significant in expressing the hospital’s Catholic ethos. Bishop Mageean inaugurated the new facility, commenting that ‘Catholics are bound by that [Roman Catholic] teaching and ... they should have facilities to follow it’. He expressly ruled out the provision of contraception, birth control, abortion and craniotomy.⁷ The ethos was also evident in the make-up of the Mater’s management board, where clergy and nuns considerably outnumbered medical people.⁸ The service grew from 440

⁴ P.R.O.N.I., CAB/9/B/91, A. W. Long to W. A. Magill, 2 Nov. 1925.

⁵ P.R.O.N.I., CAB/9/B/91, W. A. Magill, summary to Cabinet, 5 May 1926.

⁶ D.C.D.A., MH.1, *Mater Infirmorum Hospital Belfast, Souvenir and History* (1943).

⁷ D.C.D.A., MH.1, report on Mater Hospital, Nov. 1949.

⁸ D.C.D.A., MH.1, report on Mater Hospital, Nov. 1949.

admissions in its first year to 642 in 1958. By then the hospital authorities had plans to develop a larger maternity hospital, had acquired property and had sent nurses to Drogheda and London for training.⁹

In many ways the situation of the Mater in the post-war environment was typical; Belfast's hospital service was in need of planning and investment. Meanwhile, despite ideological qualms, the Northern Irish government had resolved to implement the N.H.S. in full. In Britain a hospital such as the Mater would have been faced with a choice between full integration into the service or being disclaimed by the minister and remaining independent. The Northern Irish minister William Grant implemented a subtly but significantly different system: any hospital which refused to join the N.H.S. would not be considered a hospital at all for the purposes of the act and would be barred from any N.H.S. activity. This precluded any contractual arrangements to treat N.H.S. patients such as were made in Britain. This policy was at the heart of the controversy which dominated the Mater's history until 1972.

The Mater faced a challenge to its identity; there was little confidence in the Catholic community that the hospital would retain its character in the hands of a Protestant state. Grant offered no sympathy, telling one meeting, 'if I had introduced the word "religion" into my bill, the nationalists would have accused me for doing so. Now they have accused me of ignoring their interests'.¹⁰ In 1948 Bishop Mageean commissioned a report on the Mater's situation. The result made uncomfortable reading. This hospital was running a substantial shortfall: annual income was £42,000 but expenditure was £53,000. In the past it had raised substantial sums from the workers of North Belfast, both Catholic and Protestant, but the existence of the N.H.S. threatened to undermine the communities' support for voluntary hospitals. The same was expected to be true of bequests and gifts. The staff members were consulted and were critical of the hospital's management for allowing the situation to deteriorate so far. Several were adamant that the hospital would have to join the N.H.S. One commented that it was the 'only way the Mater can continue to exist'. Another asked 'why have a Catholic Hospital at all? [It is] necessary if question of morality enters or required because of bigotry shown by non-Catholics. Hence [it is] necessary to have one but [it] must be a first class one. [The] Mater [is] heading for status as second class'. The same writer questioned, reasonably enough, why 'Catholics stand to gain more from the Health Act than others yet Catholic opinion, clerical, [and] political is hostile'.

⁹ P.R.O.N.I., Vivian Simpson papers, D3233, Mater Infirmorum Hospital, *Annual Report* 1958.

¹⁰ *Irish Times*, 25 Oct. 1947.

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The hospital was old-fashioned in a number of ways. Visiting hours were limited, doctors met patients’ relatives in the linen room and nurses complained of poor facilities and conditions.¹¹ The superioress was effectively in charge and corporate governance was ramshackle. The system depended on individuals rather than strong management structures. The medical staff complained that they were rarely consulted and were losing out professionally because of the low pay and poor facilities with which they dealt. Some wondered why there was no effective planning for the welfare state and how seriously the authorities had negotiated with Stormont.¹² It seems that the Mater was in need of reform and investment in any event. It was in the same situation as voluntary hospitals across the U.K. and Ireland. Purely on medical and financial grounds there was no argument against it joining the N.H.S.

Of course, the issues were not purely medical or financial. The real problems were of ethos and control. Ethos should not be confused merely with ethics. There was little detailed discussion of what procedures were to be forbidden or what curriculum was acceptable. It seems that everyone took these for granted. Rather the issue was of the hospital having a clear Catholic identity. It was to be a teaching hospital for Catholic students. There would be a clear role for nuns and priests in running it. There was a Catholic feel to the place, from the statuary on the building to the chapel, where the high altar portrayed the Blessed Virgin bending over the body of Christ. The writer ‘Camillus’ in the *Irish News* argued that, though it was open to all, the Mater ‘is quite definitely an ecclesiastical institution’.¹³ Officially the government had pledged to respect these aspects but there was understandable suspicion of such promises. The bishop was warned that there was no guarantee that he would remain chairman of the Management Committee if it went into the state system. The committee would control all the hospital’s funds and endowments.¹⁴ To Catholics this seemed like a familiar story: state-run education in Northern Ireland was effectively Protestant due to the campaigns of attrition run by various pressure groups which had taken over the bodies running the schools. The Catholic Church was also in dispute with the state over the secondary education system and had preferred independence to full state funding in that sphere also. Ethos meant more than just dogma, it also implied power. The property of the Mater was owned by the diocese. Under canon law it was not meant to

¹¹ D.C.D.A., MH.1/8, ‘Notes of conversations with staff’, Mater Infirmorum Committee report.

¹² D.C.D.A., MH.1/8, ‘Letters from staff December 1948’.

¹³ *Irish News*, 25 Sept. 1947.

¹⁴ D.C.D.A., MH.1/8, Ryan to Mageean, Nov. 1949.

be transferred to the state. The board of management of the hospital was headed by the bishop and dominated by priests and nuns from the Sisters of Mercy. There was no appetite to transfer this to a Hospital Authority answerable to an apparently hegemonic Unionist government. In his report to the archbishop, Ryan commented that their situation was 'part of the great battle of modern times, between the officialdom of the omnicompetent State and the voluntary principle of free co-operation'.¹⁵

The government was guilty of a misjudgement over the issue. The minister for health, William Grant, was a passionate supporter of the N.H.S. but was also representative of a brand of populist loyalism which had little understanding of Catholic fear or pride. He believed the hospital would capitulate, telling the Cabinet 'we need the hospital and the hospital needs the money and the status which we can give ... I would not recommend any half measures. Either the hospital comes and enjoys the full benefits or it stays out and enjoys none'.¹⁶

As was the case in many voluntary institutions across the U.K., the Mater faced a funding crisis even before the N.H.S. As we have seen, it ran a large deficit just to maintain its normal level of service. There was no room for development or even for accident. At this time the hospital's funds came from very conventional sources for a voluntary institution. One of the largest contributors was the Workers Maintenance Committee. This organized the collection of voluntary deductions from workers' wages. The evidence supports the contemporary view that this was an ecumenical undertaking. As such it was especially vulnerable to donor fatigue. The fear of a collapse in workers' contributions can be explained by two factors: first, the N.H.S. was being paid for by compulsory deductions so it seemed unreasonable to many to pay again for another hospital; second, the dispute over the Mater politicized its role and seems to have alienated many Protestants.¹⁷ This was a risk which the hospital management knew about in advance and it was addressed in Ryan's 1949 report. He also warned that many of the Mater's pre-1949 bequests had come from non-Catholics and this would most likely decline with the advent of the N.H.S. More explicitly Catholic forms of fundraising were the church collections and especially the annual Hospital Saturday Collection held throughout Northern Ireland. These also declined substantially after 1948 suggesting that donor fatigue was

¹⁵ D.C.D.A., MH.1/8, Ryan to Mageean, Nov. 1949.

¹⁶ P.R.O.N.I., CAB4/719/5, 'The Health Services Bill', memorandum by William Grant, 18 June 1947.

¹⁷ Verzan, 'A short history of the Mater Hospital' (unpublished manuscript), p. 29. The author is grateful to Bishop Walsh, retired Bishop of Down and Connor, for giving him a copy of this chapter.

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not simply sectarian. Ryan warned that unless the Mater’s needs ‘are kept constantly and forcibly before our Catholic people, a substantial falling off of legacies may occur’.¹⁸

The group which was to become the most important in the Mater’s survival was the Young Philanthropists (Y.P.). They were initially formed to organize fundraising events, but after the hospital elected to opt out of the N.H.S. more radical measures were required. They began to run football pools in December 1948. Members of the public paid a shilling a week for membership of the pools and the winners were based on English, Scottish and Welsh soccer matches. The organization was closely connected with the diocese of Down and Connor through Fr. P. J. Mullally, the secretary to the bishop. Despite that, the organization was careful to remain at arm’s length from the hospital itself. Its funds were given merely as donations and its records, wherever they may be, were not kept with those of the hospital or the diocese. The government at first threatened to shut the pools down and then decided to tax them at 30 per cent.¹⁹ The pools were also of dubious legality in southern Ireland and the sellers were prosecuted in 1953 for running an illegal lottery. The prosecution was dismissed by Mr. Justice O’Sullivan on the grounds that the pools were necessary for the Mater’s survival.²⁰

Bishop Mageean had sought direct help from the government of the Republic, requesting funds from the Irish Hospitals Sweepstake. This was not legally possible but, as Coleman discusses, there was also opposition to the Mater’s claims from sources within the state and church. A ‘high ecclesiastical authority’ complained that the Y.P. pools damaged local charities and the Department of Justice commented: ‘charity begins at home and ... the Mater Hospital has scandalously abused the toleration extended to it’. The pools were legalized in the Republic through the setting up of a Dublin-based company to administer them there.²¹

By the late nineteen-fifties the hospital was all but dependent on the Y.P. pools. This was not simply because of the decline of its other sources of income but also because of increasing costs. Before 1948 the Mater had relied on paying extremely low wages to both nurses and doctors; up until 1950 the medical staff was not paid, and after that only a small honorarium was provided. Nurses, on the other hand, were eventually brought up to the level of their N.H.S. counterparts in 1956. The 1958 accounts show that

¹⁸ D.C.D.A., MH.1, report on the Mater Hospital, Nov. 1949.

¹⁹ Verzan, ‘A short history of the Mater Hospital’, pp. 30–1.

²⁰ *Irish Times*, 7 Oct. 1953.

²¹ M. Coleman, *The Irish Sweep: a History of the Irish Hospitals Sweepstake 1930–87* (Dublin, 2009), pp. 161–3.

the Y.P. endowment fund supplied £66,111 of the Mater's total income of £111,282, or 59.4 per cent of its funds. Despite this the hospital was still in the red to the tune of £2,713. By 1963, the Y.P. fund had increased its contribution to £118,623. This was now 69.3 per cent of the hospital's annual income, but expenses had also risen and were £10,941 more than income.

The Mater was in an unexpectedly strong situation as a result of the Y.P. pools. The government had expected the hospital to come crawling into the N.H.S. effectively bankrupt. Instead, it proved capable of surviving if not exactly thriving. At the same time, attitudes on the government side had thawed a little. Grant's successor, Dehra Parker, could play the sectarian political game as well as any of her male colleagues but she was an able minister. In 1951 she presented the dilemma to the Cabinet thus: 'were it not for the services which the Mater is providing in North Belfast, the [Hospitals] Authority would certainly have to provide a hospital of its own in that area'.²² The Mater's extern department treated over 50,000 patients per year and while the majority of the in-patients were Catholics, approximately 85 per cent of the extern cases were not. Essentially the Mater was two hospitals: a Catholic establishment for intern cases and a non-denominational extern service. There was an obvious anomaly in asking taxpayers to pay for the N.H.S. when their local hospital was not part of it. More subtly, the Mater circumvented the zero-sum game of Northern Irish politics: it could not be written off as a service for the Catholic population as unionist voters also used it. How then could the government be seen to support the diverse, open Mater without also funding the more explicitly Catholic intern services, teaching hospital and the Sisters of Mercy?

There were also overtures from the Catholic side. In 1952 Dehra Parker received a letter from Archdeacon Macauley, a well-regarded priest who was trying to foster a more 'friendly atmosphere' between the government and the hospital. He compared the Mater dispute to the events of the nineteen-twenties when nationalist teachers had refused to recognize the Northern Irish government but had later accepted the situation. He was willing to explore a solution on his own initiative but believed that any compromise which satisfied him would find favour with the board of the hospital also.²³ Parker did not take him up on his offer but revealed that her department was 'in informal touch' with the Mater, and had been provided with financial information.²⁴

²² P.R.O.N.I., CAB4/861, Dehra Parker, 'Mater Infirmorum Hospital', 14 Dec. 1951.

²³ P.R.O.N.I., CAB4/861, Macauley to Parker, 11 Nov. 1951.

²⁴ P.R.O.N.I., CAB4/861, Parker to Macauley, 17 Nov. 1951.

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Table 4.1 Mater Hospital income and expenditure, 1958 and 1963²⁵

	1958	1963	% change
Income	£111,282	£171,268	+ 54
Expenditure	£113,995	£182,209	+ 59
Balance	£2,713	£10,941	
Overdraft	£123,539	£143,735	

Source: Mater Infirmorum, *Annual Hospital Reports*.

Table 4.2 Mater Hospital expenses, 1958 and 1963

	1958	%	1963	%
Provisions	£20,273	17.8	£22,878	12.6
Surgery and dispensary	£11,553	10.1	£16,908	9.3
Domestic	£1,601	1.4	£3,190	1.7
Fuel and lighting	£11,280	9.9	£15,445	8.5
Establishment	£2,704	2.4	£7374	4.0
Wages and salaries	£63,913	56.1	£109,373	60.0
Other	£2,630	2.3	£7,046	3.9
Total	£113,935		£182,209	

Source: Mater Infirmorum, *Annual Hospital Reports*.

Table 4.3 Mater Hospital income, 1958 and 1963

	1958	%	1963	%
Subscriptions	£504	0.5	£465	0.2
Donations	£3,350	3.0	£3,678	2.1
Workers' collections	£4,799	4.3	£4,205	2.5
Hospital's Saturday	£15,151	13.6	£16,786	9.8
Church collections	£5,110	4.6	£6,756	4.0
Rents and dividends	£5,526	5.0	£6,840	4.0
Y.P. endowment fund	£66,111	59.4	£118,623	69.3
Nursing institution	£277	0.2	£78	0.04
Patients' payments	£10,318	9.3	£13,867	8.1
Total	£111,282		£171,268	

Source: Mater Infirmorum, *Annual Hospital Reports*.

²⁵ P.R.O.N.I., Vivian Simpson papers, D3233, *Annual Reports of the Mater Infirmorum Hospital 1958, 1963*.

In 1955 the Tanner Committee which reviewed the Northern Irish health services explicitly recommended that the Mater be given similar terms to the disclaimed hospitals in Britain. This would result in the state paying for the use of twenty-five to thirty beds and the money would cover about 14 per cent of the hospital's annual costs.²⁶ Parker warned the Cabinet that 'strong opposition' would come from backbenchers to this, and the Cabinet agreed with her that the proposals 'could not be accepted'.²⁷ Indeed, one of the factors which continually held the government back from decisive action was its refusal to do anything too close to a general election. The Catholic Church took the Tanner Report as a hopeful sign. In a confidential memorandum priests were told that the committee had understood why the Mater had stayed out of the N.H.S., and had recommended that it be recognized as a hospital once more and should receive some acknowledgement of its contribution to health provision. There were problems with the proposal for the Catholic side too. They feared that taking patients already diagnosed by other consultants would be interpreted as a slight on their own senior doctors, that the patients would be the least valuable from a teaching perspective, and that the public might misinterpret cases where the hospital had to refuse a patient. Their view was that the 'Mater staff should receive remuneration on the same scale as their colleagues in [Northern Ireland Hospitals] Authority hospitals. The hospital should receive financial assistance commensurate with its public service [to all patients] and its outlay in the performance of these services'.²⁸ This was far more than the disclaimed hospitals in Britain received and shows a substantial gap between the public demands of the Mater's allies and their real aims. Their ideal outcome was not a state contract for use of a few beds but full state funding without state control – something they knew no Unionist government would give.

The Mater was also placed in a dilemma by the success of the pools. While the hospital's advocates still protested that it was not treated as well as disclaimed hospitals in Britain, the fact was that such a settlement was no longer suitable. There was no prospect of earning the £100,000 a year or more it needed from per capita compensation for treating N.H.S. patients. The result was a subtle shift in its supporters' campaign for recognition. The Republic of Ireland did not offer any money but it did exert diplomatic pressure via the Commonwealth Relations Office.²⁹ Meanwhile, a series of talks and pamphlets by Fr. Michael Kelly, chaplain to the medical school

²⁶ D.C.D.A., MH.1, memorandum, 'Confidential to priests' [1955].

²⁷ P.R.O.N.I., CAB4/974, Cabinet minutes, 24 May 1955.

²⁸ D.C.D.A., MH.1, memorandum, 'Confidential to priests' [1955].

²⁹ P.R.O.N.I., CAB9/C/67/7, F. H. Boland, 'Memorandum', 15 Aug. 1951.

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at Q.U.B., articulated an argument for the Mater based more on issues of practice and ethos than governance and property. He asserted that the running of hospitals was a historic right of the church and that a Catholic hospital was essential in Northern Ireland. Even if the government were to offer guarantees of its ethos, ‘we should be slow to accept it unless some power of selection or veto was vested in the Bishop’.³⁰ The hospital also had requirements as to the ‘moral character’ of its nursing staff. Kelly went into most detail about the need for a Catholic teaching hospital. He identified two areas of concern: that students in conventional teaching hospitals could lose their faith; and that they should not see ‘immoral operations’, but be shown alternatives.

What Kelly was demanding was therefore very different from disclaimed status. He compared it to the position of Catholic schools. The state would pay some or all of the hospital’s running costs while the existing board would continue to pay for capital expenditure. This represented a radical change from the model previously proposed and was most likely a negotiating position. However, it had considerable logic in the Northern Irish context, where the state already paid part of the costs of Catholic voluntary schools while fully funding the state sector, which was effectively Protestant. That agreement had emerged from a long and acrimonious battle in the inter-war years and no Unionist government could simply have agreed to such terms for no return. By contrast, the disclaimed hospitals in Britain were paid the actual weekly cost of the beds used and little N.H.S. out-patient work was done in them.³¹ Therefore, while the Mater’s advocates made numerous references to the hospitals in Britain and appeared at times to be demanding parity with them, in fact they needed a much more comprehensive restructuring of the hospital’s relationship with the state.

Perhaps the best summary of the government’s policy was offered by William Morgan, the minister for health and local government, in 1962 when he told the Cabinet that the hospital had previously rejected a contractual settlement and ‘while it was unlikely that their views had changed, the possibility of acceptance could not be ruled out. The Minister felt therefore that it would be unwise of the Government to open the question’.³² While both sides needed each other, the status quo could work, at least temporarily, and there were enormous political and legal problems to be overcome.

³⁰ M. Kelly, *Why?* (Belfast, 1954), p. 12.

³¹ P.R.O.N.I., Simpson papers, D3233, A. R. Akers (assistant general secretary, Confederation of Health Service Employees) to W. J. Jackson (Labour Party), 16 Jan. 1964; Mrs. M. Albert (intelligence officer, Ministry of Health) to Howard Glennerster (Labour Party), 7 Feb. 1964.

³² P.R.O.N.I., CAB4/1197, Cabinet minutes, 3 July 1962.

The accession to power of Terence O'Neill saw a shift in government policy towards Catholic grievances. O'Neill hoped that a change of tone and the fruits of economic growth could reconcile Catholics to the Northern Ireland state and maintain his party's control of it. Nationalist and Northern Ireland Labour Party politicians regularly put down motions calling for government money to be given to the Mater. One of these, tabled for February 1964, allowed O'Neill's Cabinet to reconsider its attitude. In April 1963 the government had approved a deal to provide funds to the Belfast Charitable Society for their home in Clifton House. If the Mater were to demand the same for its own facility in Beechmount the government would have no grounds to refuse. The chief whip confirmed that although the majority of Unionist M.P.s opposed any aid to the Mater, a minority could accept a contractual arrangement for accident and emergency services. A decision was taken that 'no financial support should be given to the Mater but that the refusal should not be expressed in too intractable terms'.³³

On 18 February 1964, Morgan spoke on the nationalist motion. He dismissed the whole concept of a Catholic hospital, arguing that there were no explicitly Protestant ones. He rejected the British disclaimed model as a solution and argued that the real problem was the risk that the Mater would become 'a minor medical backwater' due to its isolation. To most observers it seemed to be a typical piece of rhetoric from a Unionist minister. Nationalist members protested loudly at the perceived insult. Bishop Philbin of Down and Connor, however, having procured a copy of the speech for study, underlined a sentence towards the end in which the minister offered that should the hospital join the N.H.S., 'it would have an honourable place and an assured future and would enjoy all the benefits of partnership and association with other hospitals in the state service without suffering loss of identity'.³⁴ Philbin wrote to O'Neill and Morgan asking exactly what this meant. Informal discussions between officials were arranged which revealed that the hospital board was open to negotiating entry to the N.H.S. under certain conditions. Morgan thought they showed 'a marked change of attitude on behalf of the Hospital and ... render it feasible to negotiate for a settlement'. His presentation of this news to his Cabinet colleagues showed a change of attitude on the government's part as well, if only in private. The attorney general had advised him that the protections for a hospital's ethos in the 1948 act were considerably weaker than 'described by successive Ministers

³³ P.R.O.N.I., CAB4/1253, Cabinet minutes, 22 Jan. 1964.

³⁴ D.C.D.A., MH1.8, 'Typed copy of minister's speech', 18 Feb. 1964.

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of Health over the years’. He now proposed changes to the act to provide protections for the Mater’s denominational identity. He also suggested that the transfer of the Mater to the N.H.S. be subject to defeasance if the authorities failed to observe the promised safeguards. The proposal, like many pursued by O’Neill’s government, was as concerned with image as practicality. Morgan suggested that it would ‘end a long-standing grievance which has been used as propaganda to our detriment for many years. If the [Mater] board of management decline entry on this basis it would equally and finally dispose of the alleged injustice’.³⁵

The negotiations for the Mater’s entry into the N.H.S. continued for years. Both sides bargained for the maximum they could get. Both were also under real pressure for a deal: the government risked being outflanked among moderate Protestant voters by Labour, which had always supported the Mater and needed to show the government in Britain that it was serious about reform; the Mater needed investment and security, which the state could offer. By 1967 an outline of terms was in place which was far more favourable than could have been imagined just a few years earlier. This evolved over the following two years into a comprehensive settlement. The Mater would have its own Hospital Management Committee (H.M.C.) with fifteen members, of whom the bishop would nominate twelve; in return he did not seek control of other appointments and accepted that Protestants could be appointed to the H.M.C. Staff appointments were to be considered part of the character of the hospital, implying that doctors hostile to its ethos would not be brought in. The buildings would be transferred to the state by means of a long lease and could revert back if the state defaulted on its obligations. The assets of the Mater Hospital Trust, valued at £3 million, were a sticking point as the state would be taking over all of the hospital’s expenses and this could have made the Mater the richest hospital in Northern Ireland. It was agreed that the income from the fund would pay for the renovation of the hospital.³⁶ This was the basis for the final settlement but discussions continued over the long-term role of the hospital. The board of management wanted promises that the maternity unit would be extended. Both sides agreed that it needed renovation urgently but the government saw the issue as a test of whether the Mater was serious about integrating into the Belfast hospital system, which had enough maternity beds. In March 1969 negotiations almost broke down

³⁵ P.R.O.N.I., CAB4/1268, Cabinet minutes, memorandum by the minister of health and local government, ‘National Health Services, position of the Mater Infirmorum Hospital’, 21 May 1964.

³⁶ P.R.O.N.I., CAB4/1419, Cabinet minutes, ‘Mater Hospital: progress of negotiations, report by the minister for health and social services’ [Nov. 1968].

over just sixteen maternity beds: the board of management wanted forty but the government demanded the figure stay at twenty-four.³⁷

By this time the optimism of O'Neill's early term was forgotten and his premiership was under threat. He resigned in May 1969, a month before Philbin accepted the terms for the Mater in principle. The enormous complexity of the legal documents required a long period of preparation, as did discussions with the staff.³⁸ O'Neill's successor, James Chichester Clark, presided over a Cabinet struggling to control the region as the Troubles erupted. The issue of the Mater was becoming part of a bygone age when parliamentary speeches rather than street battles were the main expressions of discontent. Progress towards a settlement had gained enough momentum to keep going and the full terms of the agreement were presented to Cabinet in January 1971. The Mater would be transferred to the state on a 999-year lease, its denominational character would be safeguarded and the deal was to be legally enforced by the High Court. The Young Philanthropists would retain control of the money they had raised for the hospital, though it would be spent over the coming decades on an extensive modernization programme.³⁹ After yet another change of prime minister, the Mater entered the state system on 1 January 1972. The parliament at Stormont would last just three more months.⁴⁰

Conclusion

The Mater is an interesting case study in British healthcare as it applied in the region of Northern Ireland. First, it illustrated the powerful symbolic role that a voluntary hospital could play in an ethnic minority's construction of its own identity. The Mater offered a physical manifestation of Catholicism, a showcase for Catholic professionals and a model of the religious tolerance which Catholics believed was denied them in Belfast. These roles were not entirely compatible but it won acceptance from the local community and the medical and educational establishments. This symbolic success concealed several shortcomings in administration and financing which presented real challenges by 1948. Even without the coming of the N.H.S. it is hard to see how the Mater could have coped with the increased demand for and cost of medical treatment in the post-war world. Given the sectarian nature of the Northern Irish political system any state role would have been problematic.

³⁷ P.R.O.N.I., CAB4/1432, memorandum by minister of health and social services [W. K. Fitzsimons], 21 March 1969.

³⁸ P.R.O.N.I., CAB4/1506, memorandum by Fitzsimons, 25 Feb. 1970.

³⁹ P.R.O.N.I., CAB4/1580, memorandum by Fitzsimons, 'Mater Hospital', 23 Dec. 1970; Cabinet minutes, 29 Jan. 1971.

⁴⁰ P.R.O.N.I., CAB4/1628, Cabinet minutes, 30 Nov. 1971.

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The Mater also demonstrates some of the problems inherent in the British approach to devolution. The welfare state envisages a benevolent and neutral government which makes decisions in a rational, fair way. This assumes a degree of national unity which Northern Ireland did not possess. Instead, the Catholic minority did not have the trust in the state which the system required. They were behaving entirely rationally in this regard as the Northern Ireland Hospitals Authority and the various hospital management committees were dominated by Protestant unionists. The government’s intransigence made the situation worse but the problem was inherent in the assumptions behind the devolution of the British state model to a divided society.

Finally, to address the question ‘why have a Catholic Hospital at all?’, it is important to recognize that the ‘Catholicism’ at issue was not merely doctrinal. Scholars have long argued that religion in Northern Ireland is an ethnic signifier rather than just a set of beliefs. The hospital’s Catholicism was in part about ethics and procedures but it is interesting how little space these took up in the debate. Instead ownership and identity dominated discussions. The desire to preserve ‘our’ hospital from ‘them’, on the one hand, and to deny ‘our money’ to ‘their priests’, on the other, was the real crux of the matter. By the time a settlement was reached, the unionist political system was in crisis and ministers were desperate to find reforms which could pacify the British government and the civil rights activists.

5. Cottage hospitals and communities in rural East Devon, 1919–39

Julia Neville

Recent studies of the changing pattern of hospital care in the U.K. between the wars have not so far taken account of the role of ‘cottage’ or ‘G.P.’ hospitals, except in the general context of the overall voluntary hospital movement, even though some assessments of the total number of beds in the nineteen-thirties suggest that as many as 12,000 of the 73,000 hospital beds were located in cottage hospitals.¹ Cherry’s 1992 article, ‘Change and continuity in the cottage hospitals c.1859–1948: the experience in East Anglia’, remains the most robust assessment of cottage hospital history.² For rural and semi-rural communities and their G.P.s, cottage hospitals were an important resource for care and treatment, and their place in inter-war hospital history requires closer examination, as Doyle has suggested, to develop our understanding of ‘the mixed economy [of hospital provision], especially at the local level’.³ This essay uses a case study of the cottage hospitals in East Devon to explore a significant facet of this mixed economy.⁴

Within the study a particular focus is the change in the use of and support for the hospitals within their local communities. This encompasses the question posed by Gorsky, Mohan and Powell in 2002 about the extent of ‘the reorientation of the hospital towards the middle class’ in inter-war

¹ M. Emrys-Roberts, *The Cottage Hospitals, 1858–1990* (Motcombe, 1991), p. 157.

² S. Cherry, ‘Change and continuity in the cottage hospitals, c.1859–1948: the experience in East Anglia’, *Medical History*, xxxvi (1992), 271–89. Other relevant studies include Emrys-Roberts, *The Cottage Hospitals*, n. 1; H. C. Burdett, *The Cottage Hospital: its Origin, Progress, Management and Work* (1877); R. M. S McGonaghey, ‘The evolution of the cottage hospital’, *Medical History*, xi (1967), 128–40; J. Hall, ‘From cottage to community hospitals: Watlington Cottage Hospital and its regional context, 1874–2000’, *Local Population Studies*, lxxxviii (2012), 33–49. There are also numerous histories of individual cottage hospitals.

³ B. M. Doyle, ‘Competition and collaboration in hospital provision in Middlesbrough, 1918–48’, *Medical History*, li (2007), 337–56, at p. 339.

⁴ The public hospital sector of Devon’s mixed economy has already been explored in J. Neville, ‘Explaining local authority choices on public hospital provision in the 1930s: a public policy hypothesis’, *Medical History*, lvi (2012), 48–71. This complements the present study.

Britain.⁵ This essay explores that reorientation by considering changes in demand for local hospital care, generated by demographic, social, clinical and technological change, and the way in which these drove the expansion of cottage hospital facilities and services. McCarthy's recent reassessment of inter-war associational voluntarism⁶ sees this period as one when the divisions within community associations based on gender, class and denomination were breaking down. The study specifically reviews evidence for such changes in community stakeholder involvement in the cottage hospitals.

Context for the study

The first cottage hospital is generally considered to be that established in Cranleigh, Surrey, in 1859. By 1918 there were about 300 cottage hospitals in the U.K., and the concept of small hospitals with G.P.s acting as medical officers for their own patients had an accepted place in the range of hospital provision available, not just in the U.K. but also, for example, in New Zealand and Canada.⁷ The distribution of cottage hospitals in the U.K. was variable. While Cherry found no more than twenty-one in the whole of East Anglia, the South-West was one of the best provided regions, with seventy-five identified in the 1941 Ministry of Health survey.⁸ Twenty-four of these were located in Devon. Like those in East Anglia, they were principally based on market towns serving a rural hinterland, or on the coast. Pickstone noted a similar market town focus in rural Cheshire.⁹ Figure 5.1 demonstrates the high percentage of hospitals in Devon and Cornwall with fewer than twenty beds.

The present essay is based on a case study of the five cottage hospitals in the East Devon towns of Axminster, Sidmouth, Ottery St. Mary, Budleigh Salterton and Exmouth.¹⁰ The towns lie south-east of the county

⁵ M. Gorsky, J. Mohan and M. Powell, 'The financial health of voluntary hospitals in inter-war Britain', *Econ. Hist. Rev.*, lv (2002), 533–57.

⁶ H. McCarthy, 'Associational voluntarism in interwar Britain', in *The Ages of Voluntarism: how we got to the Big Society*, ed. M. Hilton and J. McKay (2011), pp. 47–68.

⁷ As described in D. A. Dow, *Safeguarding the Public Health: a History of the New Zealand Department of Health* (Wellington, 1995); G. S. Lawson and A. F. Noseworthy, 'The cottage hospitals of Newfoundland', *Canadian Bulletin of the History of Medicine*, xxvi (2009), 477–98.

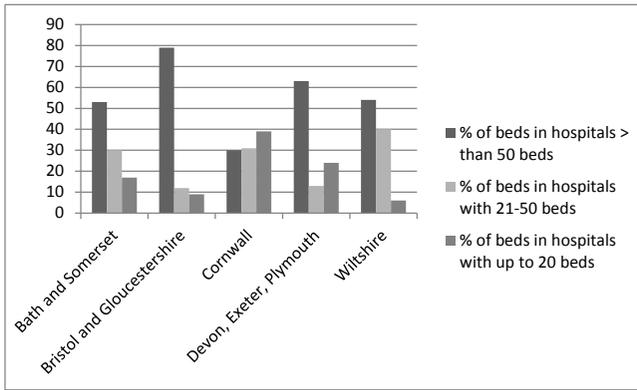
⁸ Cherry, 'Change and continuity', p. 289; Ministry of Health, *Hospital Survey: the Hospital Services of the South-Western Area* (1945).

⁹ J. V. Pickstone, *Medicine and Industrial Society: a History of Hospital Development in Manchester and its Region, 1752–1946* (Manchester, 1985), p. 264.

¹⁰ Two further East Devon towns, Honiton and Seaton, had no cottage hospital, although Honiton had a workhouse infirmary.

Cottage hospitals and communities in rural East Devon, 1919–39

Figure 5.1 Distribution of hospital beds in the South-West by size of hospital, 1938¹¹



town of Exeter, the site of the principal local voluntary hospital, the Royal Devon and Exeter Hospital (R.D.&E.H.). Exeter was thirty-two miles from Axminster, the most easterly of the East Devon towns. In the inter-war period, this was primarily an agricultural area, cultivated by tenant farmers holding land from substantial landowners such as Lord Clinton, Devon’s largest landowner, and from minor gentry. There was some fishing and shipping on the coast, minor industrial enterprises, such as the paper mill at Ottery or the cider factory at Whimble, and a growing holiday and retirement trade. The main trunk road from Exeter to London, the A30, passed through the north of the area and the main road between Exeter and Lyme Regis a few miles further south.

The cottage hospitals in East Devon had all been founded in the final quarter of the nineteenth century: Axminster, Exmouth and Ottery by individual philanthropic ladies, Sidmouth by a consortium of philanthropists, and Budleigh Salterton as the town’s commemoration of Queen Victoria’s golden jubilee. By the First World War all were run by a Management Committee elected by the subscribers under the overall governance of a set of trustees. The number of beds at each hospital was eleven at Axminster, thirteen at Ottery, fourteen at Sidmouth, sixteen at Budleigh Salterton and sixteen at Exmouth.¹² A short-lived attempt had been made by a group of philanthropists to establish a ‘district nursing home’ in Honiton in 1905. By 1913 it was running at a loss and had to close.¹³

¹¹ Ministry of Health (1945).

¹² Figures taken from the Voluntary Hospitals Database <<http://www.hospitalsdatabase.lshm.ac.uk>> [accessed 8 Jan. 2014].

¹³ *WT*, 12 Aug. 1913.

Hospital catchment areas were based on parishes, although the absence of a cottage hospital in Honiton meant that some parishes, such as Honiton itself, were not formally covered. In practice patients from these parishes might be admitted for hospital care at Ottery, although they were more frequently referred to the R.D.&E.H.¹⁴

The administrative sources available for this case study are the surviving annual reports of the hospitals concerned and of the R.D.&E.H., minutes of local boards of guardians and the County Council Guardians' Committee minutes. Annual reports available at the Devon Heritage Centre consist solely of those deposited by the Charity Commission. There are none for the relevant period for Axminster; for Budleigh Salterton those deposited are for 1923, 1925, 1926, 1927 and 1933; for Exmouth those for 1923, 1927, 1928, 1931–7 and 1939; for Ottery those for 1923, 1924 and 1926–8; and for Sidmouth only that for 1923. No other documentation for the hospitals in this period has yet been traced.

These administrative sources are supplemented by accounts in local newspapers, used with the caution always necessary when interpreting journalists' reports. The three daily newspapers covering local issues in the period were the *Devon and Exeter Gazette*, *Western Morning News* and *Western Times*. Dawson¹⁵ has demonstrated the convergence during the nineteen-twenties of points of view in these once distinctly liberal (*W.T.*) or Conservative (*D.E.G.*, *W.M.N.*) papers, and the overall impression of coverage is that it was more dependent on the availability of local journalists to investigate stories than any specific editorial policy on coverage of cottage hospital issues. Coverage of Exmouth in the *D.E.G.* and of Sidmouth in the *W.T.* is fuller than that of other places.

The changing demand for local hospital care

In 1919 hospitals and local communities took stock of the impact of the First World War. At Sidmouth, Exmouth and Uplyme (close to Axminster) there had been first-line Red Cross auxiliary hospitals. Their closure allowed the recycling of some of their equipment to the cottage hospitals; the transfer of the Sidmouth X-ray plant enabled the establishment of this service for the first time.¹⁶ For the cottage hospitals at Axminster and Ottery, where soldiers had been sent for care, there was a loss of the income paid to them by the

¹⁴ In 1937 the R.D.&E.H. recorded 83 admissions from Honiton but only 16 from Ottery, a town of comparable size (Devon Heritage Centre, 1260F/HA/16, *Annual Reports of the Royal Devon and Exeter Hospital, 1936–8*).

¹⁵ M. Dawson, 'Party politics and the provincial press in early 20th century England: the case of the South West', *Twentieth Century British History*, ix (1998), 201–18.

¹⁶ *W.T.*, 11 March 1920.

War Office. The hospital committees expected to return to their pre-1914 levels of activity, and their major concerns were financial, as they recognized the increase in wages and other items of expenditure and the static or falling nature of their income. None of the early post-war committees appears to have predicted growing demand. The expectation was probably that the cottage hospitals would continue their original function of nursing the sick poor, treating domestic and occupational accidents and undertaking some surgical procedures.

Demand in East Devon, however, rose inexorably across the period. Table 5.1 shows the increase in inpatient admissions across the two decades 1919–38. Outpatient activity also rose, although the information is more patchy. The major drivers for this were demographic, social, and clinical or technological change. The demographic change that put the greatest pressure on East Devon cottage hospitals was the growth in population, primarily caused by immigration from other areas. The population of Devon overall increased by only 3 per cent between 1921 and 1931, and the growth in England and Wales was only 5.4 per cent. The population in the catchment areas of the East Devon hospitals grew, as shown in Table 5.2, by over 10 per cent, chiefly along the coast. Even had there been no other changes, the cottage hospitals would have needed to expand to keep pace with population growth. Unsurprisingly waiting lists and problems over access to beds were increasingly reported in the nineteen-twenties.¹⁷

Table 5.1 Inpatient admissions to East Devon cottage hospitals, 1919–38¹⁸

Inpatient admissions	1919	1929	1938	Increase in admissions, 1919–38
Axminster	65	199	278	+427%
Budleigh Salterton	61	136	290	+432%
Exmouth	189	241	447	+236%
Ottery St. Mary	121	140	178	+147%
Sidmouth	153	210	411	+268%

¹⁷ Sidmouth (*D.E.G.*, 2 March 1921, 11 March 1926); Ottery (*D.E.G.*, 23 Jan. 1924); Axminster, *W.T.*, 22 June 1928); Exmouth (*D.E.G.*, 1 Aug. 1928); Budleigh (*D.E.G.*, 10 Jan. 1929).

¹⁸ Voluntary Hospitals Database <<http://www.hospitalsdatabase.lshtm.ac.uk>> [accessed 8 Jan. 2014].

Table 5.2 Demographic change in East Devon, 1921–31

Catchment area	Population, 1921 census	Population, 1931 census	Population change, 1921–31
Axminster	12,800	14,000	+9.3%
Budleigh Salterton	4,500	5,200	+15.5%
Exmouth	23,200	25,500	+9.9%
Ottery St. Mary	9,500	9,900	+4.2%
Sidmouth	7,300	8,500	+16.4%

Within the context of overall population growth, there were three principal social changes that drove the additional demand on cottage hospitals. First, the development of the East Devon area as a retirement destination meant that the populations included increasing numbers of people requiring end-of-life care. Respiratory disease was a leading cause of death among elderly people, and hard to treat in the days before antibiotics. The cottage hospital provided a better environment for the patient than many homes or retirement boarding houses.

The second change was increasing demand from those who, before the war, were unlikely to have considered admission to a cottage hospital established for 'poor persons'. Cherry estimated that in the late nineteen-twenties about 10 per cent of patients paid the full charge in Beccles, Gorleston and North Walsham hospitals.¹⁹ In East Devon the numbers of 'private patients' increased at all the local hospitals, evidenced by the income yielded from the private wards. The public wards too saw more patients in middle-class occupations. For example, an analysis of the occupations of patients whose deaths in Axminster Hospital (excluding those who died from accidents) were reported in the newspapers, shown in Table 5.3, gives an indication of use by a broad section of the community, from labourers to the middle-class schoolteacher or farmer and on to doctor and gentlewoman. References elsewhere show use by the clergy, such as the vicar of Ottery, who later paid tribute to the quality of the care he had received.²⁰ Deaths in the coastal towns illustrate the relatively affluent retired population, such as retired army officer Brigadier-General Charles Compton and retired businessman Mr. Keep, 'younger son of a Birmingham manufacturer', keen sportsman and a leading member of the Conservative Association, both of whom died in Budleigh Salterton Hospital.²¹

¹⁹ Cherry, 'Change and continuity', p. 284.

²⁰ *D.E.G.*, 27 July 1928; *D.E.G.*, 17 Dec. 1931; *W.T.*, 18 Aug. 1933, 2 March 1934.

²¹ *D.E.G.*, 24 Nov. 1933; *W.T.*, 26 Oct. 1928.

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Table 5.3 Social/occupational status of patients who died in Axminster Hospital, 1919–38

1919	G.P.
1921	Son of mayor of Lyme Regis
1925	Postman
1927	Railway ganger foreman
1929	Sister of Roman Catholic priest
1930	Clerk
	Domestic servant
1931	Farmer
1932	Wife of retired farmer
	Farm labourer
1933	Teacher at council school
	Publican, former policeman
1934	Wife of chairman of Axminster Urban District Council
1935	Labourer
	Retired blacksmith and local preacher
1938	Hairdresser
1939	Elderly gentlewoman
	Widow of landowner (collapsed in town)

The third change in the social environment that put extra pressure on inter-war hospitals was the rise in the number of motor traffic accidents. *The Lancet*, reflecting in 1931 on the changing nature of cottage hospital work, suggested that motoring had changed the profile of the cottage hospital and that ‘Nowadays any cottage hospital is liable to have to handle dangerous accidents, fractures and the like, involving the highest skill in general and orthopaedic surgery’.²² Hospitals close to main roads, such as Axminster or Ottery, were particularly liable to be called upon for the treatment of patients involved in accidents. These increased demand for beds and also for medical and nursing time. Dr. Thomas (Exmouth) said in 1927 that: ‘A quarter of the total admissions to the Hospital during the past year had been accident cases, and the public did not realize the enormous amount of work that meant. An accident case would sometimes occupy two or three men for four or five hours, for it was the surgical work that was so heavy’.²³ Many of these cases,

²² Leader, *The Lancet*, ccxviii (27 June 1931), 1410.

²³ *D.E.G.*, 3 Aug. 1927.

particularly the head injuries, were beyond the skills of cottage hospital medical officers or even of visiting consultants, but their long hospital stays consumed resources. The 1922 *Annual Report* for Budleigh Salterton referred, for example, to the case of a patient with a fractured skull who required ‘constant day and night attention for seven weeks, and this case cost the hospital for a special nurse over £23’.²⁴ After the Road Traffic Act of 1930 insurance companies were required to pay hospitals for the treatment of injured patients,²⁵ but hospitals did not consider the payments adequate. The British Medical Association estimated that hospital payments only covered one-seventh of the costs of in-patient treatment of motor accident cases in 1931.²⁶ Nor did the act do much to reduce the numbers of deaths and accidents.²⁷

Emrys-Roberts described the changes in the practice of medicine in the inter-war period, insofar as they affected cottage hospitals, as ‘relatively gentle’, with the ‘dramatic exception’ of the development of X-ray services.²⁸ However, the post-war generation of doctors had new skills, learned during the war or their recent training. Dr. Kenneth Lane, a G.P. in Radstock, Somerset, described the role of the G.P. in the nineteen-thirties: ‘We were general and orthopaedic surgeons, physicians, obstetricians, gynaecologists, and pathologists ... did our own blood transfusions’.²⁹ As Dr. Charles Flemming, a leading advocate of cottage hospitals, pointed out: ‘We must remember that it often happens that what was the work of the specialist yesterday is that of the general practitioner to-day’.³⁰

Honigsbaum suggested that ‘the efficiency of cottage hospitals tended to be gauged by the number of operations they performed’, quoting Flemming’s view that this was because ‘the results of surgery are generally more immediately manifest, more dramatic, than are those of medical treatment’.³¹ The traditional nursing home, lacking operating theatre, X-ray provision and laboratory facilities, was becoming ‘obsolete’.³² Unfortunately the case registers for East Devon do not survive, but the ratio of surgical to medical procedures was certainly high. Cherry suggested from evidence at

²⁴ *D.E.G.*, 26 Jan. 1923.

²⁵ W. Plowden, *The Motor Car and Politics* (1971), p. 259.

²⁶ Plowden, *The Motor Car*, p. 271.

²⁷ Plowden, *The Motor Car*, p. 266.

²⁸ Emrys-Roberts, *The Cottage Hospitals*, p. 153.

²⁹ K. Lane, *Diary of a Medical Nobody* (1982), p. 46.

³⁰ C. Flemming, ‘Cottage hospitals’, *B.M.J.*, i, no. 3565 (4 May 1929), 177.

³¹ F. Honigsbaum, *The Division in British Medicine: a History of the Separation of General Practice from Hospital Care, 1911–68* (1979), p. 306.

³² Honigsbaum, *The Division in British Medicine*, p. 144.

Corlestone that it was 3:1,³³ and in Exmouth it grew from 101:38 in 1923 to 165:42 in 1927.³⁴

As a result of these changes there was, as Emrys-Roberts has shown, a need to keep pace with the developments in X-ray equipment, for better operating theatre provision, for laboratory facilities, and for space and equipment for ancillary treatments such as physiotherapy and electrical treatments.³⁵ These were not easy to accommodate in hospitals established in what had been intended originally as a homely environment. All the cottage hospitals in East Devon expanded their facilities during the nineteen-twenties and nineteen-thirties.

Nationally there were enough proposals for a manual to be produced in 1930 on the planning, construction and equipment requirements of cottage hospitals, co-authored by an engineer, an architect and a surgeon.³⁶ Their perception of a cottage hospital (defined as a hospital with fewer than 100 beds) was that it was ‘a “first-aid” station for all minor complaints, for serious accidents or acute surgical emergencies’ and that ‘the life of the hospital revolves round two suns, the Matron’s Room and the Operating Theatre’.³⁷ Table 5.4 provides a schedule and chronology of the developments at the hospitals in East Devon and indeed shows improvements to operating theatre and staff accommodation in all five towns. By 1939 Ottery was the only one with no X-ray department. The most extensive developments took place in the seaside towns, where, as Table 5.2 illustrates, the population increase was greatest. There were fewer developments at Axminster and Ottery; in fact Axminster did not expand its in-patient provision at all. The plan to do so had still not reached the funding target when the Second World War broke out.

³³ Cherry, ‘Change and continuity’, p. 279.

³⁴ D.H.C., 3761R/0/A/152, annual reports for Exmouth Cottage Hospital, 1922–3 and 1926–7.

³⁵ Emrys-Roberts, *The Cottage Hospitals*, pp. 161–6.

³⁶ F. M. Du-Plat-Taylor, J. Coleridge and J. Johnston Abraham, *Cottage Hospitals* (1930).

³⁷ Du-Plat-Taylor and others, *Cottage Hospitals*, pp. 36–7.

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Table 5.4 Extensions and developments at the East Devon cottage hospitals, 1919–39

	Axminster	Budleigh	Exmouth	Ottery St. Mary	Sidmouth
	11 beds (1919)	Salterton 9 beds (1919)	16 beds (1919)	13 beds (1919)	14 beds (1919)
	11 beds (1939)	26 beds (1939)	36 beds (1939)	18 beds (1939)	27 beds (1939)
1919					X-ray equipment
1923		New operating theatre			
1924				Second bathroom; staff rooms upgraded; gas apparatus for use in minor operations	
1926			X-ray equipment upgraded		
1927	'New Room', probably related to massage/ electrical treatment	More adult beds			
1930	New operating theatre	X-ray equipment			
1931	X-ray equipment		More adult beds; operating theatre suite; children's ward; outpatients' department; X-ray suite; staff rooms		More adult beds; maternity and children's wards; outpatients' department; operating theatre suite

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1932	More adult beds; private wards; staff rooms; out-patient room; masseuse room/ electrical department		
1933	Lift	X-ray equipment upgraded; night staff rooms	
1936			Staff rooms
1938		Extra private wards; staff room	Extra staff rooms; diathermy apparatus
1939	Open-air balconies; staff rooms; extra private wards		

In addition to the expansion of existing hospitals, other initiatives to create new beds were pursued. A G.P. in Honiton pressed the case for a local hospital in 1919.³⁸ His idea was opposed by those who recalled the failure in 1913, but it did lead to an initiative by the Honiton guardians to open the workhouse infirmary to non-pauper patients, at least for medical and maternity care.³⁹ A proposal was also developed to establish a cottage hospital in the seaside town of Seaton. G.P. advice in the early nineteen-twenties had been that this was unnecessary given the availability of nursing home provision and the R.D.&E.H. only ten miles away.⁴⁰ In 1934, however, the proposal was revived following discussions between local G.P.s and the chairman of Seaton Urban District Council, and an active planning and fundraising process began, still under way at the start of the Second World War.⁴¹

Alternative methods of meeting demand might have been to collaborate with other hospital providers. Consultants from the R.D.&E.H. provided

³⁸ Exchange of correspondence in *D.E.G.*, 24, 29 Sept. 1920.

³⁹ D.H.C., P.L.U. Honiton, 5, 6 Aug. and 3 Sept. 1921.

⁴⁰ *W.T.*, 21 Jan. 1919; *D.E.G.*, 26 June 1919; *D.E.G.*, 5 Nov. 1919.

⁴¹ *D.E.G.*, 29 March 1934; *W.T.*, 28 July 1939.

honorary services at the cottage hospitals too, and as their numbers grew, so more of them came onto the cottage hospital lists.⁴² There was a Devon Voluntary Hospitals Committee (D.V.H.C.), established in 1921 following the national Voluntary Hospitals Committee (the Cave Committee), on which the cottage hospitals in East Devon had a representative.⁴³ This was intended to prepare plans for co-ordinated development of hospitals. The D.V.H.C. did carry out two surveys of hospitals, in 1924 and 1927, and reported that the new schemes in hand would generate sufficient additional capacity. No analysis of future demand was undertaken and, beyond approving the establishment of the Exeter and Western Counties Hospital Aid Society, no attempt was made to ensure that income would be sufficient to meet the additional costs.⁴⁴ The committee of the R.D.&E.H., struggling to meet demand itself, was aware of the potential of the cottage hospitals to provide follow-on care for their patients,⁴⁵ and indeed was reminded of it by the Ottery Committee in 1924.⁴⁶ In practice it rarely seems to have happened.

Relations between the guardians and the cottage hospitals were generally straightforward. Cottage hospitals would sometimes transfer pauper patients to workhouse infirmaries, particularly if they were considered likely to need longer-term care, but this only happened infrequently.⁴⁷ None of the workhouses in the area made provision for surgery, and the workhouse medical officer referred patients to cottage hospitals for treatment when necessary.⁴⁸ For this the guardians paid a charge (less than the actual cost); and they also made an annual donation. The level of donation varied between boards of guardians and, when Devon County Council assumed control of Poor Law services in 1930, the council decided to standardize practice, abolishing the system of donations and paying entirely on a cost-per-case basis. There is no indication that the East Devon hospitals found this disadvantageous. On one occasion early in the nineteen-twenties overcrowding in the Axminster Infirmary (the smallest infirmary serving East Devon) caused the guardians to ask for assistance from Axminster Hospital, but the hospital secretary, himself a guardian, deflected the request, saying

⁴² At Exmouth, the 1923 report lists four honorary consulting surgeons; by 1933 this had risen to seven (D.H.C., 3761R/o/A/152).

⁴³ *W.T.*, 23 Sept. 1921.

⁴⁴ *W.T.*, 20 June 1924; *D.E.G.*, 17 Sept. 1927.

⁴⁵ *W.M.N.*, 26 Oct. 1923.

⁴⁶ *W.T.*, 23 May 1924; *D.E.G.*, 17 Sept. 1927.

⁴⁷ See *D.E.G.*, 4 June 1928, for a Sidmouth case; *D.E.G.*, 4 Aug. 1933, for an Ottery case.

⁴⁸ For an example, see the case referred by Dr. Ash (D.H.C., Poor Law Union Honiton, 5, 14 June 1919).

that he had visited the ‘chronic cases’ in the infirmary and none of them was suitable for transfer, although he indicated that the hospital had taken patients from the infirmary in the past.⁴⁹ With the reorganization under the County Council, Honiton Infirmary took responsibility for Axminster patients and the pressures eased.

It appears that access to hospital care in the different parts of East Devon depended on the particular configuration of resources within a specific locality. The five cottage hospitals formed the first resource for local G.P.s immediately around them, and drew on the specialist services of their honorary consultants, whose main practice was in Exeter. In Honiton, however, with no cottage hospital, residents were generally admitted directly to hospital in Exeter, and the guardians made special provision for the use of the workhouse infirmary by non-pauper patients. These patterns were dictated by the inheritance of hospital and infirmary buildings from the past. The institutions were run by committees of voluntary members and elected guardians, whose considerable cross-membership facilitated a pragmatic approach to resource management. This was reinforced by the fact that the medical staff involved in Poor Law services were themselves usually local G.P.s. Where there was dissatisfaction with the provision available, as at Seaton in the nineteen-thirties, the movement to plan new accommodation was generated by a combination of local G.P.s and the town council, but seen clearly as the responsibility of the voluntary sector.

Community stakeholders

As Gorsky, Mohan and Powell demonstrated, the financial health of hospitals in the voluntary sector between the wars has been seen as both good and bad.⁵⁰ In East Devon both were true. At Budleigh Salterton and Ottery income almost always exceeded expenditure. In Axminster and Exmouth, by contrast, years of deficit exceeded those in balance, and at Exmouth the financial situation was so serious that in 1931, following the opening of the new buildings, the hospital had to raise a mortgage of £6,000 on the hospital property.⁵¹ Sidmouth also moved from balance to deficit in the mid nineteen-thirties after the opening of a major extension. All the hospitals, however, needed to broaden the range of sources of their income. In order to survive they had to become not merely the province of philanthropic ladies and gentlemen but institutions in which there was a wide range of community stakeholders.

⁴⁹ *W.T.*, 22 June 1923.

⁵⁰ Gorsky, Mohan and Powell, ‘The financial health of voluntary hospitals’, p. 533.

⁵¹ *D.E.G.*, 17 Feb. 1931.

In a recent study on ‘associational voluntarism’, McCarthy has put forward the hypothesis that the history of voluntary associations in the interwar period is one where the old hierarchies and divisions between classes, genders and denominations in community life were breaking down.⁵² This study of East Devon hospitals tests this hypothesis by considering evidence for change in class, gender and denomination, first, in relation to the membership and role of the hospital management committees, and then, in relation to engagement in fundraising.

The 1893 Ottery Hospital rules, reprinted in the 1918 *Annual Report*, state that: ‘The Hospital shall be under the direction of a committee of gentlemen who are subscribers’.⁵³ Other hospital rules were not as explicit in their prescription of the gender of the committee members, but nonetheless the practice was for the trustees and committee to be drawn from those who gave sizeable annual subscriptions to the hospital, usually the gentry. This overall pattern was slow to change. There were, however, signs of the decline of deference in the local communities almost immediately after the war. Hospital committees had seen an opportunity to develop their institutions from funds collected for local war memorials, but none in East Devon succeeded in winning popular support. In Budleigh Salterton the hospital proposal was rejected by a postcard poll of ‘ratepayers and ex-servicemen’.⁵⁴ In Sidmouth the hospital scheme, explicitly for an extension where ex-servicemen would have priority, only came third in the community postcard poll.⁵⁵ In Exmouth the idea of a Peace Endowment Fund for the hospital came to nothing,⁵⁶ and in Axminster the hospital only benefited from the small fund left over from the peace celebrations.⁵⁷

Local landowners remained important to the hospitals, acting as trustees, and giving a lead in subscribing or making donations. Colonel Balfour, lord of the manor in Sidmouth and hospital president throughout the period, gave land for the hospital extension.⁵⁸ Lord Clinton, president of Exmouth Hospital, was asked for land for both the Exmouth extension and the proposed hospital at Seaton. His practice was to sell land and donate a sum equivalent to half the value.⁵⁹ This approach was accepted without question

⁵² McCarthy, ‘Associational voluntarism in interwar Britain’, pp. 47–68.

⁵³ D.H.C., 3671R/o/A, Ottery St. Mary, *Annual Report of the Ottery St Mary Hospital for 1918*, p. 18.

⁵⁴ *D.E.G.*, 9, 18 July, 14 Aug. 1919.

⁵⁵ *W.T.*, 13 May 1919; *D.E.G.*, 27 Oct. 1919.

⁵⁶ *D.E.G.*, 21 May 1919.

⁵⁷ *W.T.*, 7 Sept. 1920.

⁵⁸ *D.E.G.*, 25 June 1925.

⁵⁹ *D.E.G.*, 1 Aug 1928.

by the hospitals but irked the superintendent of the St. John Ambulance Division when applied to the site for Exmouth ambulance station. He was reported in the paper as saying: ‘I call it wicked that any man who has tons of money and thousands of acres won’t give us a little site for an ambulance hall. The members are all working men and they give their time, and this is all the thanks we get’.⁶⁰

There were some signs of greater inclusivity within the hospital hierarchies. It was not just the ‘squire’ whose dominance was challengeable, but the ‘parson’. Anglican dominance of charitable institutions in rural Devon was long established. Although Rule XVII of Budleigh Salterton Hospital read ‘Patients shall have the utmost religious liberty and may be visited for religious purposes by anyone they may desire’,⁶¹ an elderly Anglican clergyman tried in 1921 to object to the appointment of the Methodist (Wesleyan) minister as an honorary chaplain. He was overruled, but it was not until 1931 that the resident Roman Catholic priest was so nominated.⁶² Other communities had been quicker to broaden their engagement: the Roman Catholic priest in Axminster and the Wesleyan minister in Exmouth had both been committee members.

Although women had played a central role in setting up the hospitals, the Ottery committee had never agreed that they could be committee members. In 1919 there was an attempt to change the rule requiring the committee to be composed of ‘gentlemen’. This was opposed by Sir Ernest Satow, a long-serving committee member, who saw no need for change: ‘he had no desire to oppose ladies being on the committee on ground of their usefulness, yet he would like to ask whether there was any cause for being dissatisfied with the way in which the hospital had been run since its foundation by a committee of gentlemen. If not, did it appear necessary to alter the constitution?’⁶³ In 1924 the proposal was again brought forward and, in spite of Satow’s continuing opposition, agreed.⁶⁴ A few months later Ottery became the only East Devon committee to appoint a woman hospital secretary during the period. She was, perhaps unsurprisingly, the daughter of the lord of the manor, the Honourable Phyllis Coleridge.⁶⁵ Elsewhere women committee members seem often to have been restricted to particular roles on the committee related to the quality of the patient experience (Ladies Visiting Committees), domestic economy (the Linen League) or fundraising.

⁶⁰ *D.E.G.*, 3 May 1930.

⁶¹ *D.H.C.*, 3716/01A/59, *Annual Report for Budleigh Salterton Hospital, 1914*.

⁶² *W.M.N.*, 8 May 1921; *D.E.G.*, 14 Jan 1931.

⁶³ *W.T.*, 31 Jan. 1919.

⁶⁴ *D.E.G.*, 30 Jan. 1924.

⁶⁵ *D.E.G.*, 10 July 1924.

Almost all committees recognized the need to encourage groups which had not previously contributed to hospital funds to do so. Lady Peek pointed out to a meeting in Axminster that: 'today a very different condition of things prevailed ... they must therefore stand shoulder to shoulder in a common brother hood ... The work of hospitals was something in which all must share according to their ability'.⁶⁶ The rural communities around the hospitals were a particular target. In 1921 the Ottery committee took the view that the rural parishes around the hospital, who made considerable use of it, should pay a greater share of the costs.⁶⁷ A similar view about lack of support from the surrounding parishes was expressed at the Budleigh Salterton A.G.M. in 1919, and care was taken to ensure that each of the villages developed its own section of the contributory scheme.⁶⁸ Contributory schemes provided an opportunity for 'wage-earners' to become more involved in the hospital's management via representation on the committee: Budleigh Salterton retained three places explicitly for the members elected by the scheme.

A radical attempt at change came from Exmouth: the decision in 1927 to dispense with 'recommends', thus removing the privilege subscribers had held of nominating a patient for hospital treatment. Henceforth the hospital would have open access. This had been agreed by the subscribers themselves, but came as a surprise to the Carnival Committee, who believed in the importance of the 'recommends' they were offered in return for their major donation to hospital funds. The hospital secretary responded to the report of their meeting in an open letter to the press, stating 'My Committee are not disposed to abandon the principle of the Open Door' and criticizing 'the system of discrimination or favouritism implied by recommends'. The Carnival Committee made no further protest.⁶⁹

Attempts to change committee membership, however, had very limited impact. An analysis of the occupations of identifiable members of the committees for the period 1934–9 as named in the annual reports, where these exist, or referred to in the newspaper reports of the A.G.M.s, was undertaken. This generated the names of fifty-seven individuals. Forty-three of these were listed in the *Kelly's Directory* for 1935.⁷⁰ Of the forty-three, seven were professionals (solicitors) or tradesmen, but thirty-five are listed in the 'Private residents' section of the directory, which covers about 10 per cent of the households of any community. The Ottery committee was the

⁶⁶ *W.T.*, 31 March 1920.

⁶⁷ *W.T.*, 31 Jan. 1922.

⁶⁸ *D.E.G.*, 25 Aug. 1919.

⁶⁹ *D.E.G.*, 2, 6 July, 12 Sept. 1929.

⁷⁰ *Kelly's Directory of Devonshire* (1935).

least heterogeneous; the Sidmouth committee the most; and Axminster was the only committee to have elected a non-gentry chair, Mr. Webster the ironmonger. This profile would be slightly mitigated if account were taken of the, usually unnamed, representatives appointed by the contributory schemes, where they existed.

It is in the range of participants in fundraising activities that the broadening of community stakeholder engagement is most clearly shown. Hayes and Doyle have recently discussed the topic of inter-war provincial medical voluntarism, concluding that although it might have been expected that the 'sense of localism' which had driven much nineteenth-century philanthropy was in decline as national homogeneity spread, charitable giving to local provincial hospitals was still flourishing between the wars, even where contributory schemes covered hospital costs for many wage-earners.⁷¹ They draw attention to the range and scale of fundraising activity as engaging wider sections of the community than the original subscribers' lists had done and their findings, related to larger voluntary hospitals, are paralleled in rural East Devon.

The amount of fundraising activity rose in all the five East Devon hospital areas from the one or two events per year shown in the pre-war annual reports to a complex pattern in which a range of different groups were engaged. The pre-1914 slightly genteel events, such as garden opening, still took place, and there is no trace of the fundraising event suggested by Du-Plat-Taylor and others, the chairman's annual dinner and fundraising speech with 'a blank cheque attached to the menu';⁷² but there were events with a wider appeal organized by groups such as sports clubs, choral and dramatic societies, and even schools. Carnivals became established as annual events, raising funds not only for the cottage hospital but for other health and welfare objects. An analysis of the organizations that raised funds in East Devon is shown in Table 5.5.

The diverse range of groups involved spanned the spectrum of class. Even the gentry might introduce a concert, or join their local Women's Institute. Carnivals (as lists of prize-winners demonstrate) and sporting events drew a wide range of supporters, and dramatic and musical societies catered for the growing middle class. Compared with those rooted in a locality or parish, the table shows relatively few occupational groups. This may be because much of the rural population was employed in small businesses, with farming as the major occupation. At the Budleigh Salterton A.G.M. in 1921

⁷¹ N. Hayes and B. M. Doyle, 'Eggs, rags and whist drives: popular munificence and the development of provincial medical voluntarism between the wars', *Historical Research*, lxxxv (2013), 712–40.

⁷² Du-Plat-Taylor and others, *Cottage Hospitals*.

Table 5.5 Fundraising organizations in the East Devon communities, 1919–39

Nature of organization	Districts in East Devon				
	Axminster	Budleigh Salterton	Exmouth	Ottery St. Mary	Sidmouth
Parish/Civic organization	Carnival Committee; Jubilee Committee	Carnival Committee	Carnival Committee	Carnival committees; Colyton Hospital Fund Committee	Carnival Committee
Leisure	Concert Party; Drama Society; Operatic Society; Whist Drive Committee	Drama League; Motor Club; Pantomime Company	Choral Society; Devonshire Association (exhibition); Drama League; Karnival Follies troupe; Lecture; Operatic Society; Pantomime Company	Football Jazz Band; Horticultural Society; Old Ottragian Society (London)	Arts Club; Choral Societies; Drama Society; Operatic Society; Pantomime Company; Town Band
Occupational	National Farmers' Union		Exmouth Fire Brigade		Sidmouth Brewery
Political			Co-operative Society; Conservative Club	Liberal Association	Co-operative Society
Religious	Anglican; Congregational	Anglican	Anglican; Baptist; Congregational; Exmouth Brotherhood; Wesleyan	Anglican; Congregational	Anglican; Congregational

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Service	Axminster Comrades	Comrades Band	Exmouth Welfare Committee of Ex-servicemen	Ex-servicemen's Welfare Committee/British Legion	Ex-servicemen Branch/Old Comrades/British Legion
Sporting	Football Club; Motor Cyclists Committee (football on wheels)	Clay pigeon shoot; mounted gymkhana	Cycling Club; pigeon shoot; pony gymkhana; Rugby Club	Badger Club; football clubs (Ottery Hospital Cup Competition); greyhound coursing	Bowling Club; Cricket Club; Football Club; Rugby Club
Welfare	Hospital Committee	Hospital Committee; Oddfellows Lodge	Blanket Club; Hospital Contributory Scheme; Hospital Committee; Royal & Ancient Order of Buffaloes (R.A.O.B.); Rotary Club; St. John Ambulance Club	R.A.O.B.; War Depot League (made useful articles)	Hospital Committee; Hospital Contributory Scheme; R.A.O.B.; Red Cross workers
Women's	Alexandra Rose Day; Women's Institutes	Alexandra Rose Day Co-operative; Women's Guild; Women's Institute	Alexandra Rose Day; Exmouth Cosmos Club; Women's Institutes; Women's Temperance Association	Alexandra Rose Day; Women's Institutes	Alexandra Rose Day; Women's Institute
Youth	Woodbury School; Young Farmers	'Golden Sunbeams' (operetta group); Church Day School; Girl Guides; Ingleside School; Junior Imperial League	Boy Scouts; Convent School; Grammar School; Secondary School; Southlands School; Y.M.C.A.	King's School Drama Society; Scouts' Football Club	Beehive School; Sidbury School

Dr. Sheild criticized the lack of support from farmers: 'One farmer told him he looked upon the hospital as a place where the servants of the gentry went for a rest when they were ill'.⁷³ Axminster actively sought to engage farmers when fundraising for its extension began at the end of the nineteen-thirties. An appeal was made at the Axminster Farmers' Union meeting, when it was calculated that about 200 farmers lived in the hospital catchment area. Both a collection scheme for donations and fundraising by the Young Farmers' Club were then agreed.⁷⁴

Evidence from the lists of church and chapel collections suggest widespread interdenominational support for the hospitals, and Anglican, non-conformist and Roman Catholic ministers all appear at various times on the hospital committees. Obligations to the sick as part of Christian teaching, manifested in church and chapel offertories, were increasingly supplemented by a sense of interdependence among citizens, accentuated by the experience of the war. It seems likely that youth group participation in hospital fundraising was part of a programme to teach active citizenship. Similar interest in promoting active citizenship may also have motivated the welfare organizations and indeed the new Women's Institutes, one of whose aims was 'pragmatic political action to improve the lot of rural women'.⁷⁵ Many of the bodies involved, such as the amateur dramatic societies or sports clubs, had no charitable objectives, or ideals of promoting citizenship, and yet became involved in raising funds. Cottage hospital support was becoming secularized.

The significance of the East Devon experience

In Cherry's account of East Anglian cottage hospitals at the same period, he found that some hospitals 'slipped back or closed'.⁷⁶ This was not the case in East Devon, an area of relatively high population growth. While there was, as Cherry puts it, 'no universal or linear path of development' among cottage hospitals,⁷⁷ there were some similarities in their trajectories. Dwarfed by the scale of the workhouse infirmaries around them,⁷⁸ they developed a particular niche in emergency and elective surgery in addition to their origins as safe places for the nursing of respiratory disease or the treatment of accidents.

⁷³ *W.T.*, 19 Jan. 1921.

⁷⁴ *D.E.G.*, 15 Jan. 1937; *W.T.*, 14 May 1937; *D.E.G.*, 1 Oct. 1937, 22 Apr. 1938.

⁷⁵ M. Andrews, *The Acceptable Face of Feminism: the Women's Institute as a Social Movement* (1997).

⁷⁶ Cherry, 'Change and continuity', p. 279.

⁷⁷ Cherry, 'Change and continuity', p. 272.

⁷⁸ T.N.A., MH 66–58, Ministry of Health Devon survey, sect. VII. Axminster Infirmary had 42 beds, Honiton 55 and St. Thomas 110.

East Devon was a very traditional part of England, where the tri-partite division of society described by Howkins of gentry, farmers and labourers⁷⁹ was still visible in many of the rural parishes, and where the foundation of cottage hospitals had been prompted by the time-honoured obligations of the gentry to do their best for the necessitous poor. Those attitudes continued to shape the management of the cottage hospitals after the First World War, as in this part of the country many of the gentry remained in place. Such stability, which was not the case in arable East Anglia, may be attributed to Devon's emphasis on dairy rather than arable farming, a less economically risky activity at this particular time.⁸⁰ The incomers, rather than seeking to change it, welcomed what they saw as a social structure rooted in tradition.

One of the manifestations of this patrician dominance was a resistance to change and in particular to the idea that 'the state' should take on responsibilities for hospital care. This was articulated in public at fundraising events or at A.G.M.s by people such as Sir Edward Cave, trustee of both Ottery and Sidmouth hospitals, who said as late as 1935: 'Many organisations are now run by the State ... but if this hospital was State-aided, what would happen? It would be fatal'.⁸¹ There was little pressure to change the system and no attempt to increase public hospital provision by the county council. Even when the chairman of the Exmouth A.G.M. in 1927 said that 'If a town was to be progressive, the first thing people should do was to help the sick and suffering' and 'called upon the town to help', he did not intend the Urban District Council to take action, but the community of citizens in a voluntary capacity.⁸²

The result of this was that the mixed economy of hospital provision in East Devon remained almost as it had been in the decade before the First World War. Public sector provision was confined to the Poor Law authorities. One of the boards of guardians widened access for medical and maternity cases to non-pauper patients, but this initiative was not extended and, when the County Council inherited Poor Law provision, it never succeeded in transforming workhouses into local government hospitals. The major voluntary hospital in the area, at Exeter, made little use of cottage hospital provision, although its administrators were aware of the potential of these local services to facilitate early discharge from their own beds. It

⁷⁹ A. Howkins, *Reshaping Rural England: a Social History, 1850–1925* (1991), p. 31.

⁸⁰ A. Howkins, 'Death or rebirth? English rural society, 1920–40', in *The English Countryside between the Wars: Regeneration or Decline?*, ed. P. Brassley, J. Burchardt and L. Thompson (Woodbridge, 2006).

⁸¹ *W.T.*, 1 March 1935.

⁸² *D.E.G.*, 3 Aug. 1927.

was accepted that local communities would raise funds for and run their own hospital provision. If expansion or new development were required, this would certainly not be prompted by the county's Voluntary Hospitals Committee but would be driven by local health entrepreneurs.

The middle class found the cottage hospitals a reassuring provision. They could join contributory schemes and provide for their own care and, as even the contributory scheme payments did not cover the costs, they could and did raise funds to help. McCarthy sees 'a democratizing logic at work in associational culture' between the wars, broadening the citizen base that supported development in local communities.⁸³ The evidence from East Devon suggests that the cottage hospitals did indeed become a focus for gradual democratization among their rural communities in the inter-war years but that, in this most conservative part of England, the process was slow and had very little effect on the power structures associated with decision-making.

⁸³ McCarthy, 'Associational voluntarism in interwar Britain', p. 67.

III. Healthcare and the mixed economy

6. The mixed economy of care in the South Wales coalfield, c.1850–1950

Steven Thompson

The mixed economy of care is an idea that many historians have utilized as a means to conceptualize the welfare system of any country.¹ It has been used to demonstrate the existence of different providers of welfare and medical services, and has served as a helpful reminder that the state was not the only or indeed the main provider of welfare and medical services in the past. Furthermore, the concept has very usefully allowed historians to conceptualize the medical and welfare provision of a country in its entirety, perhaps as a medical system, rather than to focus on particular parts of it in isolation, and it encourages us to consider the ways in which these different parts of the medical system related to each other. In the work that has deployed this concept historians and other writers have emphasized the ways in which the mixed economy of care varied, both over time and between different states, but they have not given sufficient attention to the numerous and fascinating ways in which it varied between different regions within states. Historians have failed to take account of the ways in which particular social, economic, political and cultural contexts determined the character of the mixed economy of provision in different parts of the British Isles or other countries. In fact, it might be argued that the mixed economy of care is a curiously under-theorized concept that is rarely articulated or defined carefully and so is left as a rather vague idea by which to understand the welfare and medical provision of any nation. Greater consideration of the concept is required and an approach that emphasizes regional variation is perhaps a useful one to adopt.

South Wales offers a fascinating case study to test ideas about regional variations in the mixed economy of care. Long considered one of the cradles of the British industrial revolution, the region witnessed considerable

¹ On the mixed economy of care, see *The Mixed Economy of Social Welfare: Public/Private Relations in England, Germany and the United States, the 1870s to the 1930s*, ed. M. Katz and C. Sachße, (Baden Baden, 1996); N. Johnson, *Mixed Economies of Welfare: a Comparative Perspective* (Hemel Hempstead, 1999); *Charity and Mutual Aid in Europe and North America since 1800*, ed. B. Harris and P. Bridgen (2007); *Understanding the Mixed Economy of Welfare*, ed. M. Powell (Bristol, 2007).

industrial development from the mid eighteenth century so that it became one of the power-houses of the British economy during the nineteenth.² Improvements in copper and iron production from the eighteenth century were surpassed in extent and importance by the breakneck growth of the coal industry in the second half of the nineteenth century.³ Thousands of people poured into the region, especially in the few decades before the First World War, so that it possessed over a million inhabitants by 1921.⁴ One of the iconic industries of the British industrial revolution, coalmining was marked by high levels of accident, disability and occupational disease, particularly in South Wales relative to other coalfields, not to mention environmental degradation and unwholesome living conditions.⁵ More than that, it might be argued that coalfields are places apart, characterized by their own distinctive work experiences, cultural practices, social relations and, most importantly, patterns of medical provision.

By the mid nineteenth century, the South Wales coalfield had a relatively simple mixed economy of care that was also characterized by a relative paucity of provision. In the first place, South Wales, similar to all other parts of England and Wales at that time, possessed a Poor Law medical system that, in theory at least, was subject to central scrutiny and direction. Historians of the Poor Law system after 1834, however, have long recognized that the local implementation of central policy varied enormously from one place to another and that systems of poor relief differed in character and scale across the two countries.⁶ The defining characteristics of poor relief in South Wales were, on the one hand, relatively low levels of pauperism and, on the other, an overwhelming use of outdoor rather than indoor relief as the means to assist paupers. The vast majority of paupers in South Wales,

² On the economy of South Wales, see A. H. John, *The Industrial Development of South Wales 1750–1850* (Cardiff, 1950); *Glamorgan County History*, v: *Industrial Glamorgan from 1700 to 1970*, ed. A. H. John and G. Williams (Cardiff, 1980).

³ S. Hughes, *Copperopolis: Landscapes of the Early Industrial Period in Swansea* (Aberystwyth, 2000); J. H. Morris and L. J. Williams, *The South Wales Coal Industry 1841–75* (Cardiff, 1958).

⁴ Census of England and Wales, 1921, *Preliminary report including tables of the population enumerated in England and Wales (Administrative and Parliamentary area) and in Scotland, the Isle of Man, and the Channel Islands on 19/20th June, 1921, with the population recently enumerated of certain other parts of the British Empire* (Parl. Papers 1921 [Cmd. 1485], xvi), pp. 2–3.

⁵ J. Benson, *British Coalminers in the 19th Century: a Social History* (Dublin, 1980), pp. 37–43; R. Church, *The History of the British Coal Industry*, iii: 1830–1913. *Victorian Pre-eminence* (Oxford, 1986), pp. 582–96.

⁶ Instructive here are K. D. M. Snell, *Parish and Belonging: Community, Identity and Welfare in England and Wales, 1700–1950* (Cambridge, 2006); and S. King, *Poverty and Welfare in England 1700–1850: a Regional Perspective* (Manchester, 2000).

it is clear, tended to be relieved in their homes: by 1891, for example, the Poor Law inspector for Wales estimated that out-relief accounted for almost 90 per cent of all relief dispensed by Poor Law guardians in the region.⁷ This was partly the product of a cultural belief that was evident in Wales from the eighteenth century, and that continued to be strong throughout the nineteenth and perhaps into the twentieth, that Welsh families were reluctant to admit sick family members into institutions and preferred to retain them within the home to care for them themselves.⁸ Such beliefs were also held by the guardians, who were reluctant to add to the cost of the rates, with the effect that Poor Law institutional provision tended to be relatively under-developed in the region. By 1920, the two counties of Glamorgan and Monmouthshire possessed 470 and 320 Poor Law beds respectively; the census of 1921 showed populations for the two counties of 814,717 and 358,331.⁹

The precise character of the medical provision made within this Poor Law system varied very little across the region. Each union was divided into a number of medical districts upon formation in the eighteen-thirties and medical and vaccination officers appointed to each one. The first were required to provide outdoor medical relief in his district, with one of the medical officers also made responsible for the care of sick paupers in the workhouse, while the latter were paid on the basis of each child vaccinated. As such, and in theory, a medical officer was available for consultation in every part of the region and provided care to every pauper who needed it. The provision made by Poor Law medical officers to pauper patients was relatively simple: doles or relief in kind were utilized to a large extent while 'medical' treatments largely consisted of grants of wine or other alcoholic drinks, the use of leeches, or the distribution of cod-liver oil, quinine, trusses, ointments, powders or other medicines, in addition to some minor surgery and midwifery.¹⁰ Nurses came to be appointed to workhouses from the eighteen-seventies onwards, while throughout the eighteen-nineties the

⁷ *Twenty-First Annual Report of the Local Government Board, 1891–92* (Parl. Papers 1892 [C. 6745], xxxviii), pp. 174–6.

⁸ For an early articulation of this view, see W. Davies, *General View of the Agriculture and Domestic Economy of North Wales: Containing the Counties of Anglesey, Caernarvon, Denbigh, Flint, Meirionydd, Montgomery* (1810), pp. 417–20; see also P. Michael, *Care and Treatment of the Mentally Ill in North Wales, 1800–2000* (Cardiff, 2003), p. 5.

⁹ Ministry of Health, *Second Report of the Welsh Consultative Council on Medical and Allied Services* (Parl. Papers 1921 [Cmd. 1448], xiii), p. 51; Census of England and Wales, 1921, preliminary report, pp. 2–3.

¹⁰ Glamorgan Archives, U/Pp 1/1, Pontypridd guardians minutes, 25 March 1863; *Return from Unions and Parishes in England and Wales, showing whether Guardians supply from Cod-Liver Oil, Quinine and other Expensive Medicines* (Parl. Papers 1877 (147), lxxi), pp. 10, 21.

Poor Law inspector for South Wales stressed the need for unions to aid in the formation of nursing institutions, through the payment of subscriptions, and argued that such nursing assistance would be a significant improvement on the doles paid to the outdoor sick.¹¹ Added to this, most unions in the region also paid subscriptions to voluntary hospitals and sent paupers there when more specialized care was required.¹²

It is evident that the relative paucity of institutional provision in South Wales was not made good by employer paternalism or philanthropic activity. Examples of employer paternalism can be discerned and some companies did develop systems of medical and welfare provision for their workers. At the most basic level, most employers in the coal, iron and steel industries in the region arranged for surgeons to attend their workers and their families. These were largely funded from the compulsory deductions from workers' wages but did, on occasion, have a more paternalist character as employers offered financial support for the arrangements. The manager of the Dowlais Iron Company insisted that the works' medical and sick fund only survived the cholera epidemic of 1831–2 as a result of the financial support of the company.¹³ Later, in the eighteen-fifties and eighteen-sixties, the medical scheme made a surplus each year, but this was used to make good the losses incurred on other aspects of the paternalist provision, primarily schools for workers' children, and the company found itself out of pocket each year.¹⁴

The Dowlais Iron Company was an exception, however, and constructed a far more comprehensive range of welfare schemes for its workers and their families than its counterparts in other parts of the coalfield. More generally, those mixed companies that produced iron and, later in the nineteenth century, steel in addition to coal tended to be the ones that developed welfare schemes, and were certainly more generous than those that produced coal alone. This was due to the differences between capital-intensive metal industries and labour-intensive coal concerns, the greater premium on skilled labour in metallurgical industries, the different patterns of ownership in the coal and metallurgical industries, and the greater risk, and hence greater cost, of injury, disablement and illness in the coal

¹¹ For examples, see *Twenty-Fourth Annual Report of the Local Government Board, 1894–95* (Parl. Papers 1895 [C. 7867], 1), p. 63; *Twenty-Sixth Annual Report of the Local Government Board, 1896–7* (Parl. Papers 1897 [C. 8583], xxxvi), p. 117.

¹² For examples, see West Glamorgan Archive Service, U/N 1/2, Neath guardians minutes, 2, 30 July 1878.

¹³ *Report from the Select Committee on the Payment of Wages* (Parl. Papers 1842 (471), ix), pp. 67–8.

¹⁴ Glamorgan Archives, DG/E/8/112, Dowlais Iron Company collection, Doctors Fund, receipts and expenditure, three years ending 31 March 1859; DG/E/8/113, summary of income, expenditure, profit and loss of various funds, c.1862.

industry. It is indicative, for example, that one of the most notable examples of company welfare provision in the early twentieth century was Alfred Mond's nickel refinery in the Swansea Valley, which possessed the most comprehensive and generous welfare scheme of any employer in the region and probably stood comparison with any company in Britain at that time.¹⁵

A notable instance of paternalism by a coal employer can be found in the case of William Thomas Lewis, later Lord Merthyr of Senghennydd, and his example also demonstrates that medical need was not necessarily the spur for provision on the part of employers. Lewis was the most prominent coal-owner in South Wales, at least until 1898, and a very powerful figure in the industrial politics of the region. He had come to prominence in the middle part of the century as the agent of the marquis of Bute, one of the largest landowners in South Wales on whose holdings so much of the industrial development of the area had occurred in the nineteenth century, including, importantly, Cardiff docks.¹⁶ At the same time, Lewis began to acquire his own industrial holdings and emerged as one of the leading industrialists in the region by the eighteen-seventies and eighteen-eighties. His leadership was evident in his founding of a coal-owners' association, first for the Cynon Valley in 1864, later extended to the whole of South Wales in 1871 and, crucially, of the sliding scale that came into operation in 1875 and that governed wages of all miners in the region through the rest of the century.¹⁷ Lewis was an Anglican in an overwhelmingly non-conformist region, a Conservative in a Liberal heartland, and militantly anti-trade union in a working-class district in which unionism was gaining ground.

Lewis had very definite views on welfare and medical provision for the workers of South Wales, and conceived of a range of services that were intended to meet quite particular labour relations purposes. First, he was the main instigator of the creation of the South Wales and Monmouthshire Miners' Permanent Provident Society, established in 1881. This society, similar to organizations in other coalfields, paid injury and death benefits to miners or their families and was funded by the weekly contributions of members and from donations amounting to 25 per cent of their workers' contributions from the employers who elected to make such payments.¹⁸ The

¹⁵ A. C. Sturney, *The Story of Mond Nickel* (Plaislow, 1951), p. 28; J. Goodman, *The Mond Legacy: a Family Saga* (1982), p. 135.

¹⁶ On the Butes and their support for, and profit from, industrialization in the region, see J. Davies, *Cardiff and the Marquesses of Bute* (Cardiff, 1981).

¹⁷ E. Phillips, *A History of the Pioneers of the Welsh Coalfield* (Cardiff, 1925), pp. 193–204.

¹⁸ On permanent provident societies, see J. Benson, 'Coalminers, coalowners and collaboration: the miners' permanent relief fund movement in England, 1860–95', *Labour History Review*, lxxviii (2003), 181–94.

Permanent Provident Society was established in response to the Employers' Liability Act of 1880, and despite the opposition of workers' representatives, and can be seen both as an anti-statist measure intended to discourage further statutory intervention and as a means to lessen the financial burden of injuries and deaths to employers, since workers who joined the society effectively opted out of the coverage provided by the legislation. This meant that workers largely funded their own sickness and disability benefits. The society was also intended as a means by which to undermine the appeal of trade unions, as they often offered friendly benefits as an inducement to membership.¹⁹

The Employers' Liability Act was one of the motivations for Lewis's initiatives in two other areas of welfare provision. Lewis was the main individual behind efforts to erect the Merthyr General Hospital, which was opened in 1888, and was also instrumental in the erection of hospitals at Porth in the Rhondda Fawr Valley and at Aberdare in the Cynon Valley.²⁰ He also promoted the work of ambulance brigades and associations in the region. The St. John Ambulance Association was founded in 1877, and so developments in South Wales were not isolated from broader currents in this sphere, but local factors were also important as Lewis used his influence in the Permanent Provident Society to get its board of management to encourage efforts in this direction from 1882 onwards.²¹ In the years and decades that followed, more and more branches of the Ambulance Association were established in the colliery communities of South Wales and workers were trained as 'dusty doctors' to administer first aid assistance to injured colleagues.²²

It is no coincidence that both these areas of activity, hospital promotion and the development of first-aid services in the collieries, came a short time after the passage of the Employers' Liability Act. Both forms of provision were intended to lessen the severity of permanent disability that followed accidents so as to minimize the financial costs of such disablements. Therefore, Lewis's paternalist provision was motivated not by the needs of those who required some form of assistance but rather by the desire to undermine the appeal of trade unionism, the need to minimize the liabilities incurred by injuries and

¹⁹ For evidence of this motivation, see J. E. Vincent, *John Nixon: Pioneer of the Steam Coal Trade in South Wales* (1900), p. 242.

²⁰ A. Lewis, 'The story of Merthyr General Hospital', *Merthyr Historian*, iv (1989), 105; Phillips, *A History of the Pioneers*, p. 200.

²¹ R. Cooter, *Surgery and Society in Peace and War: Orthopaedics and the Organization of Modern Medicine, 1880–1948* (1993), p. 86; *W.M.*, 7, 23 Nov. 1882.

²² The term 'dusty doctors' comes from B. L. Coombes, *I am a Miner* (Fact, xxiii, 1939), p. 74.

deaths in the coal industry, and the hope that such support would obviate the need for further statutory interventions in the future. Other motivations were at work but industrial and political considerations were foremost in Lewis's thinking and this is emblematic of the approach that coal employers took to the social and welfare needs of their workers and the communities in which they lived. Nevertheless, despite being able to point to certain examples of employer paternalism, albeit for many more reasons than for the sake of medical need alone, what is more notable is the large numbers of employers who did not make paternalist provision of any kind or else did so only in a very small way. Throughout the nineteenth century, critics of employers in the region pointed out their failure to invest adequately in social provision for the communities in which their works were situated, and such criticisms, in the coal industry at least, were only to increase in the early decades of the twentieth century, most notably during the investigations carried out by the Sankey Commission just after the First World War.²³

As far as philanthropy is concerned, the coalfield was similarly characterized by a marked paucity of activity. In a sense, this was the product of the particular nature of coal communities in South Wales. In the majority of cases, and in contrast to certain other coalfields, the colliery villages of South Wales were mono-industrial communities with very simple social structures in which workers formed the overwhelming majority of inhabitants and were joined only by a small number of shopkeepers, a few teachers, ministers and doctors, and a handful of colliery officials and managers.²⁴ In certain Urban District Council areas of the central part of the coalfield, 50–70 per cent of all working males enumerated by censuses in the late nineteenth and early twentieth centuries were miners and such proportions would have been even higher in colliery villages.²⁵ In this context, with the absence of a large elite

²³ See, e.g., *W.M.*, 2 Sept. 1874, p. 5; *W.M.*, 12 June 1883, p. 2; *M.E.*, 26 Feb. 1881, p. 5; *M.E.*, 24 July 1886, pp. 3, 4–5. For similar criticisms in the 20th century, see Ministry of Health, *First Report of the Welsh Consultative Council on Medical and Allied Services* (Parl. Papers 1920 [Cmd. 703], xvii), pp. 5–6; Independent Labour Party, *The Mineowners in the Dock: a Summary of the Evidence Given before the Coal Industry Commission* (1919).

²⁴ On the varied social and occupational composition of communities in different coalfields, see L. James, 'Trade union development in the Ruhr and South Wales, 1890–1914', in *Towards a Comparative History of Coalfield Societies*, ed. S. Berger, A. Croll and N. LaPorte (Aldershot, 2005), pp. 254–5; S. Catterall, 'Lancashire', in *Industrial Politics and the 1926 Mining Lockout: the Struggle for Dignity*, ed. J. McIlroy, A. Campbell and K. Gildart (Cardiff, 2004), p. 190.

²⁵ Census of England and Wales, 1901: County of Monmouth, p. 54; Census of England and Wales, 1901: County of Glamorgan, p. 62. In the most populous urban district in which mining took place, the Rhondda Urban District, 69 per cent of all males aged over 10 were engaged in coalmining.

or a sizeable or self-confident middle class, there were too few resources and too little desire in these communities to sustain significant philanthropic activity. In 1851, for example, the *Morning Chronicle* correspondent who visited South Wales noted that Merthyr Tydfil, the largest town in the coalfield with a population of almost 50,000 people at that time, possessed no almshouses, endowed charities or hospitals despite the massive fortunes that had been accumulated in the town.²⁶ Later on in the century, Poor Law inspectors for South Wales noted the absence of the better-off classes from coalfield communities and the consequent lack of charitable activity.²⁷

The crucial change in the mixed economy of care in South Wales during the late nineteenth and early twentieth centuries can be found in the increasing provision made in the voluntary sphere by the labour movement, or else the increasing power and even control exercised by that labour movement in those areas of provision that it did not itself initiate. In a sense, the labour movement attempted to fill the vacuum created by the relative absence of paternalist or philanthropic provision and set about doing so in its own particular ways and according to its own needs and values.²⁸ By the inter-war period, many coal communities in South Wales had become proletarian communities in which workers and their representatives held and exercised power.

This increasing power is most evident, perhaps, in that most significant and distinctive form of medical provision in South Wales, workers' medical schemes, more usually described in the region as medical aid societies.²⁹ These emerged from the systems of medical attendance created by employers in the nineteenth century whereby surgeons had been appointed by them and deductions made from workers' wages to pay their salaries. The members of these schemes were often aggrieved that they did not retain the power

²⁶ *Labour and the Poor in England and Wales 1849–51. The Letters to The Morning Chronicle*, iii: *the Mining and Manufacturing Districts of South Wales and North Wales*, ed. J. Ginswick (1983), p. 74.

²⁷ *Twentieth Annual Report of the Local Government Board, 1890–1* (Parl. Papers 1890–1 [C. 6460], xxxiii), p. 257.

²⁸ In his comparative history of the South Wales and Virginia coalfields, Roger Fagge makes the point that the vacuum left by the absence of any sizeable middle-class or interventionist employers was filled by the labour movement, and miners and their representatives were able to create their own structures, institutions and culture (R. Fagge, *Power, Culture and Conflict in the Coalfields: West Virginia and South Wales, 1900–22* (Manchester, 1996), p. 51).

²⁹ On medical aid societies in South Wales, see R. Earwicker, 'Miners' medical services before the First World War: the South Wales coalfield', *Llafur*, iii (1981), 39–52; S. Thompson, 'A proletarian public sphere: working-class self-provision of medical services and care in South Wales, c.1900–48', in *Medicine in Wales, c.1800–2000: Public Service or Private Commodity?*, ed. A. Borsay (Cardiff, 2003), pp. 86–107; D. G. Green, *Working-Class Patients and the Medical Establishment* (Aldershot, 1985).

to appoint or dismiss doctors, or to manage the finances according to their priorities, and efforts were made throughout the century to wrest control back from employers. The balance of power shifted in the late nineteenth and early twentieth centuries, particularly in certain communities in Monmouthshire where the companies in control had started out as iron companies in the early nineteenth century but had diversified into steel and coal production in the late nineteenth century. These companies, more so than those that produced coal alone, were more inclined to relinquish the control that they had previously exercised, and in many notable instances committees of workers came to control the funds. In these cases, doctors began to be employed on set salaries and the excess funds that accumulated were utilized to expand the range of services available to members.

The Tredegar Workmen's Medical Aid Society is perhaps the best and most famous example of these more robust and comprehensive schemes that emerged in many communities in the South Wales coalfield.³⁰ Initially confined to the miners and steelworkers of the Tredegar Iron and Coal Company and their wives and children, this scheme was extended to cover aged members of the community, workers in other collieries and workplaces in the district, teachers, shopkeepers and others. During the inter-war period, the unemployed in the district were retained in membership. Such was its comprehensive nature that by the nineteen-forties, 22,800 of the town's 24,000 inhabitants were members of the scheme. Such members gained access to an extensive range of services: as one commented in 1946, when the National Health Service Bill was the matter of much discussion, 'It's the only scheme in the country that gives you all the National Health Service sets out, and more'.³¹ Not all medical schemes in South Wales were as comprehensive as this, but a great many other communities in the region had been able to develop mutualist medical schemes that went much further than comparable organizations in most other parts of Britain at that time.³² In fact, the British Medical Association considered South Wales to be a particularly problematic region because of the extent of lay control

³⁰ On the Tredegar Workmen's Medical Aid Society, see M. Foot, *Aneurin Bevan. A Biography*, i: 1897–1945 (1963), p. 63; H. Finch, *Memoirs of a Bedwellty MP* (Newport, 1972), pp. 33–5; Green, *Working-Class Patients*, p. 174; *Picture Post*, 27 Apr. 1946.

³¹ *Picture Post*, 27 Apr. 1946.

³² On the distinctive nature of workers' medical schemes in South Wales, see Green, *Working-Class Patients*, pp. 9, 165–6, 172–5; Earwicker, 'Miners' medical services', pp. 40, 49. On the organization of G.P. services in other parts of Britain, see Green, *Working-Class Patients*; A. Digby, *The Evolution of British General Practice, 1850–1948* (Oxford, 1999), pp. 93–153; V. A. Brown, 'Public health issues and general practice in the area of Middlesbrough, 1880–1980' (unpublished University of Durham Ph.D. thesis, 2013), pp. 129–36.

that was being exercised over its members there.³³ Therefore, robust workers' medical schemes, funded, uniquely, on a re-distributive 'poundage' system, and offering a broad range of services to large proportions of the population in their respective localities, were numerous in the South Wales coalfield.

Another area of medical provision in which workers and their representatives exercised a significant measure of control was in the large number of small cottage hospitals that came to be established in the late nineteenth and early twentieth centuries. The balance between workers' representatives and individuals representing other constituencies varied from one institution to another but, again, what is most marked about these institutions in South Wales is the extent of workers' funding and control. It is possible to point to hospitals where employers played a significant role. The expense of the small hospitals opened at Merthyr and Aberdare in 1862 and 1875 respectively was borne entirely by the wives of the major industrialists in each town. Later on, the cost of erecting Pentwyn Cottage Hospital in the Rhondda Fawr Valley in 1924 was met by William Jenkins, the general manager of the Ocean Coal Company's collieries in the region, upon his retirement, on the condition that the miners of the locality would bear the cost of maintaining the institution.³⁴

Such cases are not typical, however; more representative were the institutions at Porth, Mountain Ash, Pontypool, Aberbargoed, Abertyswg and other communities, where employers made initial donations of money or land, or committed themselves to regular subscriptions or donations, but did not otherwise play an important role in their administration.³⁵ In such cases, the vast proportion of the funding came from the workforce in the locality, which also then elected the overwhelming majority of management board members and retained control of the hospitals. In a discussion of the National Health Service Bill in the Commons in 1946, Aneurin Bevan stated that in his experience of the management board of the Tredegar Cottage Hospital, a vote of thanks would be passed to the local employer despite the fact that the local miners donated 97.5 per cent of the hospital's income from weekly deductions from their wages; no vote of thanks was passed to the miners, he stated, and 'it is a travesty to call them

³³ A. Cox, *Among the Doctors* (1952), pp. 172–6.

³⁴ Treorchy Library, R2 (362), M. Evans, 'Thesis on Pentwyn cottage hospital' (1977); *The Ocean and National Magazine*, ii (Feb. 1929), 40–2.

³⁵ Sources that offer overviews of hospital provision in South Wales include G. A. Stephens, *The Hospitals of Wales* (Swansea, 1912); *First Report of the Welsh Consultative Council on Medical and Allied Services*; *Second Report of the Welsh Consultative Council on Medical and Allied Services*; A. T. Jones, J. A. Nixon and R. M. F. Picken, *Hospital Survey: the Hospital Services of South Wales and Monmouthshire* (1945).

The mixed economy of care in the South Wales coalfield, c.1850–1950

voluntary hospitals'.³⁶ These were very much workers' hospitals. Indeed, the name of the Caerphilly and District Miners' Hospital stated very clearly the provenance of the support for the institution and each ward was named after a particular colliery at which collections were made for its upkeep. When opened in 1923, £3,250 had been donated by the local colliery companies to the building fund but this was dwarfed by the £38,955 subscribed by the workmen; in subsequent years, the workmen provided over 90 per cent of the annual income.³⁷

Slightly differently, the hospitals set up at Blaenavon, Ebbw Vale and Tredegar were established by the workmen's medical aid societies in those locations, albeit with some support from their employers.³⁸ In Blaina, on the other hand, 'firebrands' decided that they did not wish for their employers to have any say in the management of their hospital and so decided not to accept any financial support from them whatsoever.³⁹ In a way, there was no need for Saturday Funds or workmen's contributory schemes for these hospitals as there was with so many other voluntary hospitals across Britain, or indeed in the three large coastal towns in the region. All workers, in any colliery or foundry where a ballot had decided in favour of financial support, paid directly into the hospital's coffers rather than to an intermediary organization that liaised with the hospital and sought representation on the management board, as in the case of contributory schemes; in return, the worker contributors gained eligibility for care in the cottage hospitals and the right to elect representatives on to the management boards, where such representatives formed the overwhelming majority of members. For this reason, the nature of these subscriber organizations was far more democratic, direct and participatory than in institutions in other parts of Britain.

The voluntary hospitals in the South Wales coalfield were not characterized by the same diversity of funding or representation as similar institutions in other parts of Britain but instead tended to be funded and controlled overwhelmingly by workers and their representatives. The institutions were self-consciously miners' hospitals and had a perception of themselves as being different to hospitals elsewhere. The strongly mutualist, rather than charitable, motivation for hospital provision in the coalfield is most clearly

³⁶ Hansard, *Parliamentary Debates*, 5th ser., cdxii, cols. 43–142, 30 Apr. 1946.

³⁷ Wellcome Library, *Annual Report of the Caerphilly and District Miners' Hospital* (Caerphilly, 1927), pp. 4, 6–7; *Annual Report of the Caerphilly and District Miners' Hospital* (Caerphilly, 1928), p. 4.

³⁸ G. Jones, *The Aneurin Bevan Inheritance: the Story of the Nevill Hall and District NHS Trust* (Abertillery, 1998).

³⁹ *M.E.*, 7 Jan. 1911, p. 8.

illustrated by an assertion in an annual report of the Mountain Ash Hospital that the institution should be renamed 'The Temple of Equal Chance'.⁴⁰

However, statements on the distinct character of the mixed economy of care in the South Wales coalfield need to be qualified by the recognition that the coalfield did not form a medical region in its own right but, rather, was part of a larger geographical unit that included the various seaboard towns to the south. While medical philanthropy was relatively undeveloped in the colliery communities of the coalfield, they nevertheless drew upon the philanthropically provided medical provision in the towns of Swansea, Newport and Cardiff. This is most evident in an institutional context and especially during the second half of the nineteenth century before hospitals were established in coalfield communities. At the same time, the cottage hospitals founded in the coalfield were, for the most part, accident rather than general hospitals and, as a result, the communities of the coalfield continued to be dependent on medical institutions at Swansea, Cardiff, Newport and further afield for more specialized medical care.

The first voluntary hospital in the whole of Wales, the dispensary founded in Swansea in 1808, which became an infirmary in 1817, was a self-consciously South Walian institution in its early years and looked for supporters from its own county of Glamorgan and the neighbouring counties of Carmarthenshire and Monmouthshire.⁴¹ The infirmary did not wholly succeed in this aim, and financial support and patients came overwhelmingly from the town of Swansea and the neighbouring localities within Glamorgan during its early decades, until this changed in about mid century. Dispensaries were founded in Cardiff and Newport in 1822 and 1839 respectively and were converted into infirmaries in 1837 and 1867; these too were largely dependent on the populations of their respective towns for both patients and subscribers in the early years, but this also came to change with the greater pace of industrialization in the coalfield during the latter decades of the century.

Accident cases from the coalfield started to place a burden on the resources of the infirmaries at Cardiff and Swansea from about the eighteenth-forties and eighteenth-fifties and efforts to solicit donations and subscriptions from the coal and iron industrialists of the coalfield were intensified from this period.⁴² Furthermore, from the eighteen-seventies, workmen's

⁴⁰ Mountain Ash and Penrhiwceiber Hospital, *Thirteenth Annual Report and Financial Statement* (1937), p. 15.

⁴¹ T. G. Davies, *Deeds not Words: a History of the Swansea General and Eye Hospital 1817–1948* (Cardiff, 1988).

⁴² For examples, see West Glamorgan Archive Service, Swansea Infirmary minutes, 2 July 1841, 30 July 1844; *Annual Report of the Glamorganshire and Monmouthshire Infirmary and*

contributions, increasingly from the industrial hinterland rather than the towns themselves, came to form an important source of funding for these institutions and, in Newport's case at least, surpassed ordinary subscriptions in amount by 1898.⁴³ Despite the funding that came from employers and workers in the coal, iron and steel industries of the coalfield, however, these were nevertheless voluntary institutions with a much broader range of supporters than the workers' hospitals of the coalfield. Landowners from the two counties of Glamorgan and Monmouthshire, in addition to the elites and middle classes of the three respective towns, not to mention port employers, were found among the supporters and governors of the three institutions. This varied model of funding and governance in institutions situated just outside the coalfield, but nevertheless serving its population, complicates the character of the coalfield's mixed economy of care.

The distinctive nature of this regional mixed economy of care was further complicated by the reliance on institutions and expertise located even further away from the coalfield. Many of the parishes in Monmouthshire had subscribed to hospitals in Bath and Bristol in the late eighteenth and early nineteenth centuries, for example, and retained links with them even as they came increasingly to send their subscriptions and patients to Cardiff and Newport as the nineteenth century progressed, and even into the twentieth century. This tendency was also evident in other contexts, as trade union lodges, friendly societies, Poor Law unions, district councils and other bodies on the coalfield subscribed to various institutions beyond South Wales, and sent patients to receive specialized medical care. As an example, many of the lodges of the South Wales Miners' Federation, the trade union that represented the coalminers of the region from 1898 onwards, subscribed to the local cottage hospital, to one of the larger general hospitals on the South Wales coast, perhaps to an institution at Bristol or Bath, and even, at times, to another hospital at London, such was the need to draw upon the varying sources of expertise in these different locations during the early decades of the twentieth century.⁴⁴ In fact, the greater the level of medical expertise required, the greater the dependence on medical services outside the coalfield. If we take the example of disabled children, what is most marked is the absence of specialized provision in the

Dispensary, Cardiff, for the year ending 31st Dec. 1848 (Cardiff, 1849), p. 8; *Annual Report of the Glamorganshire and Monmouthshire Infirmary and Dispensary, Cardiff, for the year ending 31st Dec. 1850* (Cardiff, 1851), p. 7.

⁴³ *Annual Report of the Newport Dispensary and Infirmary, 1898* (Newport, 1899).

⁴⁴ S. Thompson, 'The friendly and welfare provision of British trade unions: a case study of the South Wales Miners' Federation', *Labour History Review*, lxxvii (2012), 189–210, at p. 201.

region and the reliance on a broad range of institutions, hospitals, homes and charities in towns and cities spread across the whole of England. In a sense, South Wales exported difficult medical cases almost as much as it exported coal.⁴⁵

Even where patients were not sent from their coalfield communities to the larger institutions in the seaboard towns, these communities nevertheless drew upon the medical expertise found in the large institutions there. Colliery doctors were able to treat their patients in the cottage hospitals of the coalfield but these institutions tended to look to the staff of the larger hospitals in Cardiff, Swansea and Newport for the few consultant appointments they made, whether they be surgical, gynaecological, dental or ophthalmic, and such specialists travelled into the coalfield to attend at these cottage hospitals on a day or two each week. Furthermore, with the establishment of the Cardiff Medical School in 1893, the region, and indeed Wales as a whole, gained its first medical school and it quickly became an institution that trained a large number of Welsh doctors, many of whom went on to practise in the coalfield, again emphasizing the coalfield's medical debt to the larger towns beyond the limits of the coal reserves.⁴⁶

The most significant development in the mixed economy of care in the South Wales coalfield in the early decades of the twentieth century was the extension and diversification of publicly provided welfare and medical services. Part of this change came in the Poor Law system and it is clear, of course, that this reflected a broader development in the Poor Law medical system in England and Wales during the second half of the nineteenth century and the early decades of the twentieth.⁴⁷ New infirmaries were built at Cardiff (1897), Pontypool (1898), Merthyr (1899) and Newport (1904), while other unions built or improved infirmaries in the years down to the First World War.⁴⁸ Such infirmaries were the largest medical institutions in the coalfield at that time and dwarfed the voluntary hospitals in terms of the number of beds they possessed: Swansea Poor Law Infirmary could accommodate 390 patients by this time in comparison to the 141 that could be taken in by the nearby Swansea General and Eye Hospital, and many

⁴⁵ On the 'export' of disabled children from South Wales, see S. Thompson, 'The mixed economy of child welfare and care in industrial South Wales', in *Disabled Children: Contested Caring, c.1850–1979*, ed. A. Borsay and P. Dale (2012), pp. 43–57.

⁴⁶ A. Roberts, *The Welsh National School of Medicine: the Cardiff Years, 1893–1931* (Cardiff, 2008).

⁴⁷ M. W. Flinn, 'Medical services under the New Poor Law', in *The New Poor Law in the 19th Century*, ed. D. Fraser (1976), pp. 45–66, esp. pp. 60–6.

⁴⁸ *Forty-Third Annual Report of the Local Government Board, 1913–14* (Parl. Papers 1914 [Cd. 7444, 7610, 7611], xxxviii), p. 77.

patients preferred to receive treatment in the Poor Law infirmary due to the shorter waiting lists.⁴⁹ Even here, in the Poor Law medical system, the growing influence of the labour movement is evident. Poor Law inspectors for Wales noted the election of female and working-class guardians to boards from the eighteen-nineties onwards and the effect that these had on the administration of the system, with significant improvements to sick wards and the erection of new infirmaries in many unions.⁵⁰ Such was the improvement that the Poor Law inspector for Wales was able to comment just before the First World War: ‘what were a few years ago large workhouses for the more or less able-bodied have become to a great extent infirmaries for the acute and chronic sick’.⁵¹

This importance of public bodies became more pronounced in the twentieth century as county councils and urban district councils came to provide an increasing range of public health and medical services. Some developments came before the First World War, particularly in the form of a school medical service following legislation passed in 1907 and the establishment of the Welsh National Memorial Association in 1910. The latter, though initially founded as a voluntary organization, nevertheless came to be the body through which county councils were required to meet their obligations in relation to the provision of tuberculosis services.⁵² Provision came to be expanded more significantly in the inter-war period. This increase in provision was facilitated by a number of measures initiated in Westminster but the tendency was also partly driven by the majorities gained by the Labour Party on county and district councils in the region. The party controlled Glamorgan and Monmouthshire county councils for the duration of the inter-war years, apart from a short period from 1922 to 1925; Merthyr County Borough Council throughout the period; and the councils of most of the urban districts on the coalfield from 1919 onwards.⁵³ An act passed in 1918 provided local authorities with 50 per cent of the funds needed to supply maternity and child welfare and health visiting

⁴⁹ J. E. Thomas, ‘The Poor Law in West Glamorgan, 1834 to 1930’, *Morgannwg*, xviii (1974), 45–69; Stephens, *Hospitals of Wales*, p. 59.

⁵⁰ C. Preston, ‘“To do good and useful work”: Welsh women Poor Law guardians 1894–1914’, *Llafur*, x (2010), 87–102; *Twenty-Fifth Annual Report of the Local Government Board, 1895–6* (Parl. Papers 1896 [C. 8212], xxxvi), p. 221.

⁵¹ *Forty-First Annual Report of the Local Government Board, 1911–12* (Parl. Papers 1912–13 [Cd. 6327, 6331], xxxv), p. 134.

⁵² L. Bryder, ‘The King Edward VII Welsh National Memorial Association and its policy towards tuberculosis, 1910–48’, *Welsh History Review*, xiii (1986), 194–216.

⁵³ C. Williams, ‘Labour and the challenge of local government, 1919–39’, in *The Labour Party in Wales, 1900–2000*, ed. D. Tanner, C. Williams and D. Hopkin (Cardiff, 2000), p. 142.

services, while measures in 1920 saw county councils become responsible for the provision of services to combat venereal disease and for the welfare of blind people.⁵⁴ The various councils in South Wales expanded provision in these different areas during the inter-war period, despite the economic depression, so that by the late nineteen-thirties, the report of the Committee of Inquiry into the Anti-Tuberculosis Services in Wales was able to praise local authorities in the region for their attention to the development of public health and medical services and contrast them very favourably with the far more dilatory authorities in rural areas of Wales.⁵⁵

Not only did local authorities provide a greater range of services to their populations with each decade of the early twentieth century, their provision also served to complicate the shape of the mixed economy of care in the region as different providers formed connections with each other through the flow of funding and patients between them. Such interconnections had always existed in the modern period as friendly societies, trade unions and Poor Law authorities, both before and after 1834, had subscribed to various providers within the voluntary sphere in order to allow access to their services. This movement of funds and patients between different providers only intensified as time passed. Poor Law authorities in South Wales during the late nineteenth and early twentieth centuries were particularly notable for their reliance on more specialist voluntary provision. This was particularly notable in relation to children, as deaf and dumb institutions, epileptic colonies, 'idiot' asylums, orthopaedic hospitals, convalescent homes and other institutions, most of them located outside South Wales, were utilized by guardians from the region.⁵⁶ This interdependence grew in extent and complexity in the early decades of the twentieth century as new providers, especially local authorities, came to prominence. An interesting example is provided by the Carnegie Trust's donation of £100,000 in the early nineteen-twenties to provide maternity and child welfare clinics in four locations in England and Wales, each of which received £25,000, including the Rhondda Urban District.⁵⁷

In a movement of finances and patients in another direction, Glamorgan County Council paid an annual subscription to the Cardiff Poor Cripples

⁵⁴ For an overview of the services provided by local authorities in Glamorgan, albeit rather dated in approach, see J. H. L. Mabbitt, *The Health Services of Glamorgan* (Cowbridge, 1972).

⁵⁵ J. Davies, 'The communal conscience in Wales in the inter-war years', *Transactions of the Honourable Society of Cymmrodorion*, 1998, new ser., v (1999), 145–60.

⁵⁶ Thompson, 'The mixed economy of child welfare'.

⁵⁷ *Third Annual Report of the Ministry of Health, 1921–2* (Parl. Papers 1922 [Cmd. 1713], viii), p. 15.

Aid Society from 1927 onwards. The Poor Cripples Aid Society was able to offer orthopaedic appliances or arrange apprenticeships or training to allow disabled children and adults to provide for themselves. The society had also developed a network of contacts in specialized orthopaedic and convalescent institutions across England during the preceding years and was able to place disabled children in such places far more effectively than could the County Council. In 1931, the council decided that it would no longer pay an annual subscription but would pay the society on a case-by-case basis.⁵⁸ In a sense, the Cardiff Poor Cripples Aid Society served as a clearing house for disabled children and their families, and acted as an agency that was able to navigate the voluntary landscape to place children with very particular needs in various voluntary institutions located across England.⁵⁹ This flow of funding from local authorities to the voluntary sphere was also evident in the provision of tuberculosis services in Wales as the Welsh National Memorial Association was established in 1911. This body was funded partly through charitable donations but received the lion's share of its income from the grants paid to it by the county councils in Wales, who passed their statutory responsibility for provision to the association; this was in contrast to the situation in England where county councils retained such responsibility.⁶⁰

Another provider that came to play a more important role in this inter-war period was the central state. This was evident in the area of maternity and child welfare, as 50 per cent of the funding for services was provided to local authorities by the government under an act passed in 1918. Urban district and county borough councils extended their provision of maternity and child welfare services during the nineteen-twenties and thirties, though it needs to be understood that the economic depression of the late nineteen-twenties and nineteen-thirties slowed developments to a large extent and placed limits on what impoverished local authorities could do.⁶¹ Recognition of the difficulties occasioned by mass unemployment was partly responsible for another stream of central funding for medical services in South Wales in the nineteen-thirties. Under legislation passed in 1934, South Wales,

⁵⁸ Glamorgan Archives, Cardiff Poor Cripples Aid Society minutes, 20 Oct. 1927, 20 Sept. 1928, 7 Jan. 1931.

⁵⁹ This tendency for a county borough council to rely on voluntary agencies to achieve its health services obligations was even more marked in relation to Newport, as has been demonstrated in A. Levene, M. Powell, J. Stewart and B. Taylor, *Cradle to Grave: Municipal Medicine in Interwar England and Wales* (Oxford, 2011), pp. 169–96.

⁶⁰ Bryder, 'The King Edward VII Welsh National Memorial Association'.

⁶¹ S. Thompson, *Unemployment, Poverty and Health in Interwar South Wales* (Cardiff, 2006), pp. 235–6.

Tyneside and parts of Durham, West Cumberland and industrial parts of Scotland were designated as 'Special Areas' and various ameliorative efforts were made to ease the consequences of mass unemployment. The sum of money provided for such work was completely inadequate but it is interesting to note that a certain proportion of the financial support was channelled into public health infrastructure and medical provision. The commissioner for special areas made capital grants to local authorities for the provision of new hospitals or else the extension or alteration of existing institutions in South Wales, including £250,000 to Glamorgan County Council in 1935 for a new general hospital of 200 beds at Pontypridd; while grants were also made to many of the voluntary hospitals in the region and helped many of them avoid bankruptcy. The commissioner also provided assistance to open-air schools, district nursing associations, maternity and child welfare services, branches of the St. John Ambulance Association and the National Birthday Trust Fund, which was engaged in the provision of free or cheap foodstuffs to expectant and nursing mothers.⁶² In some ways, it is the support for voluntary hospitals that is most interesting and it is perhaps possible to see this central funding of hospital provision as a precursor of the state nationalization of hospitals under the new National Health Service after the Second World War.

It was not only public money that came to support various voluntary forms of provision in the inter-war period. The Miners' Welfare Fund, established in 1920 and funded through a penny levy on every ton of coal raised in Britain, provided some financial assistance to recreational schemes and medical services in coalfield areas.⁶³ The scheme was administered by a joint central committee consisting of employers' and workers' representatives in London and joint committees in each of the main coalfields of Britain. The South Wales District made capital grants to the value of over £500,000 to recreation, welfare and medical schemes and to institutions in the period up to 1939, including grants to twenty-two voluntary hospitals in the coalfield.⁶⁴ In this instance, legislation passed in Westminster established a tax on a single industry to support voluntarily provided medical services in the communities based around that industry and, as such, the Miners' Welfare Fund typifies the increased complexity of the mixed economy of care in the twentieth century.

⁶² *Second Report of the Commissioner for the Special Areas (England and Wales)* (Parl. Papers 1935–6 [Cmd. 5090], xiii), pp. 35–9, 109–12.

⁶³ W. J. Morgan, 'The Miners' Welfare Fund in Britain 1920–52', *Social Policy & Administration*, xxiv (1990), 199–211.

⁶⁴ Miners' Welfare Fund, *Annual Report for 1939* (1940), pp. 114–15. See also V. Chelmsford, *The Miners' Welfare Fund* (1927), p. 33.

The specific social, economic, political and cultural contexts of the South Wales coalfield produced a particular version of the mixed economy of care in which philanthropy, employer paternalism and Poor Law institutional provision were meagre. Into the vacuum created by this absence of provision came the labour movement, characterized by working-class self-help and mutualism from below and, later, public provision from above by local authorities. We lack regional studies of the mixed economy of care to know if the one that characterized South Wales was different to that in other industrial districts or even other coalfields – it seems likely that there would be a great many similarities. On the other hand, the simpler social structure of colliery villages, the more mono-industrial character of coal communities, the greater social, religious and ethnic homogeneity of the population, the less-developed middle class, the more confrontational and anti-union coal employers, the greater commitment to left-wing political parties, especially the Labour Party, and the more militant labour movement were all characteristic of South Wales relative to other industrial districts and coalfields. Such a distinctive structure perhaps led to certain differences in the nature of medical provision and in the precise mix and interaction of providers in the mixed economy of care. Robust, comprehensive and sophisticated medical aid societies, with their unique system of funding, voluntary hospitals with a greater reliance on workers' contributions and workmen's representatives on management committees, and better-developed local authority services by Labour Party-controlled councils than was the case in industrial areas where the party did not capture power to quite the same degree, were perhaps the outcome of these factors.

At the same time, however, this distinctive mixed economy of care was not able to meet the requirements of coalfield communities despite the massive medical needs that were created by industrialization. The 1945 hospital survey found that South Wales was the most 'deprived region' of Britain in terms of the numbers of beds available and the provision of specialist services for the population.⁶⁵ While the 'industrialization thesis' of welfare state creation posits industrialization as the cause of both increased needs and the resources to deal with those needs, it is evident from South Wales that it was often not able to create sufficient resources to meet the medical and welfare demands that it created.⁶⁶ In a sense, this is perhaps characteristic of coalmining communities, both in the past and in the developing world in the present: economic historians have pointed

⁶⁵ M. Powell, 'How adequate was hospital provision before the NHS? An examination of the 1945 South Wales hospital survey', *Soc. Hist. of Med.*, v (1992), 22–32.

⁶⁶ C. Pierson, *Beyond the Welfare State? The New Political Economy of Welfare* (Oxford, 1991), pp. 14–16.

out that regions dependent on primary, extractive industries do not tend to experience any diversification of economic activity into manufacturing or other activities but instead remain geared towards the export of their products to other regions.⁶⁷ In such places, communities remain simple, undifferentiated and homogeneous, without the facilities, structures or institutions to deal with more complex tasks or functions. This also chimes with Julian Tudor Hart's idea of the 'inverse care law' which states that not only are such regions characterized by a paucity of provision in inverse proportion to the massive need that exists, but also that the nature of medical provision tends to be basic and lacking in the specialized services and skills that came to characterize medicine in other regions in the modern period.⁶⁸ The mixed economy of care in South Wales, therefore, was distinctive but also inadequate for the needs of the region's population.

⁶⁷ J. Williams, *Was Wales Industrialised? Essays in Modern Welsh History* (Llandysul, 1995), pp. 14–36.

⁶⁸ J. Tudor Hart, 'The inverse care law', *The Lancet*, ccxcviii, no. 7696 (27 Feb. 1971), 405–12.

7. ‘... it would be preposterous to bring a Protestant here’: religion, provincial politics and district nurses in Ireland, 1890–1904*

Ciara Breathnach

In a country where traditional or ethno-medical practices prevailed well into the twentieth century, the interface between the wider populace and ‘modern medicine’¹ was complicated by undercurrents of class, cultural difference, a mixed medical economy and, perhaps more significantly, denominational concerns. With the exception of Gerard Fealy’s work on the history of nursing,² much discussion on the social history of medicalization in the Irish context has focused on doctors; the function of nurses in that process has received relatively little attention. Even the activity of nursing orders in Ireland remains under-explored, as most discussions form part of wider studies of female religious. Sustained accusations of proselytism in welfare institutions made by Roman Catholic clergy resulted in significant gains, particularly in workhouses, with the introduction of the Sisters of Mercy as nurses in Limerick in 1861.³ ‘Nursing nuns’ had varying degrees of competencies but, and mainly because they worked for little or no pay, by 1903 they dominated nursing in union hospitals.⁴ In such a milieu it is unsurprising that the introduction of middle-class, and invariably Anglican, ‘Jubilee’ nurses to Ireland met with the polemics of antipathy and desperate need. Jubilee nurses were women who were trained by bodies associated with the Queen Victoria’s Jubilee Institute for Nurses (Q.N.I.), which was

* W.L.A., SA/QNI/S.2/1/1, box 120, letter from Dublin Branch of Q.N.I., Inspector C. A. Blackmore to Miss Peter, 4 Jan. 1897. The author would like to thank Dr. Lindsey Earner Byrne, Dr. Catherine Lawless and Dr. Laura Kelly for their invaluable comments on earlier drafts of this essay.

¹ There are several working definitions of ‘modern medicine’. It is generally taken to mean the provision of scientific-based care by licensed and trained personnel (see D. Lupton, ‘Foucault and the medicalisation critique’, in *Foucault, Health and Medicine*, ed. A. Petersen, R. Bunton and B. S. Turner (New York, 1997), p. 94).

² G. Fealy, *A History of Apprenticeship Nurse Training in Ireland* (Abingdon, 2006).

³ M. Luddy, “‘Angels of mercy’: nuns as workhouse nurses, 1861–98”, in *Medicine, Disease and the State in Ireland, 1650–1940*, ed. G. Jones and E. Malcolm (Cork, 1999), pp. 102–17.

⁴ M. Luddy, *Women and Philanthropy in 19th-Century Ireland* (Cambridge, 1995), pp. 49–50; M. Cousins, *Poor Relief in Ireland, 1851–1914* (Bern, 2011), p. 200.

established in 1887 with £70,000 of an initial fund of £82,000 collected as a gift for the queen's jubilee. (The difference was used to purchase a commissioned piece of jewellery.)

From the eighteen-sixties until the Midwifery Act of 1918 and the Nurses' Registration Act of 1919, nursing comprised a 'mixed economy' of the relatively new phenomenon of hospital-trained nurses, nursing religious and the much maligned but prolific 'handy women'.⁵ Within these categories further distinctions could be made. Margaret Damant's work has shown how in England, in addition to providing 'a professional network', district nursing 'led to the separation of nursing knowledge and skills from domestic care, quackery and proselytising'.⁶ This essay explores the degree to which Jubilee nurses played a similar role in Ireland and argues that such a separation of duties was not a smooth process. It shows that the introduction of the Jubilee nurse was dogged by sectarianism and professional power struggles.

Virginia Crossman has likened the Irish local government system to a 'patchwork' or a 'frankenstein's monster of overlapping authorities and jurisdictions'.⁷ As in England, a 'panoply' of local government services was responsible for public health in Ireland towards the close of the nineteenth century.⁸ Overarching the 'modern' medical encounter was a national infrastructure presided over by politicians, Poor Law officials, clergy and some medical men of note. At a micro-level doctor/patient encounters for the poor usually occurred in Poor Law union hospitals or dispensaries, part of the apparatus of Poor Law medicine established under the Medical Charities Act of 1851.⁹ Dispensary and workhouse doctors operated in deference to Poor Law guardians who determined whether or not their annual contracts were renewed. In the early decades of the Poor Law system, boards of guardians were usually composed of local landlords and clergy but by the close of the century outside the northern province of Ulster the rising Catholic middle classes played a greater and in many cases a controlling

⁵ Midwives (Ireland) Act 1918, 7 & 8 Geo. 5, c. 59; Nurses Registration (Ireland) Act 1919, 9 & 10 Geo. 5, c. 96.

⁶ M. Damant, 'A biographical profile of Queen's Nurses in Britain, 1910–68', *Soc. Hist. of Med.*, xxiii (2010), 586.

⁷ V. Crossman, *Local Government in 19th-Century Ireland* (Belfast, 1994), p. 5.

⁸ M. Gorsky and S. Sheard, 'Introduction', in *Financing Medicine: the British Experience since 1750*, ed. M. Gorsky and S. Sheard (Abington, 2006), p. 2.

⁹ L. M. Geary, *Medicine and Charity in Ireland, 1718–1851* (Dublin, 2004); see also L. M. Geary, 'The medical profession, health care and the Poor Law in 19th-century Ireland', in *Poverty and Welfare in Ireland 1838–1948*, ed. P. Gray and V. Crossman (Dublin, 2011), pp. 189–206.

role.¹⁰ A survey of dispensary records reveals that there was an obvious need for auxiliary services to alleviate the exceptionally busy workloads of some medical officers. Take, for example, the Callan and Rathdown dispensary records which show how over-stretched its medical officer, Dr. Keating, was in the eighteen-seventies. Dr. Keating covered clinics over a large geographic area. An overview of his medical knowledge is insightful; to his mind the Callan Dispensary District was in ‘a healthy state’ once instances of diphtheria and scarlatina remained at bay.¹¹ Keating’s records give the impression of someone who went to great lengths to take care of his patients but who was also obliged to devote a disproportionate amount of his time to an overly bureaucratized system. Month after month he reported to the Board of Guardians appealing or accounting for the usage of coal and other sundries. The importance of accountability notwithstanding, one cannot help but think that his energy might have been more profitably expended elsewhere.

Parallel to a geographically comprehensive but politically complex public health system (a complexity that rendered it inaccessible to some), there existed an equally mixed ethno-medical economy of quacks, bonesetters, cancer curers, ‘handy women’ and wise women, and aggressive newspaper advertisement campaigns led to an increasing number of patent medicines in circulation.¹² Each type of practitioner offered services of varying degrees and costs, but because ‘traditional’ medical practitioners existed in the vernacular they are difficult to account for and often overlooked.¹³ Some traditional practitioners (persons with no formal training), primarily handy women, were deeply embedded in the social and cultural fabric and proved difficult to uproot. As a result, they offered significant competition to those with training.

Although geographically small, strong regional and denominational identities characterized Irish municipalities and local government districts,

¹⁰ The Local Government (Ireland) Act (1898), 61 & 62 Vic., c. 37, changed the boundaries of administration, but with the exception of matters associated with sanitation it did little to alter the governance of healthcare (see J. J. Clancy, *A Handbook of Local Government in Ireland: Containing an Explanatory Introduction to the Local Government (Ireland) Act, 1898* (Dublin, 1899), p. 90).

¹¹ N.A.I., 999/655/3, monthly report by Dr. P. Keating, Callan, Co. Kilkenny, July 1873.

¹² *Report as to the Practice of Medicine and Surgery by Unqualified Persons in the United Kingdom Medical Council: Unqualified Practitioners* (Parl. Papers 1910 [Cd. 5422], xliii), p. 22.

¹³ C. Cox, ‘The medical marketplace and medical tradition in 19th century Ireland’, in *Folk Healing and Health Care Practices in Britain and Ireland: Stethoscopes, Wands and Crystals*, ed. R. Moore and S. McClean (Oxford and New York, 2010), pp. 55–79. Cox relies primarily on professional directories and pays little attention to the competing influences of traditional practitioners.

making it difficult to establish district nursing schemes. Unfortunately records survive piecemeal. Indeed some district nursing associations (D.N.A.s) were, as we shall see, nearly stripped of their 'affiliation' for poor record-keeping.¹⁴ Drawing heavily on the Irish branch correspondence of the Q.N.I., and Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) records, together with newspaper reports and contemporary medical and nursing journal articles, this essay utilizes case studies from Londonderry, Limerick City and County, Achill in County Mayo, and the Rosses in County Donegal to demonstrate how denominational concerns shaped the public perception of district nursing regionally. Adopting a comparative regional approach, it shows how the success of benevolent endeavours was often beleaguered by religious, secular and medical power-brokerage. In so doing it charts how, as it professionalized, nursing faced a variety of localized gender, socio-economic and cultural obstacles.

William Rathbone, a wealthy Liverpool industrialist, is largely accredited with the foundation of the 'modern' concept of district nursing for the poor.¹⁵ In 1859 his ailing wife began to receive palliative care in their home from Nurse Mary Robinson. Driven by a 'quality of life' agenda Rathbone personally funded Robinson to conduct a three-month pilot district nursing scheme for the poor of Liverpool. Overwhelmed with demand, it quickly became apparent that Robinson needed reinforcements and it was at this point that the movement began to advance in close consultation with Florence Nightingale.¹⁶ A shared vision emerged of providing nurses with hospital training, a salary, equipment and lodgings to enable them to care for the sick poor in their own homes, at no cost to the patient.¹⁷ The foundation of the Central Home of the Metropolitan and National Association of Nursing, London, followed in 1875.¹⁸ Rathbone entered politics and was very influential in establishing the Q.N.I. The principles of district nursing had evolved somewhat from its Liverpool origins and now

¹⁴ W.L.A., SA/QNI/S.2/1/1, box 120, letter dated 17 Oct. 1898 regarding the unsatisfactory management of the Rosses District Nursing Association, Co. Donegal.

¹⁵ H. M. Sweet, *Community Nursing and Primary Healthcare in 20th-Century Britain* (2008), p. 18.

¹⁶ See *Florence Nightingale: Extending Nursing*, xiii, ed. L. McDonald (Waterloo, Ontario, 2009), 701–73; E. Rathbone, *William Rathbone: a Memoir* (1905), pp. 155–86.

¹⁷ C. Howse, "'The ultimate destination of all nursing': the development of district nursing in England, 1880–1925", *Nursing History Review*, xv (2007), 65.

¹⁸ Miss Hubbard, 'The organisation of women workers', in *Women's Mission*, ed. A. Burdett-Coutts (1893), p. 276; see also F. Nightingale, 'Sick nursing and health nursing', in Burdett-Coutts, *Women's Mission*, p. 205.

included scientific training in surgery and midwifery.¹⁹ These essential skills set Jubilee nurses apart and, according to Margaret Damant, protected the poor from quackery and the untrained practitioner.²⁰ The Q.N.I. did not employ nurses directly, instead it ‘operated a system of affiliation, training and inspection’ of D.N.A.s.²¹ Two Irish training institutions, both located in Dublin, affiliated with the Q.N.I. in the eighteen-nineties. The first was St. Patrick’s Home (for providing trained nurses for the sick poor). Although not explicitly denominational, indeed it was open to all denominations, it primarily attracted Protestant nurses and probationers. It was affiliated to the Q.N.I. in 1890, and according to the 1881 census served a population of 273,283.²² St. Lawrence’s Home was founded and affiliated in 1891 specifically to train Catholic nurses.²³

Sectarianism was always a moot point in nurse training as nurses had unequivocal access in the course of their duties to the vulnerable sick, particularly when the public health setting was the patient’s home. Various charitable institutions and religious orders had for centuries offered elements of community care for the sick but not necessarily in their own homes or by the hospital-trained. It is difficult to decode the precise edicts that inhibited how religious could tend to the sick as some pertain to missions and fall under the auspices of *Propaganda Fide*. Dictates precluding nuns from dealing with lying-in patients and infants can be traced back to Pope Boniface VIII’s 1298 papal directive *Periculoso*, later reinforced by the Council of Trent, that made clear distinctions between male and female religious and set out reasons for their cloistering, or separation from the outside world.²⁴ Sisters, unlike nuns, were permitted to work in the community. Codes of canon law regarding ‘nursing’ were regularly reinforced, often quietly elided (particularly in America), but eventually lifted in 1936 in the ‘missionary context’.²⁵

¹⁹ F. Nightingale, ‘Trained nurses for the sick poor’, *The Times*, 14 Apr. 1876.

²⁰ Damant, ‘A biographical profile’, p. 586.

²¹ E. Fox, ‘District nursing in England and Wales before the National Health Service: the neglected evidence’, *Medical History*, xxxviii (1994), 305.

²² U.C.D.A., P220/28 fo. 1, District No. 1 Dublin.

²³ See P. Scanlan, *The Irish Nurse. A Study of Nursing in Ireland: History and Education, 1718–1981* (Leitrim, 1991), p. 79. St. Patrick’s Home became affiliated with the Irish Branch of the Q.N.I. in 1890 (*Lady Dudley’s Scheme for the Establishment of District Nurses in the Poorest Parts of Ireland, First Annual Report* (Dublin, 1904), p. 3).

²⁴ E. M. Makowski, *Canon Law and Cloistered Women: Periculoso and its Commentators, 1298–1545* (Washington, D.C., 1999).

²⁵ New Advent: Catholic Encyclopedia <<http://www.newadvent.org/cathen/11164a.htm>> [accessed 30 Sept. 2013]; E. Hogan, *The Irish Missionary Movement: a Historical Survey, 1830–1980* (Dublin, 1990), p. 195. The author is grateful to Ailish Veale, doctoral candidate at Trinity College Dublin, for this reference and discussions surrounding the matter of nursing nuns.

As Maria Luddy has shown, the Sisters of Mercy were permitted to gain a foothold in workhouse hospitals from the eighteen-sixties and thus laid the foundation for 'a cheap welfare system', although one that was not without its critics.²⁶ Dr. Smyth from Naas, County Kildare, wrote an extended letter to the *Freeman's Journal* in 1897 about the problems and vicissitudes of nuns as nurses. He acknowledged nuns' ability to supervise, and provide discipline and domestic management, but argued that advances in modern medicine required the skills of a trained nurse.²⁷ He recognized and was brave enough publicly to highlight nuns' professional shortcomings, arguing that:

the science and art of nursing are not learned in the novitiate, and they are not acquired by inspiration. The vocation of a nun though a priceless foundation, cannot of itself make a hospital nurse, there must be training, not a sham or makeshift training, but honest hospital training under efficient teaching. Nursing has one great aspect in which a nun when trained simply has no equal.

Describing Sisters of Mercy at Naas Union Hospital as a 'moral antiseptic', he proceeded to point out the limitations placed on them regarding male patients and in assisting at operations.²⁸ What militated against the efforts of the nuns in workhouses was that they were bolstered by an 'apprentice nurse' system staffed by untrained inmates.²⁹ Dr. Smyth opined:

Untrained 'nursing' is bad but pauper 'nursing' goes down to the lowest depths ... It is a blot on the poor law administration ... they are ignorant, unreliable, and being unpaid are under no discipline or control. The women 'nurses' are nearly all unmarried mothers who have been confined in the house. They are coarse and fit only for drudgery.

Male pauper nurses he described as 'corner-boys' who were a 'demoralising influence', and their hands 'like poisonous bees carrying the pollen of infection from bed to bed'.³⁰

Dr. Smyth's personal agenda was to rid the system of unscrupulous pauper nurses, to which end he wrote another letter to the *Freeman's Journal* in July 1897 providing a flavour of their questionable behaviour. He cited several cases of theft, blackmail and cruelty, and one of a pauper nurse whom he had found, to his disgust, selling hospital rice to an elderly pauper

²⁶ Luddy, *Women and Philanthropy*, pp. 49–50.

²⁷ This was a major source of concern for Nightingale with regard to untrained nurses in the Liverpool workhouse in the 1870s (*Florence Nightingale on Public Health Care*, vi, ed. L. McDonald (Waterloo, Ontario, 2004), 231–40).

²⁸ *Freeman's Journal*, 7 Jan. 1897.

²⁹ Fealy, *A History of Apprenticeship Nurse Training*, p. 73.

³⁰ *Freeman's Journal*, 7 Jan. 1897.

patient at a penny a plate.³¹ While he was careful to distinguish the activities of pauper nurses from the good work performed by ‘nursing nuns’, he was not afraid to point out that the latter could not perform full nursing duties. Notwithstanding the contemporary moral sensibilities, Smyth’s aim was to raise awareness of the need for trained nursing assistance in the workhouse system, which he believed offered an opportunity for positive change.³²

Acutely aware of the problems associated with employing untrained nurses, the L.G.B. issued a circular on the subject in 1890, warning boards of guardians of the reputational damage to union hospitals. It made a strong case for the employment of trained nursing staff and argued that the use of unskilled nurses undermined the work of the medical officer.³³ From a patient perspective the L.G.B. noted that the poor had little confidence in the abilities of staff at fever and union hospitals, which, from a public health standpoint, was particularly problematic in instances of ‘eruptive fever’. Obviously, the conviction of the governors of Sir Patrick Dun’s Hospital, Dublin, expressed in 1878, that the union hospitals would become a major employer of its trainees was misplaced.³⁴ Instead the L.G.B. found union hospitals in the eighteen-nineties guilty of employing untrained nurses at salaries much lower than standard for qualified nurses and, as each Poor Law union was permitted degrees of financial autonomy, they had little recourse except to encourage change until the Local Government Act of 1898 which, as Crossman highlights, attempted to regulate the sector by clarifying the qualifications required and expected duties.³⁵

Religious tensions over training intensified after Lady Anne Lee Plunkett, wife of the Protestant archbishop of Dublin, established St. Patrick’s Home in 1876. It occupied a number of locations in the early years but settled more permanently on St. Stephen’s Green at the close of the century.

³¹ *Freeman’s Journal*, 11 June 1897.

³² V. Crossman, *Poverty and the Poor Law in Ireland, 1850–1914* (Liverpool, 2013), pp. 144–57.

³³ Circular, 10 Apr. 1890, *Annual Report of the Local Government Board for Ireland* (Parl. Papers 1890–1 [C. 6439], xxxv), pp. 68–9: ‘the highest skill and attention on the part of the medical officer may be neutralized by the ignorance and incapacity of the nurse charged with the duty of carrying out his instructions and informing him of those important changes in the condition of patients which an unskilled nurse will fail to observe and appreciate’ (cited in Crossman, *Poverty and the Poor Law*, p. 148).

³⁴ Sir Patrick Dun’s Hospital, *Report of the Governors of Sir Patrick Dun’s Hospital for the Year Ending 31 Dec. 1878* (Dublin, 1879), p. 9. Midwifery was first introduced to the hospital in 1867 under 30 & 31 Vict., c. 9, which also permitted teaching of surgery; prior to then it dealt with medical cases only.

³⁵ On the financing of the Medical Charities Act, see Geary, *Medicine and Charity in Ireland*, pp. 21–15. See also Crossman, *Poverty and the Poor Law*, p. 148.

Owing to her social position and her philanthropic endeavours she was able to obtain the help and financial support of influential patrons such as Lady Ardilaun, Lady Brabazon and Mrs. Tottenham.³⁶ The nurses trained in Ireland in the eighteen-seventies and eighteen-eighties were invariably not Roman Catholic. Sir Patrick Dun's Hospital trained midwives who were largely drawn from a cohort of military wives, whose training, while managed by the governors, was 'supported by special subscriptions' from people coming from Anglican religious persuasions.³⁷ Perhaps as a result of encroaching sectarianism, the Board of Governors at Sir Patrick Dun's Hospital (which also provided training in general nursing) was prompted to take an ecumenical stand in 1886 when it decreed that nurse training should not take account of religion. Deeming this 'unsuitable', the board declared its commitment to principles of open access that would allow for 'any young woman of good character' to be admitted.³⁸ From 1890, St. Patrick's Home began to receive a yearly sum of £140 from the Q.N.I. on the condition that it trained four probationers (trainee nurses) per annum.³⁹ As a training home St. Patrick's increasingly became a source of controversy. Although not overtly Protestant in ethos, its support base was undeniably so and it was perhaps around this time that the Roman Catholic archbishop of Dublin, William Walsh, insisted that Roman Catholic probationers receive separate training and live apart from Protestants.⁴⁰ To that end, subscriptions were gathered and St. Lawrence's Home established in July 1891, located at 21 Mary Street.⁴¹ St. Lawrence's ethos was unmistakable and it was founded, according to a contemporary observer, out of the necessity to create a body of Catholic trainees, 'the nurses belonging to which should be beyond all suspicion of tampering with the faith of their patients'.⁴²

Efforts to establish Queen's Nurses in Ireland followed the British

³⁶ *Annual Reports of St. Patrick's Home for Providing Trained Nurses for the Sick Poor, 1889* (Dublin, 1890), p. 8.

³⁷ Sir Patrick Dun's Hospital, *Report of the Governors of Sir Patrick Dun's Hospital for the Year Ending 31 Dec. 1879* (Dublin, 1880), p. 9.

³⁸ Sir Patrick Dun's Hospital, *Report of the Governors of Sir Patrick Dun's Hospital for the Year Ending 31 Dec. 1886* (Dublin, 1887), pp. 6–7.

³⁹ *Annual Reports of St. Patrick's Home for Providing Trained Nurses for the Sick Poor, 1892* (Dublin, 1890), p. 8.

⁴⁰ M. H. Preston, *Charitable Words: Women, Philanthropy, and the Language of Charity in 19th-Century Dublin* (Westport, Conn., 2004), p. 155. Efforts to find further information on the timeline of Archbishop Walsh's actions have proven fruitless. The author is grateful to Noelle Dowling, Dublin Diocesan Archives, for her efforts in trying to locate materials.

⁴¹ *Freeman's Journal*, 20 Nov. 1893.

⁴² M. J. Martin, 'St Lawrence's Catholic home', *Irish Monthly*, xxi (1893), 15 (cited in Preston, *Charitable Words*, p. 155).

template, which relied on local support and a subscription-based funding model, whereby a committee of local power-brokers, or their wives, would gather funds and administer the post. Over the years, the Q.N.I.'s Irish branch office occupied various locations in Dublin City centre. It provided oversight, administered the training, allocated posts and inspected the Irish D.N.A.s. Mary E. Dunn was its first general superintendent, ably assisted by Caroline Anne Blackmore and Mary Lamont, all of whom shared the duties of inspections, administration and correspondence. For D.N.A.s to receive 'affiliation', committees had to give the following undertakings: that there was sufficient local need and funding, that nurses would be working under the direction of the local medical doctor, that appropriate lodging was available to them and, most importantly, that the nurses had received Q.N.I. training. Described in the *Nursing Record* as 'harder than hospital nursing' owing to remote locations, the frequent lack of medical supervision, and the absence of clinical support mechanisms, district nursing was noted to have proved more successful if candidates were 'selected from a higher social position from the ordinary class of nurses'. Women 'possessed of refinement and tact', it was suggested, would be better able to communicate with the poor.⁴³ These aristocratic and female-dominated origins are usually invoked by historians to explain why 'scientific' nursing was slow to make professional gains.⁴⁴ However, Caitriona Clear's suggestion that male dominance of medicine had greater culpability is more plausible and deserving of further investigation.⁴⁵ Nonetheless, its aristocratic origins extended to the local organization of the schemes. As Damant has shown, 'the QNI operated on the basis of goodwill ... through a process of voluntary affiliation'.⁴⁶ Grafting such a system on to the Irish socio-economic and political landscape of the late nineteenth century was never going to be an easy process. Far from the humanistic philosophy of the public health movement for the poor, the immediate concerns in Ireland were primarily denominational.

The Londonderry Association, located in the northern province of Ulster, was one of the first Irish D.N.A.s to receive Q.N.I. affiliation. Political and denominational issues formed a significant undercurrent to the activities of the well-meaning wives of local dignitaries who, when outlining the case for

⁴³ *Nursing Record*, 5 Apr. 1888.

⁴⁴ D. Palmer, "'To help a million sick, you must kill a few nurses": nurses' occupational health, 1890–1914', *Nursing History Review*, xx (2012), 25; H. Sweet, 'Town nurse and country nurse: viewing an early 20th-century district nursing landscape', in *Women in the Professions: Politics and Philanthropy 1840–1940*, ed. K. Bradley and H. Sweet (Victoria, B.C., 2009), pp. 150–84.

⁴⁵ C. Clear, *Nuns in 19th-Century Ireland* (Dublin, 1987), p. 132.

⁴⁶ Damant, 'A biographical profile', p. 587.

affiliation, were at pains to stress how ‘undenominational’ the committee was in its religious persuasions, comprising two Roman Catholic, seven Church of Ireland and eight Presbyterian members. This representation was disproportionate to the religious composition of the city, which was predominantly Roman Catholic.⁴⁷ The committee emphasized that their nurses had attended 1,004 poor patients in a period of two months, irrespective of religion, and that arrangements for the acquisition of a ‘nurses home’ were underway.⁴⁸ Another prerequisite for affiliation was that a D.N.A. committee should employ a fully trained Queen’s Nurse. In this instance Nurse Isabella Cairnie had trained at the Edgware Road Home in London, and was on the queen’s roll.⁴⁹ A letter of thanks noted that granting its application for affiliation would ‘bind the loyal hearts of Derry in attachment to their Queen and will help convince the less well disposed of the beneficent intentions of the Royal Lady who would not only be their Queen but nursing mother’.⁵⁰ This expression of loyalist sentiment reflected Ireland’s state of seemingly perpetual political unrest at the close of the nineteenth century, with agitation moving from the land to the national question in quick succession, and religious concerns were never far from the surface.⁵¹ Superintendent Dunn of the Q.N.I. Dublin Branch was ever conscious of creeping sectarianism and the necessity to circumvent the problem in the wider interests of public health. In an effort to allay concerns she routinely cited the greater good and was reported speaking as follows in the St. Patrick’s Home annual report:

A short time ago two gentlemen of high social position and well known for their philanthropy came to my office. They did not come together, and the districts in Ireland in which they are interested were wide apart, but they both used the same words. They were men of different politics and different creeds, yet they both expressed to us their belief that one of the best things they could do for the people was to provide them with District nurses, in order that they might be raised, civilised, improved all round.⁵²

⁴⁷ *Census of Ireland, 1891. Part I. Vol. III. Province of Ulster* (Parl. Papers 1892 [C. 6626], xcii.1), p. 747.

⁴⁸ W.L.A., SA/QNI/S.2/1/1, box 120, letter from Rebecca Hime, Hon. Sec., Londonderry Association, n.d.

⁴⁹ *Nursing Record*, 10 Sept. 1891. U.C.D.A., P220/28 fo. 13, District No 2. Londonderry. Nurse Cairnie was number 105 on the queen’s roll.

⁵⁰ W.L.A., SA/QNI/S.2/1/1, box 120, letter from Rebecca Hime, Hon. Sec., Londonderry Association, 23 May 1891.

⁵¹ M. Kelly, ‘The politics of Protestant street preaching in 1890s Ireland’, *Historical Journal*, xlviii (2005), 101–25.

⁵² *Annual Reports of St. Patrick’s Home for Providing Trained Nurses for the Sick Poor, 1894* (Dublin, 1895), p. 9.

Londonderry's Catholic clergy did not oppose the introduction of the scheme and its largely Anglican committee. However, not all associations enjoyed such denominational harmony. An 1896 letter from the Dublin Branch recounted a most disconcerting affair in Limerick City to the London headquarters. It detailed how a well-intentioned, if misguided, group represented by Mr. Bourke proposed the idea of introducing a district health nurse to Limerick City. In the process of placating local interests, the Roman Catholic bishop of Limerick, Edward Thomas O'Dwyer, was approached for his 'blessing'. The bishop's response was to offer support in principle as he saw 'the immense value and practical benefit [that] would accrue to the poor were such an association started'. But he queried: 'Would the nurses be Catholic?' Bourke responded, 'Yes, it would be preposterous to bring a Protestant here'.⁵³ According to the account, the Anglican bishop of Limerick, Dr. Charles Graves, was far less demanding and passed no comment.⁵⁴ At this time Limerick workhouse nuns offered some district nursing care but since they did not attend maternity, male or night cases, provision could hardly be described as a comprehensive service. According to his biographer, having 'inherited a large body of nuns or religious sisters' who were primarily concerned with the provision of education, O'Dwyer introduced an English order, the Nursing Sisters of the Little Company of Mary, to run St. John's Hospital in 1888.⁵⁵ Londonderry and Limerick City shared a similar religious profile but where Londonderry had a diverse and thriving textile sector, the Limerick economy was not so fortunate; there were few employment opportunities and an abundance of unskilled women.⁵⁶ The denominational profile of the poor of both cities was, however, very similar.⁵⁷

The Limerick D.N.A. served a population of 37,155 and was affiliated in July 1897.⁵⁸ Nurse Gardiner, a qualified Jubilee nurse, was employed.

⁵³ W.L.A., SA/QNI/S.2/1/1, box 120, letter from Dublin Branch of Q.N.I., Inspector C. A. Blackmore to Miss Peter, 4 Jan. 1897.

⁵⁴ P. M. Byrne, 'Graves, Charles', in *Dictionary of Irish Biography*, ed. J. McGuire and J. Quinn (Cambridge, 2009), pp. 209–11.

⁵⁵ T. J. Morrissey, *Bishop Edward Thomas O'Dwyer of Limerick, 1842–1917* (Dublin, 2003), p. 219.

⁵⁶ *Royal Commission on Labour. The Employment of women. Reports by Miss Eliza Orme, Miss Clara E. Collet, Miss May E. Abraham, and Miss Margaret H. Irwin (Lady Assistant Commissioners), on the Conditions of Work in Various Industries in England, Wales, Scotland, and Ireland* (Parl. Papers 1893–4 [C. 6894], xxiii), p. 327. In Limerick lace-making provided employment to about 2,000 women and girls.

⁵⁷ *Census of Ireland, 1891. Part I. Vol. II. Province of Munster* (Parl. Papers 1892 [C. 6567], xci.1), p. 653.

⁵⁸ U.C.D.A., P220/28 fo. 229, District No. 38 Limerick.

Like most of the early recruits she happened to be Protestant.⁵⁹ Extenuating socio-economic circumstances notwithstanding it soon transpired that the bishop could not be swayed on the matter of mixed religion and domiciliary care, and this led to the project's failure. Shortly after Nurse Gardiner's arrival his discontent became apparent and concerns arose that nursing should be conducted in tandem with prayer. So serious was the situation for Nurse Gardiner in Limerick that the Q.N.I. inspector, Caroline Anne Blackmore, made an official visit. According to the bishop, 'had that and the political and Protestant nurse been left out everything would have gone splendidly'. His greatest 'fear' was that those attending to the sick poor might exert 'undue influence'. His concerns were 'not' that the nurse would bring pressure to bear, but that the patient would be brought into contact with those who would attempt proselytism. He also feared that the nurse 'would take away the nuns' work'.⁶⁰ It is unclear which funds sustained a 'second nurse', Nurse Kathleen Browne, who was trained at St. Bartholomew's, London, and at St. Lawrence's Home, Dublin, and arrived in Limerick in August 1897.⁶¹ She was still working there in 1899 when she received her two years' service certificate.⁶²

While in Limerick dealing with the Nurse Gardiner matter, Blackmore witnessed the case of a dying Roman Catholic woman to whom the bishop was willing to deny care rather than have her see a Protestant nurse. Blackmore appeased the situation by sending Miss Browne, whose religion was implied by her training at St. Lawrence's. Her Q.N.I. affiliation notwithstanding, the bishop consented to this. At that point he, although a 'Queen's man', wanted to have nothing to do with the Q.N.I. nurses, whom he maintained were causing reputational damage to the monarchy. Alas there were not sufficient Protestant poor in Limerick to occupy Nurse Gardiner, and it was reported to Miss Peter in London that the Limerick case was beyond rescue. Blackmore's solution to the problem was to 'offer Miss G. a post elsewhere ... as long as she was moved quickly with no mention of religion'. For Blackmore the greater concern was that the long-term reputation of the Q.N.I. was being damaged by association with Protestantism and proselytism. She described how they had already 'lost' districts like Ennis where nuns were being sent to nurse.⁶³ A decade

⁵⁹ U.C.D.A., P220/28 fo. 229. Her number on the queen's roll was 786. She was appointed a Queen's Nurse in July 1896 and her agreement ended in Apr. 1898; she left in 1909 to pursue other work.

⁶⁰ W.L.A., SA/QNI/S.2/1/1, box 120, C. A. Blackmore to Miss Hughes, 4 Jan. 1897.

⁶¹ U.C.D.A., P220/28 fo. 229. Her number on the queen's roll was 936; she was appointed in July 1897 and her agreement ended in May 1899.

⁶² *Freeman's Journal*, 24 Aug. 1899.

⁶³ W.L.A., SA/QNI/S.2/1/1, box 120, C. A. Blackmore to Miss Hughes, 4 Jan. 1897.

later, a Cork association that faced the same issues elected to implement the following rule: ‘we have decided to allow Nurse Heaps to visit Roman Catholics only when the consent of the doctor and that of the Priest have previously been given. This rule had to be made because of difficulties raised by Roman Catholics themselves not by us’.⁶⁴

On the charges of proselytism in Limerick, Blackmore tried her best to allay fears, but reported that the response to her was: ‘When I say this cannot be so they tell me Prot’s [*sic*] in Ireland are different’. She added that some of the trained nursing nuns in Ireland were English, ‘which looks as if there cannot be such bad feelings against English Catholics’.⁶⁵ Clear has noted how Bishop O’Dwyer specifically asked the Sisters of Mercy and the Little Company of Mary to ‘step up their own sick visitation with the co-operation of the local medical profession’.⁶⁶ Amid the Gardiner controversy the Limerick Chamber of Commerce met in April 1897 to consider how to bring another trained nurse to the city. Almost £1,200 had been collected in subscriptions and a committee was appointed. Interestingly, the Anglican bishop sent his apologies.⁶⁷ Bishop O’Dwyer’s position caused the city’s Catholic doctors to join a campaign against the Q.N.I. nurses, sending all of their cases to the nuns, who had divided the city into four zones. In an effort to assert supremacy the bishop sought to have his nursing nuns recognized by the Q.N.I. and, Blackmore reported, ‘especially asked that I might obtain permission to inspect his nurses and their work to find out if they were up to the mark or not. Anything we suggested he would carry out’.⁶⁸ To circumvent the problems of nuns’ inability to attend night cases the bishop planned to employ a secular nurse from London to take these.⁶⁹ He made little provision for the fact that nuns were not permitted to conduct surgical or midwifery work, a prohibition that remained until the nineteen-thirties.⁷⁰ Efforts were also made to establish a Vincent de

⁶⁴ W.L.A., SA/QNI/S.2/1/1, box 120, S. R. Day to Miss Lamont, 5 Oct. 1901. U.C.D.A., P220/28 fo. 361, District No. 60 Cork. Nurse Heaps was trained at St. Patrick’s Home. She was appointed a Queen’s Nurse in Jan. 1901, and her number on the queen’s roll was 1607.

⁶⁵ W.L.A., SA/QNI/S.2/1/1, box 120, C. A. Blackmore to Miss Hughes, 4 Jan. 1897.

⁶⁶ Clear, *Nuns in 19th-Century Ireland*, p. 133.

⁶⁷ *Freeman’s Journal*, 9 Apr. 1897.

⁶⁸ W.L.A., SA/QNI/S.2/1/1, box 120, letter from Dublin Branch of Q.N.I., Inspector C. A. Blackmore to Miss Peter, 4 Jan. 1897.

⁶⁹ By contrast Irish nursing nuns in America paid little heed to Vatican restrictions (see S. Nelson, *Say Little, Do Much: Nursing, Nuns, and Hospitals in the 19th Century* (Philadelphia, Pa., 2011), pp. 20–1).

⁷⁰ *Ingravescentibus Malis*, Encyclical on the Rosary, His Holiness Pope Pius XI, promulgated on 29 Sept. 1937, sect. 27 <http://www.newadvent.org/library/docs_piixim.htm> [accessed 22 Oct. 2013]; *Saeculo Exeunte Octavo*, Encyclical of His Holiness Pope Pius XII on the Eighth Centenary of the Independence of Portugal on 13 June 1940, sect. 42

Paul nursing nun in Limerick to bolster the work of the workhouse nuns.⁷¹ Contrary to the ethos of the Q.N.I., and the provision of free services, poor patients were expected to make contributions for visitations from the Little Company of Mary, which placed the service beyond the means of some.⁷²

In areas of extreme poverty the attitudes of Roman Catholic priests differed vastly. Faced with the imminent removal of Nurse Lee from Achill Island, County Mayo, in February 1900 due to exhaustion of funds, parish priest John P. Connelly wrote to the Q.N.I. appealing for assistance in replacing her if she were removed.⁷³ He made his case in stark human terms, noting that the year before she arrived there had been twenty-four maternal deaths, and ‘scarcely any since she came here’.⁷⁴ Apparently, for Fr. Connelly, fears of maternal mortality trumped any potential religious anxieties.

Q.N.I. inspectors found that doctors could be just as problematic as the Roman Catholic clergy. Many refused to accept the nurses not for sectarian but for professional reasons. Most nurses were drafted into relatively endogamous areas with little inward migration apart from doctors, local government officials, the judiciary and the clergy. Internecine rivalries among medical personnel and difficult personalities posed a significant threat to progress in district nursing. For instance, Dr. Thompson of Portrush had several difficulties with Nurse McGrath, whom he found attending the same case as him but under the auspices of the dispensary doctor, Dr. Martin.⁷⁵ In that instance it was reported that Dr. Thompson was so rude and “violent in his manner” to the nurse that she reported the matter’. He later wrote an official complaint about her saying that she was insubordinate and selective when it came to patients, and cited an occasion when he maintained she had refused to see an unemployed labourer.⁷⁶ His allegations appear to have been unfounded but that did not stop him from writing several letters of complaint seeking a ‘hearing’ with the committee, which did not countenance his claims. It is likely that his response to Nurse McGrath was symptomatic of the anxieties experienced by private practitioners in the face of the shifting medical landscape with all its new medical characters. Nurse McGrath was deemed ‘very satisfactory’

<http://www.vatican.va/holy_father/pius_xii/encyclicals/documents/hf_p-xii_enc_13061940_saeculo-exeunte-octavo_en.html> [accessed 22 Oct. 2013].

⁷¹ *Freeman's Journal*, 17 Nov. 1898.

⁷² Clear, *Nuns in 19th-Century Ireland*, p. 132.

⁷³ U.C.D.A., P220/28 fo. 235, District No. 39 Co. Mayo. The population of Achill was 3,000. The D.N.A. was affiliated in July 1897.

⁷⁴ W.L.A., SA/QNI/S.2/1/1, box 120, J. P. Connelly P.P., Achill, to Miss Lamont, Dublin, 26 Feb. 1900.

⁷⁵ W.L.A., SA/QNI/S.2/1/1, box 120, 25 Jan. 1900.

⁷⁶ W.L.A., SA/QNI/S.2/1/1, box 120, Dr. Thompson to Q.N.I., Dublin, 19 Jan. 1900.

by Inspector Dunn. She left Portrush in February 1898, remaining in the Q.N.I. until 15 October 1901 when she left to ‘take up private nursing’.⁷⁷ Perhaps as a consequence of Dr. Martin’s exacting standards, her successor Nurse Cassidy was inspected eight times over her four-year tenure after which the scheme in Portrush was discontinued.⁷⁸

On the surface slipshod financial and administrative management proved to be the downfall of the Rosses D.N.A. affiliation in County Donegal, but given wider denominational and professional difficulties, it can be argued that this concealed deeper underlying problems. Administrative issues were first brought to the attention of Mrs. Rathbone in May 1895 when Mrs. Sinclair, the honorary secretary, wrote saying how she was unsure if the £10 support promised for the previous year had been received. Continued cavalier approaches to finances and employment terms caused immediate concern and a subsequent investigation in August 1898, when Inspector Blackmore reported that the committee never met and nobody knew who was on it. A letter from Mrs. Pomeroy in October 1898 revealed that Mrs. Smith, the wife of the local rector, was willing to take over from Mrs. Sinclair but sectarian matters again proved a difficulty. It was highlighted by Mrs. Pomeroy that the work of the D.N.A. in a predominantly Roman Catholic community would be prejudiced were it run by the rector’s wife.⁷⁹ It transpired that Mrs. Smith had not been asked to become a committee member and it appears that from the outset Sinclair was trying to manage local tensions, which in turn gave rise to allegations of financial mismanagement. A report from the London-based Mrs. Rathbone provided the context for the Rosses D.N.A.’s disarray. According to Rathbone, subscriptions had been gathered to train a Roman Catholic, Nurse Dunn, but her health had failed prior to appointment. The fund was managed by Mrs. Sinclair who neglected to file receipts or reports with the Q.N.I. for two years. It later transpired that Nurse Glynn, who was appointed instead of Nurse Dunn, was absent on full pay for eight months, six of which were given over to compassionate leave to tend to her sick brother, and two of which were spent in Sligo providing relief to the service there, meaning that she was paid twice.⁸⁰ This

⁷⁷ U.C.D.A., P220/28 fo. 169, District No. 28 Portrush, Co. Antrim: population 1,655, affiliated Apr. 1896, disaffiliated 1905 due to ‘no fund’.

⁷⁸ U.C.D.A., P220/28 fo. 169. Cassidy’s number on the queen’s roll was 1797.

⁷⁹ W.L.A., SA/QNI/S.2/1/1, box 120, letter from Mrs. Pomeroy, 24 Oct. 1898.

⁸⁰ U.C.D.A., P220/28 fo. 157, District No. 26 Sligo. According to Rathbone’s notes a Nurse Massey was engaged as Nurse Dunn’s replacement but this is not substantiated by the Q.N.I. registers held at U.C.D. The Sligo D.N.A. was founded in Nov. 1895; it was affiliated in Dec. 1895. The population was 10,808. Nurse Glynn (number 507 on the queen’s roll) was appointed in July 1894 and temporarily employed from Feb. to May 1898 in Sligo after her predecessor Nurse Camp resigned. Maude M. Stockwin (queen’s roll 1418) was inspected by

was neither sanctioned nor acceptable. During Dunn's period of absence there was an outbreak of typhus leaving the doctor over-extended because he was required both to attend to patients and carry out nursing work:

During this terrible epidemic Typhus broke out and the medical man had to do a Nurse's work, having as many as 10 cases in a cabin: this meant whole families disabled. He often had to wash patients himself he would have been most thankful for Nurse's services at this time if only to attend his non-infected cases if she were not allowed to attend Typhus.⁸¹

This account speaks volumes about the gendered and professional division of medical versus nursing duties. After the vilified Mrs. Sinclair received the Q.N.I. reports, she wrote in defence of her actions revealing the real problems she faced. She explained that she had:

summoned dozens of meetings and never could get them to attend. On Dec 5th '96 Mrs Pomeroy, myself & the old man where the Nurse lodges constituted a meeting. We carefully consulted, I took notes of suggestions & wrote to persons agreed upon – without the slightest result. I consider this not due to lack of good will, but no one inclined to come forward ...

Clearly Mrs. Sinclair never managed to muster sufficient local support but she also acknowledged her own failings in hiding the fact that the nurse had left for an indefinite period, and permitting her payment during that time. As well as apologies, Sinclair offered personally to cover the costs.⁸²

So badly were financial affairs managed that the largest local subscribers (the marquis and marchioness of Cunningham and Mr. and Mrs. Pomeroy) threatened to stop their subscriptions.⁸³ Rathbone explained that the doctor had provided her with damning evidence that 'the books were what he called padded ... If she had a man near-by with his hand tied up or a boy with a scratch they were put down as "cases" and visited while if he sent a case in a more outlying place, the Nurse said she was too busy to go! Also she required too much of the people'. It appears that the doctor was more fully versed in local politics and averse to Glynn and Sinclair, but he offered sound advice for the future. As recounted by Rathbone, this was

Blackmore in August 1898 at the Rosses. Stockwin was transferred to Burriscarra, District No. 46 Mayo, D.N.A. (population 610, affiliated Nov. 1898, closed in 1908 due to funding collapse) in Apr. 1902; that district closed in 1905 (U.C.D.A., P220/28 fo. 277).

⁸¹ W.L.A., SA/QNI/S.2/1/1, box 120, Q.N.I. Irish Branch, inspector's report, the Rosses, Donegal, 31 Aug. 1898.

⁸² W.L.A., SA/QNI/S.2/1/1, box 120, Mrs. Sinclair to the Q.N.I., 3 Nov. 1898.

⁸³ W.L.A., SA/QNI/S.2/1/1, box 120, Q.N.I. Irish Branch, inspector's report, the Rosses, Donegal, 31 Aug. 1898.

to convene a committee to decide which patients should be seen by the nurse. Although a Protestant himself, he also advised that the next nurse be Roman Catholic as he had received ‘several subscriptions from Priests’.⁸⁴ The underlying sectarian and professional problems stood in marked contrast with a patient narrative recorded in a St. Patrick’s Home annual report where a man from the Rosses was quoted as saying, as his injured arm was being dressed: ‘I feel that even here I am near civilization when I see the Queen’s letters on your arm’.⁸⁵ The Rosses debacle concluded with Sinclair’s resignation in April 1898. Mrs. Smith was endorsed by the Q.N.I. Ireland Branch as a replacement, and Nurse Glynn resigned in 1899.⁸⁶

Professional tensions were all too common and often combined with sectarian issues to deleterious effect. In 1905 in Bruff, County Limerick, Dr. Cleary complained about the local nurse with whom everyone else was satisfied. It transpired that his complaints were motivated by petty jealousy of a new physician, Dr. Fitzgerald, who had come to the area, and who routinely referred cases to the local nurse. The situation was further complicated by the fact that the parish priest did likewise. It was an area where a ‘system of family tickets, a sort of club system’ existed. This made it problematic to upset the status quo and placed the poor at a serious disadvantage.⁸⁷ Matters reached a head when Dr. Cleary arrived at a case that was being attended to by Nurse Daly, who had been sent there by the parish priest. Although Dr. Cleary’s input was sought prior to her appointment, he clearly did not read or understand the rules and regulations and later wrote:

I got a distinct undertaking that the nurse would attend no cases except where a doctor was in attendance – the only exception being that of an accident or some hurried case where she may if present give ‘first aid’ pending the calling of a doctor. Some months after her advent to this place I found that she was more a surgical practitioner than a nurse (in fact a Quack).⁸⁸

⁸⁴ W.L.A., SA/QNI/S.2/1/1, box 120, extract from a letter from Mrs. Rathbone, 7 Oct. 1899; U.C.D.A., P220/28 fo. 91. Nurse Glynn (number 507 on the queen’s roll) was trained at St. Patrick’s in 1894, where she remained until her resignation in 1899. District No. 15 Co. Donegal (population 10,721) was affiliated in Feb. 1894.

⁸⁵ *Annual Reports of St. Patrick’s Home for Providing Trained Nurses for the Sick Poor, 1894* (Dublin, 1895), p. 9.

⁸⁶ U.C.D.A., P220/28 fo. 91, District No. 15 Co. Donegal. By 1906 the Lady Dudley Scheme had stationed nurses in Anagry, Mallinmore and Arranmore Island, Co. Donegal (*Fourth Annual Report* (1906), p. 6).

⁸⁷ W.L.A., SA/QNI/S.2/1/1, box 120, Miss Lamont, Dublin, to Miss Hughes, 3 Apr. 1905.

⁸⁸ W.L.A., SA/QNI/S.2/1/1, box 120, Dr. Cleary, Hospital, Co. Limerick, to the general superintendent of the Q.N.I., Dublin Branch, 30 Sept. 1905.

Commenting on the Bruff case, Mary Lamont at the Dublin Branch wrote, 'You know the Parish Priests are powerful in this country and when the doctor and the PP are not friends the position is difficult for the nurse'.⁸⁹ The Q.N.I. inspectors once again elected to appease local interests and it was decided that the nurse should not attend cases if the doctor objected. Dr. Cleary sought clarification after clarification on minutiae and accused the nurse of all sorts of malpractice. Matters escalated when he stated that he would not allow Nurse Daly to attend any of his patients and claimed that she was earning fees which were rightfully 'the Doctor's'. Again Dr. Cleary appears to have misrepresented the facts, accusing the nurse of spending an unnecessarily long period of three weeks on a single case. In reality she had spent thirteen days and the case was not his.⁹⁰ Lamont confessed to Miss Hughes in London that she was 'very much vexed by Dr Cleary's attitude' and, while she clearly understood the underlying agendas, she was left with little choice as to how to proceed. Dr. Cleary having stated that he would work with another nurse, to placate matters Miss Lamont recommended this as a course of action, much to the local committee's chagrin. But unlike the case of Nurse Gardiner in Limerick City, an important caveat was added, that the nurse was not at fault.⁹¹ Nurse Daly was recorded in the Q.N.I. register as 'transferred to Foxford after midwifery training' in January 1906.⁹²

Sue Hawkins has recently argued that to suggest that nurses in Britain emanated solely from the middle classes is to misunderstand their complex social composition. Using the records of St. George's Hospital in London she has shown that nurses presented textured social origins.⁹³ While it is not possible without in-depth prosopographical research to determine the social class of the Q.N.I. nurses in Ireland, some general observations can be made. For instance, we can postulate their denominational persuasions from their training institution. Furthermore, the tenor of their reception by the clergy of their host communities is equally revealing. This may also have caused tensions between the nurses and the medical profession, which was dominated by middle-class and usually Anglican men. In general terms

⁸⁹ W.L.A., SA/QNI/S.2/1/1, box 120, Miss Lamont, Dublin, to Miss Hughes, 3 Apr. 1905.

⁹⁰ W.L.A., SA/QNI/S.2/1/1, box 120, Miss Lamont, Dublin, to Miss Hughes, 13 Oct. 1905.

⁹¹ W.L.A., SA/QNI/S.2/1/1, box 120, Miss Lamont, Dublin, to Miss Hughes, 16 Oct. 1905.

⁹² U.C.D.A., P220/28 fo. 517, District No. 86 Limerick. Bruff was affiliated on 17 May 1904. She trained in St. Lawrence's Home and was appointed a Queen's Nurse in Jan 1903. Her number is not recorded on that folio; it is recorded on U.C.D.A., P220/28 fo. 565, District No. 94 Co. Mayo, as 2007. She was transferred to St. Lawrence's Home in Sept. 1910.

⁹³ S. Hawkins, *Nursing and Women's Labour in the 19th Century: the Quest for Independence* (Oxford, 2010).

Q.N.I. nurses stood apart socially from their patients and the dispensary doctors. In most areas doctors were glad of the alleviation of the burden of work in the dispensaries, but in the instances examined here the professional difficulties nurses faced operating in a patriarchal medical structure were pronounced. As this essay has shown, in some areas doctors did not need to oppose the introduction of nurses, as vociferous clergy did their bidding, even if this was sometimes inadvertent. In Limerick, doctors weighed in behind Bishop O'Dwyer by effectively waging a boycott against 'Queen's Nurses'. Perhaps another plausible reason for their silence was that the 'occupational politics' of nursing in England had presented significant challenges to the power structure of hospital medicine in particular; it threatened employment, and inter-occupational and gender relations.⁹⁴ The case of Achill acts as a revealing baseline. Here the religious, gendered and professional differences were more carefully negotiated from the outset and the Q.N.I. nurses had a real impact on maternal mortality rates.⁹⁵

The introduction of the concept of district nursing to Ireland, administering to the poor, while admirable in its aims, raised a host of political, social and ecumenical tensions, which were invariably regionally specific. From a geo-political perspective it proved easier to introduce district nurses to areas of severe poverty but political stability, of which there were several. Indeed the Lady Dudley Scheme founded in 1903 managed to introduce many nurses to some of the poorest parts of Ireland without much opposition, but its success was occasioned by a different set of personalities and socio-political circumstances.⁹⁶ In the early years the success or failure of D.N.A.s hinged to a great degree on levels of support from local clergy. For some the fear of proselytism outweighed concerns for the physical well-being of the Roman Catholic poor. This is particularly evident in Limerick, where Bishop O'Dwyer was vociferous on political matters and offered substandard alternative care. So marked was his opposition that it gave currency to similar campaigns in the nearby counties of Cork, Clare and Galway.⁹⁷ In areas where doctors were concerned about the loss of financial

⁹⁴ A. Witz, *Professions and Patriarchy* (repr., 2013).

⁹⁵ *Lady Dudley's Scheme for the Establishment of District Nurses in the Poorest Parts of Ireland, First Annual Report* (Dublin, 1904), p. 15. Similarly improved maternal health moved Monsignor Walker, Burtonport, to write in 1905 praising the efforts of the Lady Dudley Scheme in Arranmore.

⁹⁶ C. Breathnach, 'The Congested Districts Board and public health', in *Gender and Medicine in Ireland, 1700–1951*, ed. M. Preston and M. Ó hÓgartaigh (New York, 2012), pp. 258–81.

⁹⁷ W.L.A., SA/QNI/S.2/1/1, box 120, letter from C. A. Blackmore and M. E. Dunn to Miss Peter, dated 17 Dec. 1897. The bishop of Galway employed a Roman Catholic nurse so the Protestant Nurse Young was largely idle.

and professional benefits, nurses also had a terrible time. Although nurses and their personal experiences are not dealt with here, there is ample scope for further investigation. What is clear from this examination is that while district nurses undoubtedly diversified the mixed medical economy in Ireland, their level of access to the poor in the domiciliary setting posed a significant threat to priests and doctors alike.

8. To ‘solve the darkest Social Problems of our time’: the Church of Scotland’s entry into the British matrix of health and welfare provision, c.1880–1914

Janet Greenlees

Throughout the eighteenth and nineteenth centuries, Scottish society relied on an informal network of religious provision for many essential health and welfare services and to fill gaps in Poor Law provision. Towards the end of the nineteenth century, religious leaders from many denominations discussed co-ordinating and formalizing their charitable provision. In a swiftly changing urban landscape with rapidly growing inequalities, all denominations sought to be socially useful, but debated how best to do so. Of the Presbyterian sects that dominated the Scottish religious landscape, only the Established Church of Scotland decided both to broaden and formalize its health and welfare provision, and enter a welfare market in which other Christian denominations already had an established presence. In 1891, it began providing nursing services for the poor in the slums of the Pleasance District of Edinburgh. Shortly thereafter, in 1894, the church opened the Deaconess Hospital in Edinburgh to train missionary deaconesses and to provide healthcare for church members and the poor of the Pleasance. By 1904, the General Assembly agreed ‘That the Church must not shrink from taking her full share in Social and Rescue Work; and that, as the National Church, she ought to lead the way in demonstrating that the Gospel of Jesus Christ can meet the direst needs of human Souls, and solve the darkest Social Problems of our time’.¹ To that end, it formed a Committee on Social Work to research and co-ordinate service provision. This essay examines why, after centuries of informal provision, the Established Church of Scotland decided to enter the formal health and welfare market, particularly when other Presbyterian groups did not; what services it provided and why these were chosen; and where such provision fitted within the existing mixed economy of the Scottish health and welfare market. By the onset of the Great War, the Church of Scotland was an established provider of institutional welfare in Scottish cities, particularly Glasgow. This essay argues that the decision to

¹ *R.C.S. W.G.A.C.S.*, May 1904, pp. 1200–3; and *R.C.S. W.G.A.C.S.*, 1905, p. 1211.

undertake welfare work was influenced by economic, social, political and cultural circumstances, and driven forward by dynamic individuals. The services provided were the church's response to moral anxieties about the threat that urbanization and industrialization posed to community and family values.

The significance accorded to the Church of Scotland's welfare provision by contemporaries is not reflected in the current historiography. Twentieth-century Scottish voluntary health and welfare provision has attracted surprisingly little scholarly attention, with the exception of pre-N.H.S. voluntary hospitals.² Yet local philanthropic services have been found to be significant contributors to English health and welfare provision within their area,³ and recent studies have highlighted the continued importance of the voluntary sector, including religious charities, in English and Welsh welfare provision during the twentieth century.⁴ Scotland was much more dependent on charity provision than England and Wales because of both tradition and Poor Law deficiencies, yet scholarly emphasis remains

² Notable exceptions include: A. Nuttall, 'Maternity charities, the Edinburgh maternity scheme and the medicalisation of childbirth, 1900–25', *Soc. Hist. of Med.*, xxiv (2011), 370–88; L. Mahood, *The Magdalenes: Prostitution in the 19th Century* (1990); O. Checkland, *Philanthropy in Victorian Scotland: Social Welfare and the Voluntary Principle* (Edinburgh, 1980); J. Greenlees, 'The peculiar and complex female problem: the Church of Scotland and healthcare for unwed mothers, c.1900–48', in *Western Maternity and Medicine, 1880–1990*, ed. J. Greenlees and L. Bryder (2013), pp. 47–64; S. Al Gailani, 'Teratology and the clinic: monsters, obstetrics and the making of antenatal life in Edinburgh, c.1900' (unpublished University of Cambridge Ph.D. thesis, 2010). For voluntary hospitals, see, e.g., J. Stewart, 'Sickness and health', in *A History of Everyday Life in 20th-Century Scotland*, ed. L. Abrams and C. G. Brown (Edinburgh, 2010), pp. 228–53; *The NHS in Scotland: the Legacy of the Past and the Prospect for the Future*, ed. C. Nottingham (Aldershot, 2000); J. Jenkinson, *Scotland's Health, 1919–48* (Bern, 2002); J. Stewart, 'The National Health Service in Scotland, 1947–74: Scottish or British?', *Historical Research*, lxxvi (2003), 389–410; and *Improving the Common Weal: Aspects of Scottish Health Services, 1900–84*, ed. G. McLachlan (Edinburgh, 1987).

³ E.g., S. J. Seligman, 'The Royal Maternity Charity: the first 100 years', *Medical History*, xxiv (1980), 403–18; L. Marks, *Metropolitan Maternity: Maternal and Infant Welfare Services in Early 20th-Century London* (Amsterdam, 1996); L. Marks, 'Mothers, babies and hospitals: "The London" and the provision of maternity care in East London, 1870–1939', in *Women and Children First: International Maternal and Infant Welfare, 1870–1945*, ed. V. Fildes, L. Marks and H. Marland (1992), pp. 48–73.

⁴ England and Wales have received greater attention than Scotland. In relation to unwed mothers, see P. Thane and T. Evans, *Sinners? Scroungers? Saints? Unmarried Motherhood in 20th-Century England* (Oxford, 2012); see also P. Thane, *Happy Families: History and Family Policy* (2010), pp. 18–21 and L. Black, 'There was something about Mary: the National Viewers' and Listeners' Association and social movement history', in *NGOs in Contemporary Britain: Non-State Actors in Society and Politics since 1945*, ed. N. Crowson, M. Hilton and J. McKay (2009), pp. 182–200.

largely focused on the foundations of the welfare state, an emphasis which has limited our understanding of voluntary provision in England and Scotland.⁵

Interwoven within both Scottish religious charity and Poor Law welfare provision were consistent themes of discrimination based on whom providers deemed worthy, and individual and family obligations to kin. Such beliefs remained well into the inter-war years, as did conservative attitudes towards responsibility for relief.⁶ Historians examining the Church of Scotland's motivation for entering the formal welfare market tend to argue either that the church sought to re-engage with the working classes,⁷ or that social work was an initiative designed to recast the missionary endeavour. Here, the belief was that both individuals and social structures could be reformed, alongside creating a Christian society.⁸ Moreover, historians also emphasize the importance of factional struggles between Presbyterians in influencing the social reform agenda.⁹ This essay extends these arguments by examining how and why voluntary bodies engaged with an increasingly complex Scottish welfare market. It provides a more nuanced understanding of the interaction between the state and the voluntary sector, and the changing position of religious charity in Scottish and broader British society, as well as the developing relationship between church and state concerning social policy. Lastly, it shifts the focus of understanding about Scottish religion and voluntarism

⁵ M. A. Crowther, 'Poverty, health and welfare', in *People and Society in Scotland, 1830–1914*, ed. W. H. Fraser and R. J. Morris (Edinburgh, 1990), p. 286.

⁶ C. Macdonald, *Whaur Extremes Meet: Scotland's 20th Century* (Edinburgh, 2009), p. 137.

⁷ C. G. Brown, *Religion and Society in Scotland since 1707* (Edinburgh, 1997), esp. ch. 6; D. J. Withrington, 'The churches in Scotland, c.1870–c.1900: towards a new social conscience', *R.S.C.H.S.*, xix (1975–7), 155–68; and D. J. Withrington, 'Non-church-going, church organisation and "crisis in the church" c.1880–c.1920', *R.S.C.H.S.*, xxiv (1990–2), 199–236; C. G. Brown, *The Social History of Religion in Scotland since 1733* (1987), p. 191. Stewart adds the church's ideological approach to social concerns (J. Stewart, "'Christ's Kingdom in Scotland": Scottish Presbyterianism, social reform, and the Edwardian crisis', *Twentieth-Century British History*, xxii (2001), 1–22).

⁸ L. Orr Macdonald, *A Unique and Glorious Mission: Women and Presbyterianism in Scotland, 1830–1930* (Edinburgh, 2000), pp. 64–6.

⁹ Brown, *Religion and Society*, ch. 6; C. G. Brown, "'To be aglow with civic ardours": the "Godly Commonwealth" in Glasgow 1843–1914', *R.S.C.H.S.*, xxvi (1996), 169–95; S. J. Brown, 'Reform, reconstruction, reaction: the social vision of Scottish Presbyterianism, c.1830–1930', *Scottish Journal of Theology*, iv (1991), 489–518; M. McCabe, 'The tears of the poor: John Glasse, Christian socialist (1848–1918)', *R.S.C.H.S.*, xxviii (1998), 149–72; and D. C. Smith, *Passive Obedience and Prophetic Protest: Social Criticism in the Scottish Church 1830–1945* (New York, 1987), ch. 10. This is not to imply that these authors adopt the same analysis.

away from existing debates about how the new social theology contributed to the gradual secularization of Scottish society.¹⁰

The early twentieth-century initiatives of the Church of Scotland's Committee on Social Work highlight how the church sought to capitalize on its central role within Scottish society to address issues of social reform, while also retaining its core position within the social fabric of a rapidly changing Scottish industrial landscape. The church believed social reform was entwined with social policy. Social reform prioritized reinvigorating Christian morality and values as part of the solution to social and economic inequalities. By addressing social problems surrounding poverty, the church hoped to influence public policy on issues including housing, welfare, education and unemployment. Activities in these areas reflected church efforts to be the primary shaper of Scottish social values while securing to the hierarchy civic and medical recognition, and political influence, without disrupting the centuries-old parish traditions of informal charity. Philanthropy was also an act of authority because it created a dependent, albeit sometimes only temporary, relationship between the rich and the poor. Church social welfare, as with all social welfare, was a political act.¹¹ As such, it reinforced the hierarchy's desire to 'create a comprehensive social service worthy of a National Church'.¹² The church sought to influence social change and social reform in order to secure and retain its position as the National Church in Scotland, with the associated political benefits.

The aim to establish the Church of Scotland as *the* National Church grew out of the rapidly changing make-up of religious organization in the late nineteenth century, which paralleled urban growth and high poverty levels, particularly in Glasgow. Earlier Presbyterian rifts¹³ meant that the new United Free Church (U.F.C.), a 1900 union of the United Presbyterian Church and the Free Church, formed the greatest rival to the Established Church for members and influence in Scotland's cities. The growing poverty levels in urban centres highlighted to the General Assembly the social need to address issues surrounding poverty.¹⁴ In 1901, half the Scottish population

¹⁰ Brown, *Religion and Society*, esp. ch. 6; Brown, 'Reform, reconstruction, reaction'; Stewart, "Christ's Kingdom"; C. G. Brown, *The Death of Christian Britain* (Abingdon, 2001); H. McLeod, *Religion and Society in England, 1850–1914* (Basingstoke, 1996), esp. ch. 4.

¹¹ For more on the relationship between philanthropy and political motivations, see M. Ignatieff, 'State, civil society and total institutions: a critique of recent social histories of punishment', in *Social Control and the State*, ed. S. Cohen and A. Skull (Oxford, 1983), p. 102.

¹² L. Cameron, *Opportunity my Ally* (Cambridge, 1965), p. 233.

¹³ For a brief summary of these rifts, see Brown, *Social History*, pp. 34–41.

¹⁴ Dr. Theodore Marshall argued the case for social work to the General Assembly (*The*

lived in one or two rooms. In 1911 20 per cent of Scots resided in one-room single-ends in multi-storey tenements with five or more people, providing a haven for disease.¹⁵ State assistance through the Scottish Poor Law helped only the poorest and most helpless members of society. Moreover, the Poor Law Amendment Act of 1845 had effectively taken the direct responsibility for the care of the poor out of the hands of the church. With its social and economic function declining, the church sought a new role. Addressing social problems was core to the evangelicalism characteristic of the Free, Established and United Presbyterian churches, as well as the Methodist and Congregational churches.¹⁶ Evangelical welfare initiatives in Scotland operated alongside those of other charities active throughout Great Britain, including the Charity Organisation Society, the Church of England, the Y.W.C.A. and the Salvation Army, as well as the extensive, and little-documented, neighbourly charity. At the same time the Catholic Church had extended its outreach and welfare provision among the growing working classes, focusing predominantly on the new Irish immigrants. By the late nineteenth century, in addition to the Magdalene Home for unwed mothers established in 1805, the Catholic Church in Glasgow operated industrial schools for both girls and boys and institutions for the aged poor, orphans and incurable children.¹⁷ Yet of all these providers, it was the other Presbyterian groups that the Established Church considered the greatest threat to its goal of becoming *the* National Church.

Nevertheless, the Established Church of Scotland's formal entry into social work was not spontaneous. Rather, it was the culmination of decades of study and debate about the extent and causes of social problems and the nature and scope of existing provision. Dr. Archibald Charteris (b. 1835) directed the attention of the church towards increasing its Christian social work. Son of a schoolmaster, Charteris ascended rapidly through church ranks. In the mid nineteenth century, after serving the ministry in Ayr and at Park Established Church, Glasgow, and despite facing much criticism from conservative church elders, he persuaded the General Assembly to

Layman's Book of the General Assembly of 1904, ed. Revd. H. M. B. Reid (Edinburgh, 1904), p. 117).

¹⁵ Many families also had a boarder (L. Abrams, *The Orphan Country: Children of Scotland's Broken Homes from 1845 to the Present Day* (Edinburgh, 1998), p. 6; *Report of the Royal Commission on the Housing of the Industrial Population of Scotland Rural and Urban* (Parl. Papers 1917–18 [C. 8731], xiv), p. 106 (as cited in Macdonald, *Whaur Extremes Meet*, p. 124)).

¹⁶ For more on women's mission work, see Orr Macdonald, *A Unique and Glorious Mission*, esp. ch. 2 (quotation at p. 43); Brown, *Religion and Society*, pp. 116–21.

¹⁷ *Catholic Directory for Scotland* (Edinburgh, 1911–12), pp. 187–91, 32–3; for more on the Magdalene Home, see Mahood, *The Magdalenes*.

form the Committee on Christian Life and Work in 1869, with the aim of increasing voluntarism and evangelism.¹⁸

The Church of Scotland's debates about social reform were further influenced by Glasgow's second medical officer of health, Dr. James Burn Russell, who was appointed in 1872. Early in his career, Russell had worked at the Glasgow Royal Infirmary, the City Poorhouse and as physician superintendent of Glasgow's fever hospitals. His experiences in these institutions convinced him that better living conditions were essential to improving the health of the city. He argued his case in an 1888 lecture, 'Life in one room', delivered to the literary society of Park Established Church, Glasgow, Charteris's former parish. The lecture, which was subsequently published and secured a wide readership, provided a detailed account of the overcrowded housing in which over a quarter of Glasgow's population lived. The Park Church minister, Donald Macleod, added a religious dimension to Russell's interpretation by pointing out how in Glasgow, a close correlation existed between poor housing and non-churchgoing.¹⁹ These arguments convinced the Church of Scotland's Glasgow Presbytery to commission a report on *The Housing of the Poor in Relation to their Social Condition*, published in 1891, which examined the relationships between housing, poverty and non-churchgoing.²⁰ These early questions about the nature and extent of existing church provision fuelled discussions about the future shape of church voluntarism. However, the need for formal Christian charity did not go unchallenged.

By the eighteen-eighties, the role of voluntarism was being debated throughout Britain. The philosophy of social progress by individual action that had characterized earlier Christian charity was gradually being overtaken by the collectivist action of the state. Indeed, in Glasgow, the Presbytery's investigations were followed by a series of Glasgow Corporation reports on the relationship between housing and poverty which prompted pioneering civic housing reforms.²¹ State initiatives expanded in the early years of the twentieth century with the introduction of National Insurance and old-age pensions, the medical inspection of school children, and expanding

¹⁸ L. L. L. Cameron, *The Challenge of Need: a History of Social Service by the Church of Scotland, 1869–1969* (Edinburgh, 1971). pp. 12–14.

¹⁹ D. Macleod, *Non-Church-Going and the Housing of the Poor* (Edinburgh, 1888), p. 13 (cited in Brown, 'Reform', p. 498).

²⁰ *Presbytery of Glasgow: Report of Commission on the Housing of the Poor in Relation to their Social Condition* (Glasgow, 1891).

²¹ Mitchell Library, Glasgow Corporation papers, *City Improvement Department Report on Proceedings at a Conference on Cheap Dwellings* (Glasgow, 1901); *Subcommittee Report on Uninhabitable Houses* (Glasgow, 1906); *Better Housing – Will They Pay* (Glasgow, 1899); *Housing of the Working-Classes* (Glasgow, 1900); *Backlands and their Inhabitants* (Glasgow, 1901); C. Booth, *Life and Labour of the People of London* (1889).

municipal ownership of utilities. Moreover, new initiatives in social and political action were being undertaken by trade union leaders, social intellectuals and the new labour politicians. Such schemes also coincided with broader British social investigations into poverty, including those of Charles Booth and Seebohm Rowntree, as well as the Royal Commissions on Housing and the Poor Law.²² Such extensive civic and religious debates about the causes of social problems, and the moral principles of permitting their continuation, convinced the General Assembly that poverty, insanitary and overcrowded housing and ill-health were all immoralities. The church had to respond to such social injustices out of social and civic duty, and to retain its position as the National Church with the associated political influence.

In Glasgow, a small band of Presbyterian Christian socialists emerged and led the drive towards social work rather than social reform. In 1895, the Revd. Donald Macleod, having left Park Church in 1888 to become the convener of the Home Mission Committee, was elected moderator of the General Assembly. Known for his scepticism about evangelicalism, he used his moderatorial address to urge the church to develop a new social conscience to meet the challenges of organized labour. Yet, while Brown argues that the challenge of labour was the key motivator for action,²³ other events suggest that this was only one of a number of motivating factors. For half a century, one of the main architects behind both the new Social Christianity and the strategy of the Committee on Social Work was David Watson. Watson had become interested in social work while minister from 1886 to 1928 of St. Clement's Church, a poor working-class congregation in the east end of Glasgow. From its inception in 1904, Watson was the vice-convenor of the Committee on Social Work. He was a prolific author and preacher on social reform, being highly critical of the existing social order.²⁴ Both Watson and Macleod took up Charteris's cry for the Church of Scotland to engage in a social mission, tackle poverty and make the gospel message more relevant to all of Scottish society. Yet Watson and other church leaders, including John Glasse, minister of old Greyfriars Church in Edinburgh and arguably the most famous Christian socialist clergyman

²² B. S. Rowntree, *Poverty: a Study of Town Life* (1902); and *Royal Commission on the Housing of the Poor in Relation to their Social Condition, 1888–91*. For an overview of housing in Glasgow, see J. Melling, *Rent Strikes: Peoples' Struggles for Housing in West Scotland, 1890–1916* (Edinburgh, 1983).

²³ Brown, *Religion and Society*, pp. 131–2.

²⁴ Watson's best-known works are D. Watson, *Social Problems and the Church's Duty* (1908); *Social Advance – its Meaning, Method and Goal* (1911); and *The Social Expression of Christianity* (1919).

in Scotland, were divided on strategy.²⁵ Rejecting the primacy of religious conversion and morality as the outcomes of social reform, Watson favoured practical social work. Glasse was opposed, arguing that social work would deter the church from tackling the evils and injustices in the existing social order (true Christian socialism rather than practical Christian socialism). While social work, or practical Christianity, became the prevailing church strategy, Watson's ideological split with Glasse was representative of broader rifts within the church concerning social strategy. The conservative church hierarchy worked within the existing social order rather than try to reform it. From the outset, the Committee on Social Work prioritized helping the deserving poor (social work) rather than tackling broader social and economic inequalities (social reform). This choice limited the church's social influence but raised its political profile.

The Established Church of Scotland was not alone among religious denominations in debating whether and how best to address social inequalities in Scotland, though not all arrived at the same understanding about service provision. From 1900, the General Assembly of the U.F.C. also debated its social responsibilities. In 1902, in response to Rowntree's study on the condition of the poor in York, John Smith, convener of the General Assembly, argued that the church 'cannot simply avail herself of these studies. She has her own point of view'.²⁶ By 1904, the assembly concluded that: 'the problem of poverty can only be solved by getting back to the moral foundations on which all human well-being can alone rest'.²⁷ He argued that while civic authorities were responsible for regulating housing and addressing poverty, the church maintained responsibility for morality because:

Social conditions and moral habits react on each other. To provide better houses, and to attempt to enforce habits of cleanliness, will be to a large extent to throw effort away, unless moral reformation goes hand in hand with sanitary legislation. The homes are dirty because the dwellers are drunken, and filthy because the tenants are foul ... The social question is at bottom the religious question. Little progress towards reclaiming the sunken masses will be made, unless there be betterment of their surroundings and conditions of life. But, on the other hand, new and healthy houses will do little lasting good, unless the tenants are reformed in character – made new men and women by the grace of God.²⁸

²⁵ Smith, *Passive Obedience*, pp. 338–9, 302.

²⁶ *R.G.A.U.F.C., 1902* (Edinburgh, 1902), p. 3.

²⁷ *R.G.A.U.F.C., 1904* (Edinburgh, 1904), p. 4.

²⁸ Report of the Committee on Church Life and Work (*R.G.A.U.F.C., 1906* (Edinburgh, 1906)), p. 5.

To 'solve the darkest Social Problems of our time'

Increasingly, the U.F.C. tried to pressurize civic authorities to act rather than join the extensive, religious voluntary welfare market. Nevertheless, by 1908, the U.F.C. recognized a need to co-operate more closely with existing providers.²⁹ By 1912, it realized that 'sooner or later' it would need to appoint a 'specially equipped department' for practical Christian service.³⁰ The U.F.C.'s slow response to growing social and religious criticism of the social order, combined with its continued moral and evangelical priorities, distanced the church from the working classes and decreased its political and civic influence. Moreover, declining membership convinced the church hierarchy to focus on uniting the U.F.C. and the Established Church, rather than on its social mission. The Church of Scotland's increasing centrality in the religious fabric of Scottish society thus made it well placed to address health and welfare issues, and to influence policymakers.

In a complex welfare market in which the state, family and voluntary bodies were established and important players, the Church of Scotland sought to avoid duplicating existing social services. It surveyed local charitable provision throughout Britain and overseas,³¹ examining projects run by the Church Army and Salvation Army, and smaller initiatives, including the Scottish Labour Colony in Dumfries, the Glasgow Mission to the Friendless, the Water Street Mission in New York, and others.³² The Committee on Social Work concluded that it should emphasize localized social and rescue work, with institutions organized by professionals and controlled by the centre (the church hierarchy), rather than through the congregational mainstream.³³ The church's charitable work of earlier centuries was now formalized and it did not study social questions or advocate social reform.³⁴

Recognizing that decent accommodation formed part of the solution to many of Scotland's health and social problems, in 1905 the church opened two homes for men and one for boys. This provision soon expanded to include a variety of hostels, boarding houses and homes for young men and women in Scotland's cities, particularly Glasgow.³⁵ Young people were a particular concern as they were susceptible to temptation, frequently

²⁹ Report on Church Life and Work, app. (*R.G.A.U.F.C., 1908* (Edinburgh, 1908)), p. 30.

³⁰ Special Committee on Social Problems (*R.G.A.U.F.C., 1911* (Edinburgh, 1911)), p. 9.

³¹ *R.C.S.W.G.A.C.S., 1904*, pp. 1186, 1179.

³² *R.C.S.W.G.A.C.S., 1904*, app. 1, pp. 1188–206.

³³ *R.C.S.W.G.A.C.S., 1904*, pp. 1203, 1179.

³⁴ Smith, *Passive Obedience*, p. 338.

³⁵ See, e.g., *The Layman's Book of the General Assembly of 1911*, ed. Revd. H. M. B. Reid (Edinburgh, 1911), pp. 146–7; *Layman's Book of the General Assembly of 1913*, ed. Revd. H. Smith (Edinburgh, 1913), p. 123.

having only recently left the moral constraints of their parents in rural communities, and had limited urban housing options. As healthy, able-bodied members of society, these groups were often overlooked by existing charities. Most urban private and local authority boarding homes prioritized ability to pay over personal circumstance. While some of these homes were well run and in good repair, others were not. Overcrowding was also a common problem. The church sought to ensure that its accommodation provided moral surroundings. To this end, it employed married couples or matrons to provide a 'family' atmosphere and moral supervision. Such homes catered only for the respectable working poor, or those thought capable of being redeemed.³⁶ By 1906, the Committee on Social Work was operating two labour homes in Glasgow which had admitted 380 men over the previous the year.³⁷ These numbers were comparable to the Church Army's homes in the east end of London.³⁸ They also operated men's homes in Edinburgh and Dundee, both of which had admitted over 100 men the previous year. Their Humbie Farm Home took fifty-three boys, while their Glasgow Home for Lads accepted fifty-one. The committee also commenced women's work, taking over the running of Glasgow's Industrial Home for Destitute Women and Children on Watson Street, which could accommodate 100 residents, and opening a home in Morham Vale which could accommodate twenty 'wayward' women.³⁹ These figures suggest that the Church of Scotland hoped to become a major player in the welfare market. It was aided in this goal by the shortage of quality accommodation in Glasgow.

Alongside the church's efforts, Glasgow Corporation was also improving and expanding available short-term accommodation. A 1904 report by the Corporation of Glasgow noted that there were now sixty-seven model lodging houses in the city, seven of which belonged to the corporation. The others were operated by private individuals, presumably for profit. Fifty-one of these were for men and sixteen for women.⁴⁰ These model lodging houses replaced earlier lodging houses that were in poor repair and subject to serious overcrowding, and where religious and social observers believed immoral conduct was commonplace. Yet the corporation did not provide the important moral supervision the church desired.

³⁶ *R.C.S.W.G.A.C.S., 1905*, pp. 1199–205 and *The Layman's Book of the General Assembly of 1905*, ed. Revd. H. M. B. Reid (Edinburgh, 1905), pp. 47–9.

³⁷ *R.C.S.W.G.A.C.S., 1906*, p. 1161.

³⁸ *The Layman's Book of the General Assembly of 1906*, ed. Revd. H. M. B. Reid (Edinburgh, 1906), p. 103.

³⁹ *R.C.S.W.G.A.C.S., 1906*, pp. 1153–65.

⁴⁰ Cited in *R.G.A.U.F.C., 1906* (Edinburgh, 1906), p. 9.

To 'solve the darkest Social Problems of our time'

As with much early twentieth-century charitable provision, Church of Scotland services soon prioritized women. Discussions with the Y.W.C.A., the Sisters of Charity of St. Vincent de Paul, the Salvation Army and others had highlighted the difficulties in dealing with fallen women and those 'not yet confirmed in immorality', but on what was seen as the slippery slope.⁴¹ Nevertheless, the boundaries between health and morality were vague and easily manipulated to meet changing priorities. In 1906, the Committee on Social Work agreed a four-pronged strategy of hostels, boarding houses and 'preventive' and 'rescue homes' in the Scottish cities of Glasgow, Dundee and Paisley. Hostels and boarding houses provided Christian accommodation. The 'preventive' homes offered accommodation, a 'kindly supervision', 'affection, and wise guidance, and spiritual atmosphere' for adolescent girls from 'respectable' homes who were believed at 'particular risk' from the perils of city life. The admittance policy was fairly liberal, only requiring that the girls or their families were church members. However, provided there was space, the homes accepted 'any young girl' living in unhealthy lodgings, and motherless girls. The only groups specifically excluded were 'weak-minded girls' and prostitutes.⁴²

'Rescue' homes sought to save girls either homeless or estranged from their families, and 'just entering upon the downward path', or who were first time offenders in the Police Courts.⁴³ Strict rules were implemented to restore these women to 'self-respect and social efficiency'.⁴⁴ Residents were expected to stay for a maximum of two years, to escape old associations, bury the past, and learn work from which they could make an honest living. This included laundry work, mattress-making, sewing projects, homework, including plain cookery, garden work for farm service, and domestic service.⁴⁵ In 1909 the church operated three homes for women. Viewpark Women's Home was a rescue home for women and their children in Uddingston, near Glasgow, and replaced the Watson Street Home. Between May and December 1909, the home admitted seventy-three women. The average number in residence was forty. A new Women's Receiving Home in Glasgow had provided trial accommodation for 105 women and girls over the previous year, up to eighteen being accommodated at a time. The women moved on either to Viewpark or a situation, or to other destinations such as friends' or other homes, or simply left. Another home at Morham

⁴¹ *R.C.S.W.G.A.C.S., 1905*, pp. 1215–17.

⁴² *R.C.S.W.G.A.C.S., 1914*, pp. 747–8; see also *R.C.S.W.G.A.C.S., 1933*, p. 304.

⁴³ *R.C.S.W.G.A.C.S., 1916*, pp. 517–18; *R.C.S.W.G.A.C.S., 1922* (Edinburgh, 1922), p. 474.

⁴⁴ *Life and Work*, xxxiv, 7 (June 1912), 215.

⁴⁵ *R.C.S.W.G.A.C.S., 1906*, pp. 1161–2; *Life and Work*, xlvii, 12 (Dec. 1925), 269; Mahood, *The Magdalenes*, p. 73.

Vale, East Lothian, accommodated women for up to two years, with twenty-seven admitted in 1909.⁴⁶ These three homes were regularly full and the girls were reported to be devoted to the matrons in charge, often visiting after they left.⁴⁷ Middle-class social reformers believed the homes provided a service worthy of a National Church by offering the same moral and physical supervision found in a good Christian home.⁴⁸ The church had successfully entwined health and morality, securing its position in the British social work matrix while distancing itself from broader social reform. Such projects provided opportunities for evangelism, but this was not the primary objective, as it was for much British and Irish religious charity.⁴⁹ The moral behaviour of residents was a greater priority. Conversion was the outcome of social reform, not the cause.⁵⁰

While the church had started social work as an experiment, by the First World War it was a powerful and co-ordinated provider. Indeed, in 1913 its men's, lads' and women's homes together admitted nearly 2,000 people, in addition to those accommodated in their seven hostels, four of which were located in Glasgow (see Table 8.1), while Miss Mary Hill, the Edinburgh Police Court sister, and her assistant, Miss B. R. M'Lean, worked with the court to provide help and advice for young, female, first-time offenders.⁵¹ The church's success in social work provision stemmed from several factors. First, public authorities, including the medical officer of health, and the community recognized the Church of Scotland's quality accommodation and efficient organization.⁵² While residents could leave at will, many found attractive the comfortable, affordable housing in an urban landscape with an acute shortage of such provision. Perhaps unsurprisingly, by the First World War, most of the church's homes were full and any vacancies quickly filled. Moreover, while provision and quality of municipal housing had increased since the late nineteenth century, the associated social problems remained. Institutional provision was, however, more successful at raising the church's political profile than in addressing poverty. Indeed, there was a convergence of much, though not all, of the social policy agenda of the Scottish Protestant and Catholic churches and the emerging labour movement. Christian socialism and

⁴⁶ *R.C.S.W.G.A.C.S.*, 1909, pp. 990, 992.

⁴⁷ *R.C.S.W.G.A.C.S.*, 1911, pp. 821–5.

⁴⁸ The church's 'rescue and preventive work on behalf of girls appealed to all who were interested in the welfare of their country' (Miss Balfour of Whittingehame on visiting a church home (*Life and Work*, xxxiv (Oct. 1912), 311)).

⁴⁹ P. Thane, *Foundations of the Welfare State* (2nd edn., 1996), p. 21.

⁵⁰ Brown, *Religion and Society*, p. 136.

⁵¹ See also *Church of Scotland Yearbook, 1914* (Edinburgh, 1914), pp. 84–5.

⁵² *Life and Work*, xxxiv, 7 (June 1912), 215; Church of Scotland, *Report of the Committee on Christian Life and Social Work to the General Assembly* (Edinburgh, 1943), p. 217.

Table 8.1 Church of Scotland institutional social work, 1913

	In home 31 Dec. 1912	Admitted during 1913	Left for situations	Restored to friends	Transferred to other homes	Left to look for work	Left without assigning any reason	Remaining in home at 31 Dec. 1913
6 men's homes	163	898	397	26	5	176	194	176
5 lads' homes	85	109	19	26	9		36	79
4 women's homes + Edinburgh Police Court sister's work with discharged prisoners	78	841	185	198	380	24	26	80
<i>Total</i>	<i>326</i>	<i>1848</i>	<i>601</i>	<i>250</i>	<i>394</i>	<i>200</i>	<i>256</i>	<i>335</i>

Other destinations were for small numbers, including apprenticeships, enlisting, hospital admittance, death and dismissal. This is only a partial list of their service provision. Figures are unavailable for all homes, including hostels, of which there were six for girls and one for elderly women in Scottish cities. There is an erratum in the original where the total remaining in Church of Scotland Homes in December 1913 is given as 339. Source: *Report of the Committee on Social Work, 1914*, p. 761.

political socialism were becoming complementary.⁵³ The Catholic Church, however, remained committed to reformatory and industrial schools, rather than branching into other institutional provision.⁵⁴ Indeed, social work, combined with indications that the Established Church of Scotland and the U.F.C. would soon unite as one 'National Church', contributed to church leaders and middle-class members being elected to a number of civic posts and government committees, including Glasgow Corporation and advisory councils to the Scottish secretary of state, particularly those concerning health and welfare matters.

Notwithstanding growing self-confidence within the Church of Scotland regarding the potential of social work to aid its social and political agenda, it was clear that new health and welfare services were necessary if the church was to maintain its authority in Scotland's matrix of health and welfare. Church influence was declining in Glasgow's hospitals, a traditional area of religious involvement. While the Deaconess Hospital served as a focal point for healthcare provision in Edinburgh, the church did not open a hospital in Glasgow. Instead, it had an established relationship with existing city hospitals. Since the opening of Glasgow Royal Infirmary in 1794, the church had played a prominent role in funding the hospital. Glasgow and West of Scotland parishes were regular early subscribers; sufficiently so that by 1806 the Hospital Board of Managers permitted each Glasgow Church of Scotland minister annually to nominate two patients for admission to the infirmary. This gave the church influence on hospital management, appointments and patient admissions.⁵⁵ Throughout the nineteenth century, the Glasgow Kirk sessions remained regular donors to hospital funds, especially in times of crisis, such as epidemics.

In contrast, there were no recorded, comparable hospital donations from Roman Catholic parishes; nor did the Catholic Church have formal representation on the hospital board.⁵⁶ Moreover, there was a long-standing mistrust between management of the Royal and Catholic chaplains who visited the infirmary. While there were occasional instances of religious discord,⁵⁷ it was a sectarian controversy that erupted in the newspapers

⁵³ For more on interdenominational relations, see Brown, *Religion and Society*, p. 139.

⁵⁴ The Catholic Church operated a reformatory school for boys in Glasgow, three industrial schools for boys and one for girls in Glasgow, and another for girls in Aberdeen (*The Catholic Directory for Scotland, 1913-14* (Edinburgh, 1914), p. 46).

⁵⁵ J. Jenkinson, M. Moss and I. Russell, *The Royal: the History of the Glasgow Royal Infirmary, 1974-94* (Glasgow, 1994), p. 24

⁵⁶ Jenkinson, Moss and Russell, *The Royal*, p. 78.

⁵⁷ For more on earlier instances of religious discord, see Jenkinson, Moss and Russell, *The Royal*, pp. 78-80.

in 1877 that damaged both the hospital's reputation and the relationship between it and Church leaders. The papers claimed that the Royal employed a large proportion of Catholic nurses, with a corresponding favouring of Catholic patients. Despite the lack of evidence, the West of Scotland Protestant Association supported the accuracy of these allegations of sectarianism. A formal investigation revealed that the 'scandal' was a product of rumours. Few Catholics were employed by the hospital and none in senior positions. Yet the extensive press coverage meant that the damage had been done. In the highly charged political climate of the late nineteenth century, the Royal certainly lost some subscriptions and legacies.⁵⁸ Because the hospital had always prided itself on its 'non-sectarian principles',⁵⁹ the Board of Managers of the infirmary, seemingly led by physicians on the board, was determined that religious leaders should be excluded from running the hospital. The building of a new hospital in 1910 provided the ideal opportunity. The board formed a new constitution and reconfigured its membership. This was to include women, together with greater representation from working men and the town council. Privilege memberships were removed, including members of parliament and the Church of Scotland.⁶⁰ Formal representation from church leaders to remain on the board failed, despite support from some members. The infirmary refused to reinstate church representation, being adamant that the board should be secular.⁶¹ Exclusion from traditional healthcare structures only strengthened the church's resolve to develop further its own health and welfare services, independent of existing provision, to ensure a leading, sustained and specifically Presbyterian presence in Glasgow's health and welfare market. Not to do so would severely curtail, and possibly end, the church's political and religious influence on decisions surrounding health and welfare provision in Scotland.

Voluntary bodies provide charitable services for many reasons, not all of which are client focused. Religious provision is often designed to address particular religious concerns about society and/or to serve political agendas. This essay has highlighted how voluntary providers are rarely motivated to

⁵⁸ The Royal had been involved in sectarian controversies erupting in the 1830s and 1840s. For more on the scandal of 1877, see Jenkinson, Moss and Russell, *The Royal*, pp. 121–3.

⁵⁹ *North British Daily Mail*, 27 Sept. 1877 (cited in Jenkinson, Moss and Russell, *The Royal*, p. 122).

⁶⁰ Glasgow, Mitchell Library, N.H.S. Greater Glasgow and Clyde Archives, HB14/1/25, records of the Glasgow Royal Infirmary, minutes of meeting of managers of Glasgow Infirmary, 13 Oct. 1910.

⁶¹ Mitchell Library, CH2/171/28, records of Glasgow Presbytery, 26 Oct. 1910, 30 Nov. 1910, 21 Dec. 1910, 28 June 1911; Mitchell Library, HB14/1/25, minutes of Glasgow Infirmary, special meeting of managers, 8 Nov. 1910; meeting of contributors, 9 Nov. 1910.

take action quickly, or by one sole issue. Examination of the development, dynamics and significance of the social work of the Established Church of Scotland offers a more nuanced explanation of how and why the church formalized health and welfare provision and how it differed from other providers. Entering a complex, mixed economy of provision was neither a sudden nor a rash decision; nor a response to one particular influence or person; nor was it purely an attempt to counter the labour movement, as Brown has argued. Concerns about religious competition, social reform, moral behaviour, political aspirations and the changing position of the church within traditional health and welfare provision, all influenced the hierarchy of the Church of Scotland to enter formal social work in the early twentieth century, prompted by dynamic individuals. While such services did not connect with the congregational mainstream, they filled important gaps in Scotland's urban health and welfare market and helped to secure the Established Church of Scotland's goal of becoming *the* National Church. Nevertheless, in the decades before the First World War, and despite increases in charitable donations, religious, voluntary and political leaders all acknowledged that charities made but a small dent in the problem of either urban or rural poverty.⁶² The Church of Scotland is a core example of this. Its main successes lay in incorporating a moral agenda into politics, not in initiating social reform or addressing social policy issues. In so doing, the church was able to withstand the threat to the national religion, at least for a short time. This contrasts with England where the gradually encroaching state increasingly threatened religious voluntary provision.⁶³ The advent of war in 1914, however, was to bring a more serious challenge to the social policies and political aspirations of the Church of Scotland, as it was to the wider role of state and voluntary bodies in health and welfare provision.

⁶² Thane, *Foundations*, pp. 59–60.

⁶³ See F. Prochaska, *Christianity and Social Service in Modern Britain: the Disinherited Spirit* (Oxford, 2006), ch. 6, esp. p. 151.

IV. Public health, voluntarism and local government

9. Feverish activity: Dublin City Council and the smallpox outbreak of 1902–3

Ciarán Wallace

A disaster which did not happen, a footnote in the history of Dublin, can tell us much about the evolution of healthcare. A serious outbreak of smallpox at the opening of the twentieth century threatened Dublin's overcrowded population and its proverbially inefficient City Council. How this looming catastrophe was averted illustrates the growing importance of local councils in safeguarding public health. Between the eras of charitable hospitals and direct state provision local government played an important role in healthcare. By modernizing local administration Westminster boosted the capacity of city and county government throughout the United Kingdom to shoulder this responsibility. Developing from earlier local government reforms in Scotland, England and Wales, the Local Government (Ireland) Act (1898) fundamentally restructured this most important – and intimate – branch of administration. Among the many radical changes which the act introduced, the most significant for the purposes of this essay are those dealing with sanitation and, perhaps surprisingly, with voting rights.

Charitable institutions and voluntary activism had played a key role in the evolution of public healthcare in Ireland through the nineteenth century. In the absence of comprehensive state provision a wide range of lay and religious groups catered to the needs of the ill, the aged and the physically impaired, typically targeting their own confessional communities. Committees of professionals and concerned citizens promoted their favourite medical causes, recruiting senior clerics and members of the nobility as patrons and honorary presidents. This patchwork of independent organizations, however, was ill-equipped to form an effective coalition against a major threat to public health. Within five years of receiving its broad new powers, Dublin Municipal Council unexpectedly proved that, in moments of crisis, it was the only provider capable of responding.

In an overcrowded, impoverished and slum-ridden city, Dublin's health services were under constant pressure. Dozens of voluntary agencies struggled to look after the daily needs of the inhabitants.¹ The city's decrepit state and

¹ In the first decade of the 20th century 36 voluntary hospitals, clinics and convalescent

crumbling infrastructure were a serious challenge to good public health, and the Municipal Council's apparent inability to improve the situation caused much complaint. The radical overhaul of Irish local government in 1898 transferred responsibility for preventing infectious diseases and controlling epidemics from the Poor Law guardians to newly created urban district councils. Thus the city became its own sanitary authority.² Under the Local Government (Ireland) Act (1898), Dublin acquired a wide range of new administrative and financial powers. Most relevant to the topic at hand were the clarification of its disease prevention role, an increase in its borrowing capacity, and a dramatic widening of the municipal franchise. The financial qualification for local voters was lowered to allow thousands of Dubliners in cheaper rented accommodation to join the electoral register. In addition, many women owning property in their own name could vote for the first time. Across the city the electorate suddenly leapt by 370 per cent; in some districts the increase was over 500 per cent.³ The excitement caused by these new electoral rights, and by regular elections for a body that provided so many daily services, from footpaths and playgrounds to the enforcement of food standards, strengthened both the public's interest and the council's democratic mandate.

The council had, however, always struggled to fulfil its existing sanitary duties; in this as in many municipal operations, reform was needed. In other cities the voluntary sector, medical charities and discontented ratepayers might join forces in an urban reform movement; religious divisions in Dublin's civil society prevented this, allowing inefficient and outdated practices to continue.⁴ In the field of public health and sanitation the

homes catered for the city's diverse medical needs, along with the state-funded Westmoreland Lock Hospital and the Hardwick-Richmond workhouse and infirmary complex (*Thom's Street Directory and Official Guide* (Dublin, 1900–14)).

² A complicated division of responsibilities for public health emergencies was clarified by the Local Government (Ireland) Act (1898) (61 & 62 Vic., c. 37), sect. 32. The Sewage Utilisation Act (1865) and Sanitary Act (1866) had appointed towns in Ireland as sewer and nuisance authorities, with power to prevent infectious disease. Poor Law guardians, however, had a disease prevention role under the Disease Prevention Act (1855). Sect. 150 of the Public Health (Ireland) Act (1878) gave guardians full control of emergency powers during an epidemic, while sect. 3 of the Epidemic and Other Infectious Diseases Prevention Act (1883) allowed urban authorities to share in this role. Such a system of overlapping authorities would have struggled to cope with a genuine emergency.

³ C. Wallace, 'Local politics and government in Dublin City and suburbs 1899–1914' (unpublished Trinity College Dublin Ph.D. thesis, 2010), p. 110.

⁴ Examples of reform coalitions from either side of the Atlantic are dealt with in J. P. D. Dunbabin, 'British local government reform: the 19th century and after', *Eng. Hist. Rev.*, xcii (1977), 777–805; and K. Finegold, *Experts and Politicians: Reform Challenges to Machine Politics in New York, Cleveland and Chicago* (Princeton, N.J., 1995).

leading group of concerned citizens was the Dublin Sanitary Association. Members of the association criticized City Hall, prodding councillors to improve sanitation by adopting a stream of new regulations coming from Westminster. City councillors, for their part, resented this interference from a body of self-appointed experts.

The balance of responsibilities between local grass-roots voluntarism, urban administration and national legislation during the smallpox crisis of 1902–3 reveals the limits of voluntary healthcare and points towards the emerging role of the state. This essay highlights the vital function performed by Dublin's Municipal Council in tackling the epidemic. It considers the interaction between the voluntary sector and the city authorities and explains how, despite ethnic and political differences, the state used new legislation to harness urban government to avert a deadly public health crisis.

Voluntarism in Dublin was well developed by the late nineteenth century with many groups existing to address specific social needs. The confessional divide separating medical charities, and voluntary groups more generally, limited the ability of civil society to act in a cohesive manner. In the absence of a fully evolved state system Protestant hospitals and Catholic relief agencies served the daily health and welfare needs of their separate communities. Differences in religion were closely aligned to deep-rooted political differences. Protestants, as a rule, favoured the maintenance of the union with Britain while Catholics were overwhelmingly nationalist and regularly voted for Home Rule – a form of limited self-government within the British empire. The divided nature of Dublin's civil society weakened its overall effectiveness, however, and limited its ability to lobby the City Council for reforms and action on sanitation and public health.

The complex structures linking the state and the city did not encourage health and welfare reforms. Between Westminster and Dublin Municipal Council was the complicated and complicating presence of Dublin Castle. An anachronistic inheritance from Ireland's colonial past, the castle was the regional administration for the Irish portion of the United Kingdom. It filtered, and occasionally frustrated, state policies in Ireland. Relations between the elected nationalists in City Hall and the appointed unionists in the castle were never smooth; had they worked well together many of Dublin's chronic problems might have been resolved. The 1898 Local Government Act delegated a great deal of power to the Local Government Board for Ireland, the agency responsible for supervising the operations of the new urban, rural and county councils. Sir Henry Robinson, the unionist head of the L.G.B., was an influential member of the castle administration.

While Dublin's municipal government had been radically restructured by the 1898 act, its politics remained unchanged. The city increasingly saw itself as the voice of nationalist Ireland in opposition to the unionist administration in Dublin Castle. This political antagonism left the city out of step with the state, as each eyed the other with undisguised suspicion. The nationalist population, as much through civil society as through their votes, supported the Municipal Council. They defended it from outside attack while using it to promote their Catholic and Gaelic identity. Dublin's Protestant unionists, meanwhile, held City Hall in considerable disdain, making it difficult for constructive co-operation to take place.

In many American and British cities at this time voluntary bodies and ratepayers' associations collaborated on reform campaigns against municipal corruption and on forcing councils to improve sanitation, building regulations, food processing, housing, street cleansing and water supply.⁵ Dublin's divided civil society was unable to make such co-ordinated efforts. The structural reforms introduced by the 1898 act were, seemingly, of limited value in modernizing the performance of urban government and the delivery of services to the public. While mortality statistics had improved on both sides of the Irish Sea from the mid nineteenth century, Dublin had begun from a lower base and failed to keep pace with improvements in Britain. This widening gap meant that Dublin stood out as particularly unhealthy at a time when the disparity between mortality levels in different English cities was declining.⁶

In the absence of co-ordinated public pressure to mend its ways Dublin Municipal Council continued to get away with chronic underperformance, as evidenced by the L.G.B.'s 1900 inquiry into the public health of Dublin City. Government statistics showed that in the decade to 1899 Dublin's mortality figures exceeded those of London and the thirty-three largest towns in England and Wales. The death rate among Dublin's younger population (five to thirty-five years) was more than double that of the same age groups in London. Prompted by such alarming figures the inquiry's brief was to identify the causes of this unhealthy state of affairs.⁷ During February and March 1900 a committee of six men experienced in public administration, the promotion of public health and the construction of

⁵ For a broader treatment of this international reformist trend, see E. P. Hennock, *Fit and Proper Persons: Ideal and Reality in 19th Century Urban Government* (1973); Dunbabin, 'British local government reform'; and Finegold, *Experts and Politicians*.

⁶ M. E. Daly, *Dublin the Deposed Capital: a Social and Economic History* (Cork, 1985), p. 243.

⁷ *Report of the Committee Appointed by the Local Government Board to inquire into the Public Health of the City of Dublin 1900* (Parl. Papers 1900 [Cd. 243 and 244], xxxix).

sanitary infrastructure, heard testimony about the state of the city's health. The committee found that 'the hospital accommodation for infectious diseases in Dublin is larger in proportion to the population than is the case in any English city',⁸ but the city had greater need of such beds because overcrowding meant that it was impossible to keep patients in isolation at home. An extreme example illustrates the point; the committee heard of a tenement in which four families lived in the four corners of one room, each separated by blankets hung over ropes, while the landlady lived in the centre of the room between these four screens. The enquiry noted that the existing stock of fever beds in voluntary hospitals was sometimes inadequate to meet the city's needs and it recommended that 'these hospitals should not be used for Smallpox, for which disease a separate hospital should be provided sufficiently distant from populous neighbourhoods'.⁹ The committee identified overcrowding, primitive or non-existent sewerage and filthy alleyways as major contributors to the spread of disease. Ignorance of legislative powers and the confused layers of property ownership and tenancy law also played a major part. Much of the problem, they argued, rested on the Municipal Council's poor enforcement of existing regulations.¹⁰

The committee also compared the impact of a range of diseases on the death rate in Dublin and London over the five years up to 1898. The list of zymotic, or contagious, conditions showed Dublin to have a higher death rate than London for eight out of the ten conditions listed.¹¹ Enteric fever, for example, killed 0.447 'per 1,000 persons living' in Dublin compared to 0.136 per 1,000 in London, and scarlet fever killed 0.279 in Dublin as against 0.185 in London. The most deadly disease by far, however, was tuberculosis (TB), described in the report as 'Phthisis or Pulmonary Consumption'. It accounted for 3.735 deaths per 1,000 of the population in Dublin and 1.769 in London. Significantly, TB was not categorized with the contagious diseases but was listed under 'Constitutional Diseases', which may help to explain why the condition had not received the attention it deserved from public health administrators.¹² Attitudes were changing at this point and

⁸ *Inquiry into the Public Health of Dublin 1900*, p. 8

⁹ *Inquiry into the Public Health of Dublin 1900*, p. 17.

¹⁰ Fourteen years later another parliamentary inquiry into the perilous state of Dublin's tenement housing stock found that weak enforcement was still a major cause of concern (*Report of the Departmental Committee Appointed by the Local Government Board for Ireland to inquire into the Housing Conditions of the Working Classes in the city of Dublin* (Parl. Papers 1914 [Cd. 7273], xix)).

¹¹ The zymotic diseases listed were: smallpox, measles, scarlet fever, typhus, whooping cough, diphtheria, simple and ill-defined fever, enteric fever, diarrhoea and dysentery. London's death rates from measles and diphtheria exceeded those in Dublin.

¹² Daly, *Dublin the Deposed Capital*, p. 266.

in January 1901 TB was made a notifiable disease, although on a voluntary basis only. Widespread overcrowding certainly facilitated the spread of TB in Dublin, and British studies showed a correlation between the number of rooms which a family occupied and rates of infection. Underlying poverty resulting in poor diet was also a contributing factor. As Mary Daly states, 'tuberculosis ... raised complex questions of income, diet and housing beyond the narrow confines of public health'.¹³ But the circumstances which contributed to its spread in the city made the arrival of other infectious diseases such as typhus and smallpox a very grave worry.

A further significant element contributing to Dublin's high death rate was the region's unusual administrative structure. A patchwork of small independent townships, or urban districts, surrounded the city proper. Unlike in Belfast, Glasgow or Birmingham, Dublin had failed to absorb its satellite townships in the late nineteenth and early twentieth century. This was not for want of trying. Continuous pressure from City Hall had produced a parliamentary commission in the eighteen-eighties, and a series of local bills in parliament, but none of these had succeeded in expanding the city boundaries to incorporate the suburban townships. Dublin's surrounding ring of self-governing suburbs looked and felt different from the nationalist city, that difference lying in their political, social and ethnic make-up. Prominent among the townships preventing Dublin's expansion were the unionist districts of Rathmines and Pembroke. Each was determined to resist the ambitions of the city's nationalist City Hall to form a 'Greater Dublin'. These tiny unionist entities were home to prosperous middle-class businessmen, professionals and administrators; the proportion of Protestants among their population was much larger than in the city.¹⁴ Unionist M.P.s and peers in Westminster supported their suburban cousins; for them the notion of loyal Rathmines or Pembroke coming under the authority of Dublin's nationalists was anathema. The logic of enlarged urban administrative areas, generally applied in Edinburgh, Birmingham and Belfast, was rejected in Dublin, where an influential minority was permitted to maintain an inefficient patchwork of councils. Thus the overcrowded and unhealthy city was trapped inside its eighteenth-century boundary, while the spacious new suburban townships enjoyed their broad avenues and enviably low death rates.

Although Dublin's political and sectarian divisions did not produce the street violence witnessed in Belfast, Liverpool and Glasgow, they were real nonetheless. The emergence of separate spheres of voluntary activity

¹³ Daly, *Dublin the Deposed Capital*, p. 268.

¹⁴ The census of 1901 shows a non-Catholic population of 37.6 per cent in the suburbs compared with 18.3 per cent in the city (Wallace, 'Local politics and government in Dublin', p. 91).

illustrates the gap between the Catholic and predominantly nationalist middle class and their Protestant unionist neighbours. For every Reformed Prisoners' Rescue Mission operating under the patronage of an Anglican bishop or a peer of the realm, there was a matching Roman Catholic agency guided by a member of the Catholic hierarchy. Specialist clinics and hospitals catered for the public 'of all denominations' but often their boards of governors were exclusively drawn from one denomination or the other. Admittedly there were a number of institutions which stood in the middle ground but, in general, the region's network of philanthropic hospitals, clinics, refuges and missions was woven from two very distinct threads. These operated effectively enough on a daily basis, but mutual suspicion and confessional loyalties meant that co-ordinated action was virtually impossible.

The 1898 Local Government Act increased the powers of councils across the country, and their vastly expanded electorate gave them a much stronger mandate. This was relevant for Dublin's effectiveness in tackling a public health crisis. Assessing local government in Canada, Norton E. Long has argued that municipal councils acted as flexible joints linking the local population to the state. In an ideal situation, Long claims, the people, the city and the state share a broad sense of identity. Any regional differences within this identity are accommodated by the municipal council which is firmly linked to the state while also representing the local loyalties of its voters. At the same time the city expresses an acceptably local version of the state to the people. According to Long, civil society, in the form of voluntary groups, engages with the city through representation on advisory bodies and council committees. Activists, for example, could be seconded onto committees dealing with education, policing or welfare. In this way the elected council becomes the manifestation of local civil society in action. In the early twentieth century this model worked for Birmingham or Edinburgh (or for Dublin's unionist suburbs), where the local council and Westminster shared a sense of national identity. Dublin's Municipal Council, however, was in an awkward position. It represented its electorate and engaged with the Catholic and nationalist element of civil society, but it was not fully connected with the layer above; the city did not share the United Kingdom's British identity.¹⁵ In addition, that section of society most likely to produce experts and activists who could advise and reform the city, the professional middle class, was predominantly Protestant and unionist and did not share the city's nationalist identity. These dysfunctional

¹⁵ N. E. Long, 'Aristotle and the study of local government', in *Politics and Government of Urban Canada*, ed. L. Feldman and M. Goldrick (Toronto, 1969), pp. 300–1.

relationships prevented reforms of Dublin's many difficulties, including its sanitation and public health challenges.

Municipal reformers were active in many cities from New York to Birmingham, Edinburgh to Leeds. Concerned citizens pressed the local city fathers to improve infrastructure, expand services, introduce greater efficiencies and end corruption. The D.S.A. was one such group. It lobbied the Municipal Council to adopt a range of sanitary legislation aimed at improving the health of the city and its populace. In line with similar groups elsewhere, the D.S.A.'s membership comprised prominent men drawn from the medical and other professions.¹⁶ It regularly criticized the city for failing to enforce regulations on food and milk production, housing density and waste disposal. In a city with a Catholic population of over 80 per cent, all of the D.S.A.'s twenty-four committee members belonged to Dublin's minority Protestant population.¹⁷ This meant that their lobbying of the Municipal Council, however logical or constructive, was seen as motivated by politics or subtle sectarianism. The association's self-appointed voluntary activists were from a different community and social class to the more representative city councillors.¹⁸ With its recently strengthened electoral mandate the council was even less inclined to accept external criticism. While a few physicians and civil engineers served on the council,¹⁹ the D.S.A. had far greater professional expertise on its committee. None of these D.S.A. experts, however, stood a chance of being elected to City Hall, even if they had the desire to face the bear-pit of local politics. Once again mutual suspicion and misunderstanding hampered modernization and reform in Dublin.

While Britain faced the same smallpox threat as Ireland both the mechanism for combating it, and the response to that mechanism, were different. British Poor Law guardians had responsibility for vaccination policy, and the law in Britain made the vaccination of infants, and later children, compulsory.²⁰ This element of compulsion provoked a strong

¹⁶ The 1901 census shows that the D.S.A.'s 24 committee members included 12 physicians, three engineers and three lawyers (R.C.P.I., Kirkpatrick collection, TPCK/4/1/21 (see Census of Ireland 1901/1911 <<http://www.census.nationalarchives.ie>> [accessed 10 Sept. 2012])).

¹⁷ 1901 *Census of Ireland*, tables XXXI and XXXIII. The religious profile of the D.S.A. committee was: 19 Church of Ireland (Anglican), two Presbyterians, one Quaker, two members of other Protestant sects; there were no Roman Catholics (R.C.P.I., Kirkpatrick collection, TPCK/4/1/21).

¹⁸ In 1899 the religious profile of Dublin Municipal Council was closely aligned to that of the city. It became gradually more Catholic than the local population over the next decade (Wallace, 'Local politics and government in Dublin', p. 159).

¹⁹ Grocers, publicans, builders and small businessmen made up the bulk of the councillors (Wallace, 'Local politics and government in Dublin', p. 310).

²⁰ The Vaccination Act (1840) provided free vaccinations for the poor and prohibited

campaign of opposition to vaccination, resulting in the formation of the National Anti-Vaccination League and a number of periodicals including *The Health Inquirer and Anti-Vaccination Gazette*. The public was familiar with variolation as a defence against smallpox. In this method doctors, or itinerant quacks, deliberately infected the patient with smallpox, typically by blowing infected matter into the nasal cavity through a straw. Jenner's novel use of the less dangerous cowpox to stimulate the body's immune system led to a variety of objections. An 1802 cartoon entitled 'Vaccination', by James Gillray, showed tiny cows erupting from patients' bodies, illustrating fears of the unnatural mixing of animal and human diseases. This sense of something insanitary or non-human entering the body survived into the late nineteenth century when parents worried that other diseases would be transmitted along with the cowpox. Ironically it was the growth of hygiene as a moral good, and the resultant public awareness of dirt and infection, which fuelled resistance to vaccination. Anti-vaccination campaigners warned parents against the risk of infecting their children with syphilis from the 'filth' injected during vaccination.²¹ Opposition to vaccination also rested on its alleged ineffectiveness, publicizing instances of patients who had become infected with smallpox despite being vaccinated. At the heart of all opposition, however, was a rejection of the notion of compulsion. The government's interference in parents' natural rights and duties was seen as tyrannical and continental – it was essentially un-English.²² In Britain, prolonged resistance produced an oppositional voluntary movement whose campaign ultimately forced the government to allow 'conscientious objectors' to opt out of compulsory vaccination. Successive governments became embroiled in debates about how the validity of an individual's conscience could be assessed, and who was entitled to have a conscientious

variolation. In 1853 vaccination became compulsory for infants under three months, with penalties for non-compliance. In 1867 children up to 14 years were brought into the compulsory vaccination bracket (J. R. Fitchett and D. L. Heymann, 'Smallpox vaccination and opposition by anti-vaccination societies in 19th century Britain', *Historia Medicinæ*, ii (2011), 3).

²¹ Early anti-vaccination marginalia in E. Jenner, *An Inquiry into the Causes and Effects of the Variolae Vaccinae: a Disease ... Known by the Name of the Cow Pox* (1798) p. 47 (cited in Fitchett and Heymann, 'Smallpox vaccination', p. 7). This same argument was in use a century later in A. Paul, *The Vaccination Problem in 1903: the Impracticability of Compulsion* (1903), ch. 3 and app. B, 'The Leeds case of vacino-syphilis'.

²² N. Durbach, 'Class, gender and the conscientious objector to vaccination, 1898–1907', *Journal of British Studies*, xli (2002), 58–85. Ironically, in 1875 and 1885 when the authorities in Canada tried to enforce compulsory vaccination on the French Canadians of Montreal, rioters resisted this most despotic and 'English' of practices (see V. D. Vandervelde, *Anti-Vaccination Art and Ephemerata in the UK* (1991), p. 4).

objection.²³ The anti-vaccinationist became a feature of British political life in the late nineteenth and early twentieth century, challenging the rise of the medical expert and this new form of scientific state ideology.

While Ireland shared much of the same legislation as Britain, there was no exemption for parents who objected to vaccination on conscientious grounds.²⁴ Surprisingly, perhaps, Ireland did not produce a serious campaign of anti-vaccination resistance until 1910, and the conscientious objector never emerged as a significant category in Irish life.²⁵ At an address to the Institute of Public Health in 1898 Charles Cameron, Dublin's long-serving and renowned medical superintendent of health, expressed his satisfaction that vaccination was still compulsory in Ireland, and regretted the introduction of a 'conscientious objection' clause in England and Wales. He added, to the laughter of the assembled worthies, that 'the complete absence of any [anti-vaccination] agitation in Ireland is proof of that respect for law and order so characteristic of the Irish people'.²⁶ Dublin newspapers generally echoed Cameron's attitude by presenting objectors as cranks. In 1902, when the British press gave regular coverage to anti-vaccinators, Cameron again noted how few there were in Dublin.²⁷ A further difference between Irish and British vaccination arrangements was the transfer of responsibility for sanitation from the outdated Poor Law system to the country's newly formed urban and county councils.²⁸ Indeed, the British Medical Association called for sanitary responsibility for vaccination in England and Wales to be moved from Poor Law boards to the city and county councils, as was the case in Ireland.²⁹

Vaccination remained compulsory in Ireland and the City Council was responsible for enforcing the regulations, but in advance of the 1902–3 outbreak, the press carried no reports of warnings or prosecutions against

²³ Durback considers the different outcomes when women, workers and professional middle-class males invoked the conscience clause in the British vaccination legislation (Durback, 'Class, gender and the conscientious objector', p. 64).

²⁴ A survey of the legislative framework across the United Kingdom can be found in D. Brunton, *The Politics of Vaccination: Practice and Policy in England, Wales, Ireland, and Scotland, 1800–74* (Rochester, N.Y., 2008).

²⁵ Enniscorthy in Co. Wexford became the scene of a concerted anti-vaccination campaign, motivated in part by nationalist opposition to intrusive British regulations (C. Cox, 'Health and welfare in Enniscorthy, 1850–1920', in *Enniscorthy: a History*, ed. C. Tóibín (Wexford, 2010), pp. 265–87).

²⁶ *The Irish Times*, 19 Aug. 1898. For a fuller treatment of this most interesting public servant, see L. Carroll, *In the Fever King's Preserves: Sir Charles Cameron and the Dublin Slums* (Dublin, 2011).

²⁷ *The Irish Times*, 16 Jan. 1902.

²⁸ Local Government (Ireland) Act (1898), 61 & 62 Vic., c. 37, pt. II, sect. 32.

²⁹ *The Irish Times*, 31 July 1902.

parents for failing to have their children vaccinated. The heated debate about vaccination created greater public awareness in Britain, but the absence of vociferous opposition had no apparent effect in Dublin. Dubliners dutifully attended their local dispensary or the emergency vaccination centres set up by the Municipal Council during an epidemic. Whatever non-compliance may have existed was covert. Opposition to Dublin's smallpox management did emerge, however, when the epidemic of 1902–3 was reaching its height. Cameron's poster campaign urging renewed vaccination referred only briefly to the penalties for concealing a case of smallpox, but the D.S.A. repeatedly raised the threat of non-compliance at its meetings.³⁰

It was in this context that Dublin's outbreak of smallpox occurred, initially in 1902 and more worryingly in 1903. On 4 February 1902 a visitor from Glasgow fell ill while staying at a public lodging house in the crowded tenement district of Townsend Street. The medical officer at a nearby municipal dispensary identified the condition as smallpox and the man was removed to Cork Street Fever Hospital. The cab which carried the patient to the dispensary was promptly located and disinfected, as were the cab-driver's clothes.³¹

Some years earlier Charles Cameron had established an isolation unit for people who were in contact with anyone suffering from a serious infectious disease. The occupants of the lodging house on Townsend Street were removed to this refuge on St. Nicholas Street in the city centre. One of these 'contact' cases went on to develop smallpox and was taken to hospital. After a suitable period the others returned home once the lodging house had been repeatedly disinfected and whitewashed. A third case, a young girl, appeared in another city hospital. Following a time in isolation all three patients began to recover. The council's Public Health Committee reported that the city had been spared 'the dreadful visitation of Smallpox'. Their relief was all the greater when they considered that 'one of the cases occurred in a crowded lodging house, and was of an intensely infectious nature'.³²

Their relief was premature, however, as smallpox again entered the city in late 1902 and erupted into a full epidemic in March 1903. In five months the city dealt with 255 cases in dozens of locations across the densely populated north inner city. Thirty-three people died. Throughout the epidemic 1,402 'contacts' passed through the St. Nicholas Street Refuge.

³⁰ R.C.P.I., DSA/2, Dublin Sanitary Association minute book, 1894–1904, 14, 21, 28 May 1903.

³¹ D.C.C.A., 'Public Health Committee report, 25 Feb. 1902', *Dublin Municipal Council Reports 1902* (Dublin, 1903), no. 42, p. 334.

³² 'Public Health Committee report, 1902', p. 335

In July 1903, Cameron reported that the outbreak was at an end, and in a lengthy document outlined in detail the sequence of cases, identifying chains of original and subsequent infections. He also set out the major steps taken to tackle the spread of the disease, a number of which reflected most favourably on his own decisions and recommendations.

In August 1902 a sailor on a steamer from Glasgow had shown signs of smallpox and was treated at Cork Street Fever Hospital. Four months later another sailor, this time from Liverpool, fell ill with the disease in the poor and overcrowded Newfoundland Street district.³³ He was sent to the Hardwicke Fever Hospital, part of a complex of welfare institutions including hospitals, an asylum and a workhouse close to the highly unsanitary Church Street area of the north inner city. While all 'contacts' in these two cases were isolated, and bedding and clothing disinfected or destroyed, they proved to be the source of the more serious epidemic of 1903. Soon other patients in both hospitals developed smallpox, evidently contracted from these earlier cases. A young girl infected at the Hardwicke lived at 56 Church Street. Along with others in her family she had recently recovered from typhus. According to the 1901 census this overcrowded and impoverished street had a total population of 743 people. Number fifty-six was the most crowded tenement on the street with thirteen families living in a single house.³⁴ With infection spreading from the hospitals and the proximity of densely populated areas of poverty the threat of an epidemic was very real.

Dublin's traditional reputation for muddle and corruption did not augur well for its handling of this crisis. For years suburban unionists and urban reformers had criticized the petty politicking and general inefficiency of the Municipal Council. The failure of the nationalist administration in City Hall, they argued, was merely a sample of the misgovernment that could be expected from a nationalist Home Rule parliament. This reputation and the political assumptions associated with it were key factors in the suburban townships' resistance to being incorporated within the city boundaries. In the event, the city's response differed dramatically from its usual operations. The effort and expense which the city was able to expend through its new powers proved vital. Charles Cameron's report traced the chains of smallpox infection from the two initial sources to family members, tenement neighbours and workmates. Once it spread to the National School at nearby George's Hill, the disease 'assumed alarming proportions', with seven new

³³ Newfoundland Street, in the city's northern docks, has been redeveloped as Mariner's Port, between Guild Street and Lower Mayor Street.

³⁴ The area was notoriously decrepit; indeed so dilapidated were the buildings on the street that a decade later in 1913 two houses would collapse, killing seven people.

cases appearing on 20 March alone.³⁵ Hospitals struggled with a further twenty-two cases by the end of the month, sixty-eight in April and sixty-two in May. The city's response of identification, isolation and vaccination began to have an effect in June as the number of new infections fell to forty-two, dropping to twelve in July.

Cameron identified five actions which had checked the spread of the epidemic. The first was the prompt removal of patients to hospital. This bland statement masks an impressive campaign to provide enough isolation hospital beds for all infected patients. Existing provision for infectious diseases was based on the Cork Street and Hardwicke hospitals. Providing a valuable addition to these were ten convalescent beds in Beneavin House at Finglas, five miles north of the city. The most significant investment of municipal money and energy, however, was the rapidly constructed smallpox hospital at the Pigeon House fort, a mile out along an isolated sea wall at the mouth of the River Liffey. This fifty-bed wood and iron unit for male and female patients took only twenty-one days to build and cost £939. The funds were provided by the L.G.B. for Ireland under the provisions of the 1898 act. This isolation hospital was operational by 4 March 1903. This significant state intervention, via the local authority, would prove to be a key healthcare innovation. While the Municipal Council built the auxiliary hospital, using funds borrowed from the L.G.B., the responsibility for staffing it fell to Cork Street Fever Hospital. The annual management reports for Cork Street Hospital show that 243 patients were treated in the new isolation unit between 5 March and 20 October 1903. By recording patients' vaccination history they were able to show a 6 per cent mortality rate among those who had been vaccinated compared to a rate of 31 per cent among those who had not. No patients who were re-vaccinated after exposure to infection died. All this medical, nursing and administrative activity had to be paid for but Cork Street Hospital's accounts show no additional funding coming from Dublin Municipal Council, or from either of the city's Poor Law unions (North and South Dublin), during the crisis. It would appear that a grant of £3,500 from Edward Cecil Guinness, head of the Guinness Brewery and recently ennobled as earl of Iveagh, plus a bank overdraft, funded work at the Pigeon House isolation unit.³⁶

³⁵ D.C.C.A., 'Report of the Public Health Committee re the recent epidemic of smallpox', *Dublin Municipal Council Reports 1903* (Dublin, 1904), pp. 535–73, at p. 541.

³⁶ *The Annual Report of the Fever Hospital and House of Recovery, Cork Street Dublin and Beneavin Convalescent Home, Glasnevin for the year ended March 31st 1903* (Dublin, 1903), p. 6; *Cork Street Fever Hospital, Annual Report to March 31st 1904* (Dublin, 1904), pp. 6, 10–11. The author is grateful to Dr. Seán Lucey for bringing these recently deposited records to his attention, and to Harriet Wheelock, archivist at the Royal College of Physicians of Ireland, for allowing him access to the unsorted collection.

The subject of payment raises some interesting points. Cork Street Hospital's annual report for 1900 pointed out that the Local Government (Ireland) Act (1898) had failed 'to make it compulsory on some public body to provide hospital accommodation for the sick poor of the city', thus all agencies could, in theory at least, decline to pay for treatment of infectious cases. The L.G.B.'s 1900 report into the public health of the city claimed that the 1898 act had disrupted the funding from Poor Law unions to Cork Street Fever Hospital. According to the report the new law made payments 'by the Guardians to this hospital ... *ultra vires*, and the Guardians have been obliged to discontinue them'.³⁷ The accounts for Cork Street Hospital, however, show that North Dublin Union continued to pay substantial sums throughout the period, while South Dublin Union, by not classifying all patients from its district as paupers, kept its contribution to about half that of the northern union.

Writing on hospital provision in Britain, Sally Sheard refers to the strained relationships between different branches of local government.³⁸ In Dublin this was not the case, and the municipal and Poor Law representatives generally worked well together. Almost a quarter of Dublin Poor Law guardians were also members of the Municipal Council, and their shared political and cultural identity contributed to this smooth working relationship.³⁹ Despite the lack of compulsion in the 1898 act, and the worry that no public body had direct responsibility for the sick poor, Dublin's population enjoyed a surprisingly generous regime when it came to infectious illness. Unlike the situation in a number of English towns and cities, as described by Sheard, no fees were charged for the treatment of infectious cases in Dublin.⁴⁰ An annual parliamentary grant of £25,000, together with smaller grants from a range of local councils and Poor Law unions, plus charitable donations and bequests, provided funding for the fever hospital, its convalescent home and the operation of the auxiliary isolation unit.⁴¹

The second essential action listed in Cameron's report was the prompt removal of all 'contacts' to the refuge on St. Nicholas Street. When Cameron established the refuge he had ensured that the premises had a large yard

³⁷ *Inquiry into the Public Health of Dublin 1900*, p. 8.

³⁸ See S. Sheard, 'The roots of regionalism: municipal medicine from the Local Government Board to the Dawson Report' (ch. 11 in this collection).

³⁹ Wallace, 'Local politics and government in Dublin', p. 202.

⁴⁰ Sheard, 'The roots of regionalism'.

⁴¹ Only the Beneavin Convalescent Home had any private patients whose payments were recorded separately in the annual accounts (*Cork Street Fever Hospital, Annual Report to March 31st 1901* (Dublin, 1901) and subsequent reports for 1902–4).

and rear entrance and had arranged for the neighbouring empty premises to be demolished, leaving the refuge itself an isolated structure in a very central location with secure access for pedestrians and ambulances. Patients detained at the refuge needed food, clothes and transport. Dublin's cabmen refused to carry such dangerous passengers from their infected homes to the refuge, so the city bought a twelve-person omnibus and two horses to ferry 'contacts' to and fro. To cope with more than 1,400 people during the epidemic the city authorities built four additional rooms to the rear of the building for mothers with small children, increasing the total capacity to sixty. Perhaps the most remarkable fact about the refuge was that there was no legal basis for detaining people in it. As Cameron bluntly admitted in his report: 'although they could not be legally brought to the Refuge or detained there, unless with their consent, the "contacts" never made any objection; probably they were under the impression that they could be compelled by law to go into it'.⁴²

The tenement dwellers evidently assumed that the city had the authority to incarcerate them, their families and children, for two weeks at a time. But how did this situation arise? As we have seen, the gradual expansion of local councils' responsibilities during the later nineteenth century was increased still further by the 1898 act. Dubliners relied on the Municipal Council for sanitation, mains water, the regulation of foodstuffs, and the provision of playgrounds, hospitals and housing. Furthermore, the recent expansion of the local franchise gave the council a very strong electoral mandate, arguably creating a particularly intense sense of identity between it and the people. It is less surprising, therefore, that people regarded city officials as the ultimate authority, with the legal right to remove them from their homes and employment to the city refuge. Significantly, however, one person refused to be moved. In late March 1903 a woman with a suspected case of smallpox, 'being in a respectable position', could not be induced to leave her home; the implication being that, unlike the great majority of cases, this woman was not from the working class. Cameron's use of the word 'induce' suggests that she was fully aware that the city health officials had no statutory right to compel her to go to the refuge.

The third action taken to tackle the epidemic was vaccination and re-vaccination. The Public Health Office placed notices around the city urging citizens to present themselves for vaccination, or re-vaccination, against smallpox. Using state funding they set up vaccination centres in various parts of the north inner city, some with evening opening hours to facilitate

⁴² D.C.C.A., 'Public Health Committee report, 1903', *Dublin Municipal Council Reports 1903* (Dublin, 1904), p. 569.

workers, and 'many thousands' were treated.⁴³ The fourth strategy was to conduct a thorough search for any concealed cases of smallpox. Early in the epidemic a mother had hidden her infected daughter from the authorities. The girl was discovered and hospitalized, and the Police Court fined the mother. The vaccination campaign posters stressed the penalties for such cases.

Cameron's final key action was the incineration of patients' clothing and bedding and the thorough disinfection of their dwellings and the clothing of any 'contacts'. Once again a major feat of co-ordination lay behind this. Council workers washed or sprayed houses with corrosive liquids, and treated them with formalin gas before whitewashing the walls and scrubbing the woodwork and floors with carbolic soap. The scope of the task and the cost of this operation can be guessed from Cameron's statement that the work went on day and night, even on Sundays. Although he did not attempt to give a full total cost for the smallpox campaign, a partial costing emerges from Cameron's report. To build, equip and staff the Pigeon House isolation hospital, and contract the convalescent home at Beneavin, cost a minimum of £1,293 (approximately £1,000,000 in current values).⁴⁴ No costs appear for the omnibus and horses, the operation of the refuge or the additional accommodation built there, nor for the countless extra hours of overtime for teams of council workers engaged in disinfecting houses and operating the incinerator.

No single voluntary organization or combination of charitable hospitals or associations could have mounted a public health campaign so rapidly and on such a scale. The state's involvement was to provide loans to build the new isolation hospital and to run the widespread vaccination programme. It also had a role in operating the Cork Street and Hardwicke hospitals, but central government did not attempt to intervene directly in the emergency. Parliament had expanded the role of local government, and had strengthened it with streamlined procedures and enhanced powers in 1898; the epidemic was seen as a job for Dublin's Municipal Council to tackle.

Part of the motivation for the wide-ranging reforms of local government in Britain in 1888, and in Ireland in 1898, was to remove the overwhelming mass of detailed legislation from the order paper in Westminster. With new local administrative machinery in place parliament would be free to deal with national and imperial matters. The new local government acts empowered councils to perform a wide range of duties and streamlined their operations

⁴³ 'Public Health Committee report, 1903', p. 570.

⁴⁴ Calculated using the equivalent project cost values (Measuring Worth <<http://www.measuringworth.com>> [accessed 25 June 2014]).

to cope with their expanded responsibilities for local utilities, sanitation, welfare and leisure services. The Irish act marked a further evolutionary step in healthcare legislation, explicitly appointing local councils as the bodies responsible for the control of epidemics, supported by central funds. The city raised its revenues through local taxation, in the form of rates on domestic and commercial property, and through rents, fees and fines. The state supplemented this primarily with loans, and occasionally with grants where national policy required it. When building healthier houses for the working classes, for example, the council could borrow a proportion of the money over a long term from the L.G.B. In pursuit of a national programme of improved public health the L.G.B. subsidized the salaries of municipal sanitary inspectors. Thus, in effect, central government employed local councils to carry out its policies on health, sanitation and housing. In the sudden emergency of Dublin's smallpox epidemic no individual charitable hospital or sanitary association had the resources to respond. Even if Dublin's divided civil society had managed to operate in unison it is extremely doubtful that an effective strategy could have been put in place quickly enough. A single co-ordinating agency was essential in enforcing the rapid and robust set of actions required at the local level.

The state did not wish to handle the epidemic directly, nor was it equipped to do so. It is likely that large teams of outsiders, sent in by Westminster or Dublin Castle, would have met resistance in the tightly-knit inner city. A lack of detailed local knowledge would have delayed the effective deployment of resources – it was far better to use forces already established on the ground. The 1898 act enabled the L.G.B. to provide prompt loans for the Municipal Council to build an emergency isolation hospital and to conduct an intensive vaccination campaign. At the end of the year the auditor could confirm if correct accounting procedures had been followed; for the moment the priority was to get the money and resources to the right place. Dublin's successful containment of the smallpox epidemic of 1902–3 would not have been possible using only the established voluntary hospitals, nor could it have happened simply through the actions of the state. The mediating role of the city, armed with a popular mandate and equipped with modern powers and state funds, was essential.

10. Influenza: the Irish Local Government Board's last great crisis

Ida Milne

In 1918–19, with Ireland in a transitional state from British rule towards independence, the Local Government Board for Ireland, the body responsible for the supervision of the Poor Law dispensary system and sanitation, faced what turned out to be the last great crisis before its abolition.¹ The 1918–19 influenza pandemic, which killed at least 20,057 people and infected an estimated 800,000 on the island, placed an enormous strain on the underfunded, over-stretched and awkwardly structured health system. This essay will explore how the influenza crisis was handled in Ireland, and will suggest that during the influenza epidemic the L.G.B. was widely perceived as being either unwilling or unable to devise a plan of action to deal with the epidemic. The L.G.B. was portrayed, through reports from boards of guardians' meetings in the newspapers, as being unhelpful and even obstructive to the boards as they tried to cope with increased demands on medical staff and resources during the crisis. In the absence of a centralized crisis management strategy emerging from the L.G.B., local authorities fulfilled their statutory obligations in relation to sanitation, while a range of voluntary healthcare providers, from hospitals and charitable societies to landlords and neighbours, devised localized strategies to feed and nurse the ill. Criticism of the official handling of the crisis in an Irish context was inevitably coloured by the rapidly increasing conflict between the state and the nationalist movement. Many voices, politically motivated and otherwise, converged to condemn the Irish authorities' inefficiency and poor communication skills. However, in the context of a disease that disabled as rapidly as the influenza did, it is difficult to say that all the blame for the handling of the crisis lay with the Irish establishment, particularly when official responses in other countries have also been criticized for their tardiness.

¹ The Irish revolutionary period could be broadly perceived as beginning with the labour agitation of 1913, which resulted in the 1913 Dublin strike and lockout, directly involving 20,000 workers; continuing through the failed rebellion of 1916 and the War of Independence of 1919–21; and ending with the civil war of 1922–3.

As the First World War lumbered towards an end, sharp rises in the price of food, combined with scarcity of fuel, reduced people's buying power and inflicted real hardship on those on lower incomes. The alarming deterioration in social conditions in Ireland led to industrial unrest as trade unions sought to negotiate better pay to enable workers to afford the higher costs of living.² The war, brought closer by returning soldiers and U-boat activity in the Irish Sea, also increased dangers, and fears about dangers, to public health. Both in Great Britain and in Ireland there was an awareness that infectious diseases such as smallpox, typhus and dysentery might radiate from regions directly affected by the war. The increased costs of food staples like bread, milk and eggs, allied with the scarcity of coal, led to an apprehension that the resistance of, in particular, the urban poor to disease would be weakened, something often discussed in the newspapers. The capital city, Dublin, had a tenement problem so severe that many considered state rather than municipal aid was needed to re-house its poor.³ The war also led to retrenchment on spending on services not directly related to the war effort, including an embargo on filling posts in the Poor Law medical service. At the same time, the treatment of war wounded and ill in civilian hospitals placed added pressure on the hospital system.⁴ Many hospitals, public and voluntary, were facing acute financial difficulties caused by inadequate funding and by substantial increases in the price of many commodities – including medicines, coal, grain, potatoes, sugar and alcohol. Other factors which formed the backdrop to the 1918–19 crisis in an Irish context included the increasing political tensions in the run up to the December 1918 general election, and the long-acknowledged need for reform of the disjointed and overburdened health and welfare system.⁵ The professional medical organizations had been battling to improve the terms and conditions of Poor Law doctors, while an Irish derogation from the 1911 National Insurance Act meant that, unlike their counterparts in England and Wales, insured workers did not have their medical care covered, placing

² E. O'Connor, *A Labour History of Ireland, 1824–2000* (Dublin, 2011), pp. 102–27; R. Barrington, *Health, Medicine and Politics in Ireland 1900–70* (Dublin, 2000), p. 68.

³ R. McManus, 'Lord Mayor Laurence O'Neill, Alderman Tom Kelly and Dublin's housing crisis', in *Leaders of the City: Dublin's First Citizens, 1500–1950*, ed. R. McManus and L. M. Griffith (Dublin, 2013), pp. 141–51. See also L. Carroll, 'The 1913 housing inquiry: Sir Charles Cameron, public health and housing in Dublin', in *A Capital in Conflict: Dublin and the 1913 Lockout*, ed. F. Devine (Dublin 2013), pp. 57–82; J. Prunty, *Dublin Slums, 1800–1925* (Dublin, 1999).

⁴ Barrington, *Health, Medicine and Politics in Ireland 1900–70*, pp. 73–4.

⁵ L. M. Geary, 'The medical profession, healthcare and the Poor Law in 19th-century Ireland', in *Poverty and Welfare in Ireland 1838–1948*, ed. V. Crossman and P. Gray (Dublin, 2011), pp. 189–206.

an added load on the Poor Law medical system.⁶ The influenza epidemic laid renewed emphasis on many of these problems.

The L.G.B. was arguably the public face of government in Ireland, its members being better known than officials at Dublin Castle through their interaction with the local authorities and the boards of guardians who administered the Poor Law health system at local level. In the lead up to the influenza crisis, relations between the mainly nationalist boards of guardians and the L.G.B. had been deteriorating.⁷ As Sir Henry Robinson, the long-term vice-president and *de facto* head of the L.G.B., observed in his second memoir:

The LGB, because of its drastic powers for regulating local expenditure by governing bodies, was naturally regarded by the patriotic local Guardians and Councillors as the statutory Saxon curse of the country and a department which could never appreciate the high spirited Irish contempt for the restriction of dirty little English Acts of Parliament.⁸

The L.G.B.'s diligent insistence on tight control of Poor Law doctors' fees during the influenza crisis became a major issue between them and the Poor Law boards of guardians. When the L.G.B. failed to take a proactive stance on the developing health crisis in the summer and autumn of 1918, appearing out of touch with the situation, few were surprised. The issue became one more spark point between the government and its discontented local agents.

The pandemic occurred in three waves in Ireland, a mild wave in the early summer of 1918, and two much more severe waves in the autumn of 1918 and spring of 1919. While 20,057 were certified as dying from the disease, this figure should be taken as a conservative estimate. The L.G.B. itself admitted that Poor Law doctors were under such pressure during the peak weeks of the epidemic that they found it hard to keep up with all the paperwork.⁹ Using a generally accepted death rate of 2.5 per cent of all cases, it is estimated that there were about 800,000 cases of influenza on the island of Ireland over the two years, about one-fifth of the population.¹⁰ So the

⁶ P. Martin, 'Ending the pauper taint: medical benefit and welfare reform in Northern Ireland, 1921–39', in Crossman and Gray, *Poverty and Welfare in Ireland 1838–1948*, pp. 223–36.

⁷ See, e.g., V. Crossman, *Politics, Pauperism and Power in Late 19th Century Ireland* (Manchester, 2006), p. 3. Crossman notes the tensions between the L.G.B. and boards of guardians that were increasingly nationalist in composition, suggesting that boards exercised a certain amount of autonomy in their administration of the Poor Law at local level.

⁸ H. Robinson, *Further Memories of Irish Life* (1924), pp. 185–8.

⁹ *Annual Report of the Local Government Board for Ireland* (Parl. Papers 1920 [Cmd. 578], xxi), p. xxvi.

¹⁰ I. Milne, 'The 1918–19 influenza pandemic in Ireland: a Leinster perspective' (unpublished Trinity College Dublin Ph.D. thesis, 2011). This morbidity figure was

key feature is not so much the death toll as the havoc caused by wide-scale illness. Entire towns were silenced as the flu passed through, with commerce disrupted as staff and customers alike fell prey to the disease. Court sittings and public meetings were postponed, libraries and other public buildings were closed, and sports fixtures and concerts cancelled. In March 1919, Goodbody's factory and flour mills in Clara had 300 members of its staff ill. Newspaper reports indicate that this situation was replicated in factories and businesses across the country as the influenza passed through.¹¹ Services suffered too: on 5 March 1919 it was reported that over seventy members of the Dublin Metropolitan Police were out sick.¹² In late October 1918, illness among the Naas Gas Company's staff put serious pressure on the town. Businesses were only receiving a sporadic supply of gas to fuel their machinery, townspeople had no gas for cooking or light, and it impinged, as journalists observed, on the treatment of influenza patients.¹³

In many households, entire families were incapacitated by the disease, incapable of doing anything except struggling to live. Would-be rescuers broke down doors to find entire families either dead or beyond help. The *Irish Times* recorded the inquest of Frances Phelan, aged twenty-seven, who lived with her husband, child and sister-in-law on Corporation Street, Dublin.¹⁴ Neighbours, noticing the Phelans had not been seen for some time, broke into their rooms and found Mrs. Phelan dead in the bed, with her husband, infant son and sister-in-law also lying on the bed, seriously ill. These three were removed to Dublin Union Hospital by ambulance, but were beyond recovery. Cases similar to that of the unfortunate Phelans occurred in many parts of the country.

Most influenza sufferers did not go to hospital, as there would not have been enough beds. In New Ross, for example, in the last week of October 1918 at the height of the second wave, there were 950 cases, with 300 being treated in the infirmary, forty in the Haughton Hospital, and others in nursing homes or in their own residences.¹⁵ Dundalk had 2,000 influenza patients the same week.¹⁶ Some of the estimated one-fifth of the population who showed symptoms had relatively mild attacks. The burden of care for the rest fell on private practitioners and the medical officers of health in the

calculated by the author, and corroborated by medical statistician Anthony Kinsella, Royal College of Surgeons in Ireland.

¹¹ *Irish Independent*, 4 March 1919.

¹² *Irish Independent*, 5 March 1919.

¹³ *Kildare Observer*, 26 Oct. 1918.

¹⁴ *Irish Times*, 26 Feb. 1919; *Weekly Irish Times*, 1 March 1919.

¹⁵ *Enniscorthy Guardian*, 2 Nov. 1918.

¹⁶ *Dundalk Democrat and People's Journal*, 2 Nov. 1918.

employ of the boards of guardians who administered the Poor Law medical system at local level, supported by whoever was available to nurse them.¹⁷ Only the most severe cases, which usually meant those with respiratory or pneumonic complications, were removed to hospital if space permitted. Close contact with vast numbers of ill patients, coupled with the long hours they worked, made medical officers more vulnerable to catching the disease themselves. The boards of guardians then had to find temporary replacements through their relieving officers, and when the replacements fell ill, substitutes in turn for them. All this was rendered more difficult by shortage of staff due to the absence of many doctors serving in the armed forces, by demands for higher locum fees from a medical profession which suddenly found its bargaining power increased, and by the marked reluctance of the L.G.B., noted by several boards of guardians, to sanction the payment of those higher fees.

The accounts given by some medical officers to their boards of guardians, as reported in newspapers and in the guardians' minute books, indicate that many worked around the clock during the crisis. Dr. H. J. Rafferty, for example, the medical officer of health for Bray number one district, reported to the Rathdown Board of Guardians about a fresh epidemic of influenza in Bray in the second week of October 1918, involving about 600 cases.¹⁸ The relieving officer for Bray, Patrick Dempsey, informed the guardians that the previous Saturday, having visited seventy-four houses with six or eight people in each house requiring attention, Dr. Rafferty had requested extra medical help. If the medical officer of health had spent fifteen minutes in each household, his working day would have lasted over eighteen hours. Two days later, Dempsey had had to appoint two more doctors as the situation had worsened; they had, he said, dealt with around 600 cases since Saturday.¹⁹ The Rathdown guardians thought the matter so urgent they sent a wire to the L.G.B.: 'Terrible influenza epidemic in whole Rathdown district; 600 alone in Bray affected; union [hospital] full; several deaths; immediate action of Local Government Board requested'.²⁰ The L.G.B. responded, but by post, by suggesting that the sanitary authorities of Rathdown might get volunteers to visit houses in their areas where there were patients. There was, the L.G.B. explained, a shortage of nurses, and because the epidemic area was so wide it would be impracticable to obtain a large number of trained nurses to assist the medical officers. If the medical

¹⁷ See Milne, 'The 1918–19 influenza pandemic in Ireland', for an assessment of the morbidity of the disease in Ireland, based on available statistics.

¹⁸ *Irish Times*, 17 Oct. 1918.

¹⁹ *The Wicklow People*, 19 Oct. 1918.

²⁰ *The Wicklow People*, 19 Oct. 1918.

officer could not cope it was up to the relieving officer to get help for him. By this time Dempsey had in fact appointed six doctors in addition to Dr. Rafferty.²¹

The response of the L.G.B. to the Rathdown guardians highlighted issues that were to become common themes in reports about the flu from boards of guardians around the country: shortage of manpower, appeals to the central authorities to take action, and the L.G.B.'s apparent belief that flu was a local issue and was better dealt with by local agents rather than by a central body. Newspaper reports, even from newspapers such as the *Kildare Observer* which were considered to be pro-establishment, documented the persistent grumbles and negative attitudes of many of the boards of guardians and the dispensary staffs towards the L.G.B., which was often portrayed as being remote and out of touch with the needs of the day. A circular issued by the L.G.B. to local authorities, boards of guardians and the public at the height of the epidemic, in November 1918, as its agents struggled to provide for the medical needs of perhaps thousands of influenza sufferers in their unions, serves to illustrate that remoteness. It urged strict economy with coal, recommending that people have fewer hot meals, less frequent hot baths and smaller fires. The situation was almost farcical given that the L.G.B.'s own recommendations for influenza treatment included good nourishment and keeping patients warm and clean. The circular caused outrage, and was covered in many newspapers.²²

Other incidences of the board's over-attentive book-keeping indicate its failure to appreciate the scale of the epidemic and the pressures it placed on local authorities and their officials. When the L.G.B. wrote to some boards of guardians complaining that they had paid too much for whiskey during the epidemic, the Youghal Board responded that they had been very lucky to get whiskey at any price.²³ The L.G.B. also refused to sanction gratuities of £75 voted to three medical officers by the Enniscorthy guardians for extra work performed during the epidemic, saying that they saw no reason why the doctors should receive extra payments. The chairman of the Enniscorthy guardians, H. A. Lett, condemned the L.G.B.'s attitude as 'most unfair'. At their meeting on 19 February 1919 the Rathdown guardians were outraged that the L.G.B. 'refused to allow Dr Pim one shilling' for all the extra work he did as medical officer of the workhouse, with 325 additional patients. Noting that the bonus had been deliberately fixed at a low amount to preclude any possible objection,

²¹ *The Wicklow People*, 26 Oct. 1918.

²² *The Nationalist*, 9 Nov. 1918.

²³ Whiskey was considered by some doctors to be one of the few treatments that brought sufferers relief.

Barrington Jellett declared that the L.G.B. clearly had very little sense of its responsibilities to the poor, and described the refusal to sanction the bonus as a 'public scandal'. A unanimous resolution was passed protesting at the action of the L.G.B.

In the absence of clear leadership from Dublin Castle or the L.G.B. during the influenza epidemic, key figures in the local authorities (the bodies vested under the public health acts with powers to administer the sanitary acts and regulations) took the initiative. Chief among these were Dublin Corporation's medical officer of health, Sir Charles Cameron, and the city's lord mayor, Laurence O'Neill. Cameron, eighty-eight years old, had worked to improve the health of Dubliners for half a century, and was constantly sought out by journalists looking for influenza advice to give to their readers. His contributions were clear, cautious and practical. He advised that most complications of influenza were caused by people getting out of bed before they were completely recovered. On his suggestion, many buildings were voluntarily disinfected every day, and the cinema houses refused to admit children; they also closed for half an hour between shows to allow ventilation and disinfection of the premises. The corporation's Public Health Department officials inspected city venues to check whether they were taking the proper precautions to curtail the dissemination of the disease in crowded situations. As the *Irish Times* remarked, 'Disinfection and purification are the watchwords just now with housekeepers and managers of all sorts of business and general establishments'.

O'Neill was a negotiator of some repute, and a highly respected politician. His initiative and problem-solving ability proved useful during the flu crisis. In mid October he helped to settle a strike in the Dublin undertakers' trade that was causing delays in burials.²⁴ He also negotiated the conditional release of Sinn Féin activist and doctor Kathleen Lynn so that she could work with influenza victims.²⁵ Cameron and P. T. Daly, chairman of the Public Health Committee of Dublin Corporation, visited Dublin hospitals on 23 October 1918 to assess the accommodation available for influenza patients, and managed to get military authorities to find alternatives for soldiers occupying civilian hospital beds.²⁶ The Public Health Committee, perhaps seeking to clarify the rather convoluted advice issued by the L.G.B. in late October (see below), issued its own practical advice on methods of avoiding and treating flu in November:

²⁴ *Irish Times*, 14 Oct. 1918.

²⁵ For further details of Lynn's work, see M. Ó hÓgartaigh, *Kathleen Lynn – Irishwoman, Patriot and Doctor* (Dublin, 2006).

²⁶ *Evening Herald*, 23 Oct. 1918.

Keep away from crowded assemblies.

Do not spit on the floor or tramcar or on the streets. Expectorated matter may be full of objectionable microbes. In sneezing keep a handkerchief on your face. Keep a little pad of cotton containing eucalyptus and smell it often, especially when in contact with other people.

Allow plenty of air into your dwelling. Avoid crowded rooms.

Vermin and dirt convey contagion. The strictest cleanliness should be observed.

Do not over exert yourself or give way to panic.

If you feel a pain in the head, or feverish, go to bed, and send for a doctor.

In recovering from influenza only see the persons you are obliged to see, so as to avoid infecting others.²⁷

Although lacking the resources of the Dublin Corporation, other local authorities also showed initiative in dealing with the crisis. Athy Urban District Council ordered the disinfection, fumigation and lime-washing of the houses of influenza victims and the removal of dung-heaps in alleyways, which were believed to be contributing to the problem. Like many of the more proactive local authorities, the Athy Urban District Council cautioned against the holding of wakes, and also advised that influenza victims should be buried and coffined as quickly as possible.

In the absence of an effective medicine to treat sufferers, good nursing was perhaps the best weapon against the disease. Crusading journalists suggested courses of action in their newspapers; volunteers provided nourishment and nursing in several communities, particularly those worst affected. Voluntary effort to feed and hydrate the ill, a key part of the nursing and recuperation process, was conducted on an ad hoc basis by local charities and individuals. Communal kitchens played an effective role in caring for the ill in Naas, and two other Leinster black spots, Athy and Dundalk. When Poor Law doctors were reporting that a quarter of the population of the Naas Union were ill at the end of October 1918, the Naas branch of the Women's National Health Association set up a communal kitchen in the town to provide 'free nourishing soups and stews to the sick poor and their relatives in the present time of distress'. The kitchen opened each day at the town hall from eleven a.m. to one p.m., and the W.N.H.A. collected contributions of food and money to support it.²⁸ The Naas St. Vincent de Paul Society also helped out.²⁹ Another communal kitchen was set up in Athy by local ladies

²⁷ *Irish Times*, 2 Nov. 1918.

²⁸ *Kildare Observer*, 26 Oct., 2 Nov. 1918.

²⁹ *Kildare Observer*, 2 Nov. 1918.

at the request of Athy Urban District Council, feeding the afflicted with hot soup, gruel and milk at the local technical school, which was closed because of the epidemic. Something badly needed to be done; the *Leinster Leader*, in its issue of 2 November 1918, described Athy as being 'from one end to another, an infirmary', with business at a standstill for several weeks and the schools closed.³⁰ At the peak of its operations this communal kitchen fed sixty-one men, 336 women and 445 children, the Athy Board of Guardians was told. The chairman of the board, Thomas Plewman, said that the fifty deaths in the town in the previous three weeks might have been 150 but for the voluntary help given by the ladies of the town.³¹

Dundalk had 1,100 cases of influenza by the end of October 1918, about one-tenth of its population; a week later, the number had doubled.³² In response to a plea from the *Dundalk Democrat*, volunteers in Dundalk technical schools had set up four committees – one each for finance, nursing, distribution and kitchen – to cope with the influenza crisis. The Nursing Committee devised a scheme to give young women the skills to nurse their family and neighbours, and to reduce infection.³³ The volunteers cooked soup, beef tea and Irish stew, and provided barley water, and people came to collect them for sick friends, neighbours and families. Some of the food was donated by local farmers, and a small fee was charged to cover the cost of the rest. Messages came from doctors and others about people who needed the food, and volunteers distributed it. The operation sometimes fed more than 200 people a day. Patricia Marsh has noted that similar community schemes were set up in Clones and Newry.³⁴

The Sisters of Charity transformed their schools at Ravenswell, Little Bray, into a hospital for children suffering from the flu.³⁵ Some landlords and farmers provided food for their tenants and employees and a number of landowners' wives distributed food and soup to the ill.³⁶ In Clonmel, with 2,000 of the townspeople laid up with the flu and local doctors begging for

³⁰ *Leinster Leader*, 2 Nov. 1918.

³¹ *Kildare Observer*, 23 Nov. 1918.

³² *Dundalk Democrat and People's Journal*, 26 Oct., 2 Nov. 1918.

³³ *Dundalk Democrat*, 9 Nov. 1918.

³⁴ P. Marsh, 'An enormous amount of distress among the poor: aid for the poor in Ulster during the influenza pandemic of 1918–19', in Crossman and Gray, *Poverty and Welfare in Ireland 1838–1948*, pp. 207–22.

³⁵ *Evening Herald*, 19, 21 Oct. 1918.

³⁶ Interview with Nellie O'Toole, Merrion Row, Dublin, 30 Sept. 2008, who helped distribute the food. Surviving the flu turned Nellie into something of a media celebrity in her later years; her story appeared also in T. Bunbury, *Vanishing Ireland* (Dublin, 2006). She was also interviewed on R.T.E.'s *Pat Kenny Show* and on the R.T.E. television documentary series on survivors of Spanish influenza and other diseases, *Outbreak*.

help, the governor of the borstal, Major William Wood Dobbin, responded by providing fifteen gallons of hot soup daily. This was delivered to the needy poor, many of whom were bedridden, by Red Cross ladies in pony traps. In a memo to the General Prisons Board, Dobbin noted that there could be 'no doubt that prompt action has saved the lives of several who had neither food nor coal or the ability to wait upon themselves'.³⁷ The kindly acts of neighbours also appear to have saved lives. Tommy Christian, who caught the disease as a five-year-old living in Boston, Co. Kildare, told of the local farming family, the O'Connors, feeding his family when they were all too ill to mind themselves; while Elizabeth Molloy told of a twelve-year-old girl in Lucan, Co. Dublin, who fed unwell neighbours before succumbing to the disease and dying herself.³⁸

Members of the nationalist movement also contributed to the voluntary effort. In her witness statement to the Bureau of Military History, Bridget Martin recalled that the Cumann na mBan National Executive had asked its members to care for the ill, because of the insufficiency of trained nurses. They did 'very good work among the poor. They visited them in their homes, cleaned their places, cooked for them, etc. Even rich people who could well afford to pay nurses could not get them and Cumann na mBan helped some of these too'.³⁹ In another B.M.H. witness statement, Máirín Beaumont said that Cumann na mBan set up a nursing depot at 6 Harcourt Street during the pandemic, where members who had been trained to nurse by the Red Cross offered their services to the influenza ill. Two members were on duty each night, in case they were called on. Beaumont said that many Jewish families availed of the service.⁴⁰ There is little evidence in the newspapers, however, to suggest that Cumann na mBan played anything more than a minor role in the nursing of the influenza ill; even those newspapers used by Sinn Féin propagandists to promote the work done by nationalist doctors during the pandemic barely mention that done by the rank-and-file Cumann na mBan members. By contrast, national and regional newspapers frequently mention the influenza work of Sinn Féin's Dr. Kathleen Lynn, who was allowed off 'the run' at the end of October 1918, at the height of the second wave of the epidemic in Dublin, on condition that she work with the influenza ill. Lynn opened a centre in Charlemont Street to care

³⁷ N.A.I., General Prisons' Board, prison correspondence register, 1918/7063.

³⁸ Interview with Tommy Christian, Ardclough, Co. Kildare, 12 Apr. 2007; interview with Elizabeth Molloy, Lucan, Co. Dublin, 16 Jan. 2007.

³⁹ See, e.g., B.M.H. witness statements, WS Ref #: 398, Witness: Bridget Martin, née Foley <<http://www.bureauofmilitaryhistory.ie>> [accessed 24 Feb. 2014].

⁴⁰ B.M.H. witness statements, WS Ref #: 385, Máirín Beaumont <<http://www.bureauofmilitaryhistory.ie>> [accessed 27 March 2014].

for influenza sufferers. An early and energetic proponent of vaccination, she found a vaccine prepared by Dr. Crofton at the National University Laboratory to be successful both as a preventive and as a curative measure.⁴¹ But again, while Lynn's work was well known and undoubtedly valuable, her diaries, which document the centre's work during the epidemic, indicate a small makeshift operation rather than something significant in scale.

Hospital records are a surprisingly unrewarding source of information about the influenza pandemic.⁴² However, the medical reports of the Adelaide (a Dublin voluntary hospital which had a Protestant ethos) for 1918 note that the pandemic of influenza caused a severe strain on the hospital accommodation. Had a reduction in the numbers of soldiers seeking admission not enabled the staff to accommodate more influenza patients in the Victoria Home, even more hardship would have been inflicted on the sick poor. The reports do not cite the numbers of influenza or pneumonia cases admitted, but attribute the increased death rate entirely to the serious nature of many of the pneumonia cases admitted, some patients dying only hours after their admission to the hospital. The peak months for admission to the hospital in 1918 were June, and October, November and December, reflecting the first and second waves. According to the annual medical reports compiled by Dr. George Peacocke, the influenza pandemic continued to place pressure on the hospital and its staff in the first four months of 1919.⁴³ The pressures outlined were probably common to all hospitals dealing with the unusually high numbers of influenza patients at a time when their finances were in a critical situation. The Adelaide's annual report for 1918 noted that compared to the pre-war standard, food had increased in price by 100 per cent, coal and light by 140 per cent, and drugs and surgical appliances by 80 per cent; the expenditure under these headings rose from £4,205 in 1913 to £7,929 in 1918. The hospital had been forced to make two extra fundraising appeals in the autumn of 1918 when the influenza epidemic was at its zenith, one to regular subscribers and another, a 'half crown fund', to bring in smaller sums from former patients.⁴⁴

⁴¹ Dublin, Royal College of Physicians in Ireland, K. Lynn diaries; see also Ó hÓgartaigh, *Kathleen Lynn*.

⁴² Many potentially relevant files are missing for the years under review, while some hospitals still refuse to allow researchers access. Those archives which are accessible, such as Cork Street Fever Hospital and Sir Patrick Dun's Hospital in Dublin, have proved silent on the crisis.

⁴³ Trinity College Dublin, Adelaide Archive, medical reports of the Adelaide Hospital for 1918 and 1919.

⁴⁴ Trinity College Dublin, Adelaide Archive, Adelaide Hospital Finance and House Committee minutes, 1918, box 26, sixty-first annual report of the Adelaide and Featherstonhaugh Convalescent Home, Rathfarnham, for 1918.

Newspaper reports and personal accounts of Spanish influenza tell of the dread which accompanied it; the unpredictability of the disease, its apparent targeting of young healthy adults and the inability of contemporary medicine and science to treat it or explain it fed into this fear. Observing that an epidemic is by implication frightening, Charles Rosenberg maintains that fear and anxiety create an imperative need for reassurance.⁴⁵ The L.G.B. did not appear to understand this need despite repeated calls from medical doctors, members of the boards of guardians, and crusading journalists for the board to show leadership during the crisis. There was no public pronouncement from the *de facto* head of the board, the vice-president, Sir Henry Robinson, or the successive chief secretaries, Edward Shortt and Ian Macpherson, who were the ex-officio heads of the board. The extent of the board's direct connection to the people during the epidemic was its memorandum on influenza, which is unlikely to have been of much influence, given the failure of the provincial press and some of the Dublin dailies to refer to it. Throughout the epidemic, the board kept a low profile, preferring, it seemed, to deal with the boards of guardians and local authorities through its inspectors; there was one notable exception, an interview by an unnamed L.G.B. source with an *Irish Times* journalist.⁴⁶ The only reasonably visible face of the board during the crisis in Leinster was its inspector, T. J. Browne, who advised local authorities on adding influenza pneumonia to the list of notifiable infectious diseases, and who also suggested to the Dublin Board of Guardians quite early in the second wave that they ought to employ more doctors in places where medical officers might need help to tend the influenza victims.⁴⁷ Browne, according to the *Evening Herald* of 31 October 1918, had conducted an official tour of Leinster and discovered flu raging everywhere, but particularly in Wicklow, Wexford and Kildare. In the same report he pointed out that in Ireland the local authorities were handicapped by their powerlessness to enforce measures to prevent the spread of infection, such as the closure of all places of public assembly.⁴⁸

⁴⁵ C. Rosenberg, *Explaining Epidemics and other Studies in the History of Medicine* (Cambridge, 1992), p. 294.

⁴⁶ *Irish Times*, 2 Nov. 1918.

⁴⁷ N.A.I., Dublin Union Board of Guardian minutes, microfilm MFGS 49/091, BG 79/A82. The minutes for 9 Oct. 1918 documented a telephone message to the clerk of the union from the L.G.B. inspector Dr. T. J. Browne, noting that he recently visited the Grand Canal Dispensary and thought that there was a possibility the medical officers would be unable to cope with the outbreak; he suggested that the relieving officers should be authorized immediately to appoint medical officers to assist if those already in place could not visit all their patients. The Dublin guardians approved his suggestion.

⁴⁸ *Evening Herald*, 31 Oct. 1918.

Influenza: the Irish Local Government Board's last great crisis

The L.G.B.'s attitude towards its perceived responsibilities was not unique to Ireland. Similar charges were laid against the Local Government Board for England and Wales during and after the influenza pandemic, and against the Local Government Board for Scotland during the cholera epidemics of the nineteenth century. While the usual explanation for this was a policy of *laissez-faire*, there may be other reasons. The Irish board was ultimately answerable to the Irish establishment, whose chief officers, in 1918, were Lord Lieutenant John French and Chief Secretary Edward Shortt. Appointed to deal with the growing Irish political crisis and to introduce conscription, neither had any experience of dealing with a public health emergency. Many of the staff positions within the Custom House could almost be regarded as hereditary, the preserve of certain families within a Protestant middle class. Concepts and philosophies of dealing with epidemic disease and with the sick poor may have changed little over generations, promoting a sense of complacency in senior officials.⁴⁹

Criticism of the L.G.B.'s handling, or more correctly, lack of handling, of the epidemic came from several different quarters. Some, such as that coming from Sinn Féin's advanced nationalists and their propaganda team, was clearly politically motivated. Other criticism came from journalists, including some working for unionist or pro-establishment newspapers, from boards of guardians and from people working in healthcare who were faced not only with a public health crisis but also with the sense that their work was being hampered by central government ineptitude. Dr. Rafferty, the medical officer in Bray, suggested that the L.G.B. should provide local depots where residents could get vaccinated.⁵⁰ *Evening Herald* journalists were among the sterner critics of the L.G.B.'s inactivity, backing up their case for more intervention with examples of strategies devised by similar bodies in the United States of America, and accusing the board of a policy of *laissez-faire* toward the crisis. The *Herald's* leader writer cited the equivalent U.S. authorities' campaign for dealing with the scourge, including mobilizing 4,000 graduate and attendant nurses to care for the sufferers, and moving nursing units from city to city depending on where they were most urgently required.⁵¹

On 21 October 1918, the *Herald's* leader writer declared:

We are also, we think, justified in this connection in asking the question: whether our Public Health Authorities are doing everything possible to combat this malignant and widespread disease? ... A policy of drift or an attitude of

⁴⁹ F. J. M. Campbell, *The Irish Establishment, 1879–1914* (Oxford, 2009), pp. 86–7.

⁵⁰ *Irish Times*, 30 Oct. 1918.

⁵¹ *Evening Herald*, 21 Oct. 1918.

laissez faire in such an emergency cannot be tolerated, and the battle against disease must be organised on systematic and thorough lines. To what extent this is being done at the present moment we are unable to say.⁵²

Two days later, as the disease continued to worsen in Dublin city, the *Herald* leader writer felt it necessary to reiterate criticism of the authorities: 'One must be careful not to create undue alarm, but we must again urge our health authorities to take urgent action and all necessary measures to grapple with what is generally recognised as a very serious scourge of humanity'.⁵³ Even papers that were generally uncritical of the establishment could not contain their puzzlement at the government's perceived inaction. The pro-establishment *Kildare Observer* decried the government's 'attitude of almost supineness towards a malady which has been the cause of a tremendous death toll. This government inertia ... should not be allowed to go on without at least a serious effort being made in the battle with the disease'.⁵⁴

Responding to this criticism in an interview with the *Irish Times*, an unnamed medical source in the L.G.B. insisted that the board had done everything it possibly could through its inspectors and by issuing advice and instructions. The Irish L.G.B., he claimed, had taken the same approach and actions as its English counterpart. Where their powers did not enable them to order certain courses of action they issued advice, when the circumstances appeared to merit it.⁵⁵ The source cited a recently issued memorandum on influenza that contained the most up-to-date scientific information. Unlike the simple bullet point memorandum issued by the Dublin Corporation Public Health Committee, the L.G.B. memo was fusty and convoluted. Printed in an article on influenza in the *Irish Times* on 30 October, it urged that

any person suffering from a fever, with or without catarrh, should at once obtain medical advice, and should remain in bed at home until quite well. The use of boracic and weak saline solution for the frequent douching of the nasal passages is recommended ... The gargling of the throat night and morning with a solution of one in 5,000 permanganate of potassium in water containing 0.8 percent of common salt is useful as a preventive measure. It should also be drawn up through the nostrils and ejected by the mouth.⁵⁶

⁵² *Evening Herald*, 21 Oct. 1918.

⁵³ *Evening Herald*, 23 Oct. 1918.

⁵⁴ *Kildare Observer*, 26 Oct. 1918. Irish contemporary regional newspapers tended to be politically aligned, either nationalist or pro-establishment. *The Observer* appealed to the landlord politician class of its North Kildare readership, and was not generally critical of the establishment.

⁵⁵ *Irish Times*, 2 Nov. 1918.

⁵⁶ *Irish Times*, 30 Oct. 1918. The memorandum does not seem to have appeared in any of the other regional or national newspapers.

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The dense, technical language of the L.G.B.'s memorandum was in striking contrast to the Dublin Corporation's more practical and intelligible advice.

Annual reports for the year of the crisis and the following year give further clues as to the board's approach. In its report for the year ended 31 March 1919, which covered most of the epidemic period in Ireland, the board took ownership of the hard work done by its subordinates during the epidemic, either omitting to mention or glossing over the obstacles it had persistently placed in their paths. The report listed the actions the board had taken to combat the epidemic:

For the general guidance of the public we issued advice and suggestions, founded on experience of epidemics of disease, for avoiding infection, and for dealing with attacks when developed ... We afforded local authorities all possible facilities for the employment of additional medical and nursing assistance, and recommended county councils that they might set free their tuberculosis officers to undertake the functions of district medical officers, where need existed.

Having considered adding influenza to the list of notifiable diseases, the L.G.B. concluded that notification was unlikely to be effective in checking the spread of the infection because of the short incubation period, the difficulties of differential diagnosis, the varied forms which the disease assumed, and its infectivity in the early stages of attack; a view, they said, that was shared by the relevant authorities in other parts of the United Kingdom. The board did decide to advise the extension of the Infectious Disease (Notification) Act 1889 to include septic pneumonia, and this course was adopted in a number of districts. Concerned about the introduction of exotic infectious diseases as a result of the demobilization, the L.G.B. introduced regulations in 1919 prescribing the notification of malaria, dysentery, trench fever, acute primary pneumonia, and acute influenzal pneumonia. Not only had the influenza epidemic demonstrated how easily certain diseases could spread, it had drawn attention to the threat posed by the various types of pneumonia, itself a major killer in 1918 quite apart from the particular strain complicating influenza. Making the regulations, the L.G.B. described them as being primarily designed to meet the need to control pneumonia, as highlighted by the recent influenza epidemic.⁵⁷ As well as covering notification, the regulations also empowered local authorities to provide medical assistance, including nursing, for pneumonia patients. The L.G.B. said it had followed closely all available information about prophylactic vaccine treatment, but had been unconvinced of its

⁵⁷ *Forty-Seventh Annual Report of the Local Government Board for Ireland* (Parl. Papers 1920 [Cmd. 578], xxi), pp. 36–40.

efficacy in conferring immunity: 'The general result of the experience of the past epidemic may be fairly summarised by saying that in order to cope successfully with future invasions further progress in the scientific determination of the microbic causation of the disease seems essential'.⁵⁸

The board's praise for the various Poor Law medical employees implied a situation far more under control and under its charge than the picture presented by newspaper reports and boards of guardians' discussions. Medical officers were said to have worked 'with most commendable zeal', and boards of guardians to have 'spared no expense in their endeavours to secure extra medical assistance'. The L.G.B.'s praise was tempered by reprimands for what it perceived to be excessively high fees demanded and paid to temporary district nurses and medical officers.⁵⁹ The board's account of its handling of the epidemic could be at best described as disingenuous, and at worst as an attempt to disguise what was in reality an organizational shambles rescued only by the goodwill and devotion to duty of Poor Law medical officers. On most issues, the decisive action it claimed to have taken actually happened either in the third phase or after the epidemic had passed. A circular withdrawing the prohibition on filling dispensary vacancies which had been in place since November 1915, for example, was only issued on 9 April 1919, as the epidemic was beginning to decline.⁶⁰ During the year from April 1919 to March 1920, the board arranged for medical officers to receive a gratuitous supply of an influenza vaccine with the proviso that they should keep careful records. But by the time the vaccine arrived, all waves of the epidemic had passed.⁶¹

The annual reports of the L.G.B. for the year spanning the influenza epidemic and for the subsequent year strive to create the impression of a caring and benevolent public body whose capable servants and well-organized public health system had fought valiantly and for the most part successfully with a formidable enemy. The reports praised the medical officers of health, and even claimed that the board had magnanimously acceded to demands for increased fees, taking cognisance of the unusual circumstances, when accounts of boards of guardians' meetings show that the L.G.B. quibbled constantly over fees. The destruction of L.G.B. records during the revolutionary period makes it difficult to assess what, if any, deliberations the board had concerning the influenza crisis.⁶² It is

⁵⁸ *Forty-Seventh Annual Report of the Local Government Board for Ireland*, pp. 36–40.

⁵⁹ *Forty-Seventh Annual Report of the Local Government Board for Ireland*, p. 27.

⁶⁰ *Medical Press*, Irish suppl., 9 Apr. 1919.

⁶¹ *Forty-Eighth Annual Report of the Local Government Board for Ireland* (Parl. Papers 1921 [Cmd. 1432], xiv), p. 40.

⁶² The Custom House, home of the L.G.B., was burned during the War of Independence.

perhaps a measure of the level of interest the L.G.B. had in the epidemic, and its confidence in its own ability to deal with it, that the long-serving permanent secretary and vice-president of the board, Sir Henry Robinson, omitted to mention the crisis in either of his autobiographies, even though he stated his intention to use the first book to document the 'final eventful years of local government administration', and referred to the 'perpetual pressure that has always been the lot of the Local Government Board'.⁶³ This omission may be silent testament to his sense of failure.

How should we account for the slowness of the Irish authorities' response to the crisis? First of all, it was not unusual in the context of other disease events. Elizabeth Malcolm, Greta Jones, E. Margaret Crawford and others have suggested that while disease has been the catalyst for change, Ireland has generally been slow in enacting and implementing health legislation.⁶⁴ Dr. James Walsh, retired deputy chief medical officer of the Irish government's Department of Health and a former dean of the Faculty of Public Health in the Royal College of Physicians in Ireland, noted that Irish authorities were traditionally tardy in responding to issues of public health, observing that when he returned to work in Ireland in the late nineteen-fifties after managing vaccination campaigns for polio and smallpox in Merseyside, he found the Irish authorities out of step with contemporary international thinking on public health issues, particularly in relation to polio.⁶⁵ In the first history of the 1918–19 influenza pandemic in an Irish context, Caitriona Foley has suggested that the fragmented system of Irish health administration limited the scope of official responses, as it was not clear who should take the lead. While the system was clearly over-fragmented, it is evident that local authorities, boards of guardians, medical officers of health and journalists expected the L.G.B. to take the lead, and repeatedly criticized its failure to do so.

Official responses to the influenza elsewhere in Britain and internationally were equally slow. Niall Johnson describes the Local Government Board for England and Wales as maintaining a low profile during the epidemic, limiting its actions to issuing the occasional memorandum with advice on how to treat and avoid influenza, distributing a film about influenza

⁶³ H. Robinson, *Memories: Wise and Otherwise* (1923), p. xi.

⁶⁴ *Disease, Medicine and the State in Ireland, 1650–1940*, ed. E. Malcolm and G. Jones (Cork, 1999); E. M. Crawford, 'Typhus in 19th-century Ireland', in Malcolm and Jones, *Disease, Medicine and the State in Ireland*, pp. 121–37; G. Jones, 'The campaign against tuberculosis in Ireland, 1899–1914', in Malcolm and Jones, *Disease, Medicine and the State in Ireland*, pp. 158–76.

⁶⁵ L. Geary, 'The 1956 polio epidemic in Cork', *History Ireland*, xiv (2006), 34–7; author's interview with Dr. James Walsh, Dublin, 9 Dec. 2009.

prevention, and generally leaving the local authorities and their medical officers to take what action they thought appropriate.⁶⁶ Ilana Lowy also notes the paucity of centralized public health responses from the British authorities, and cites Sandra Tomkins's work to show that, as in Ireland, the main relief came from lay people rather than central government.⁶⁷ In many European countries also, official responses to the Spanish flu were characterized by inefficiency.⁶⁸ Elisabeth Engberg comments on the failure of national or local authorities to take action in her study of responses to the pandemic in rural northern Sweden.⁶⁹ Even more proactive responses had limited impact, however. Beatriz Echeverri suggests that the closure of Spain's international borders and the establishment of sanitary cordons at railway stations, accompanied by quarantine measures for those with symptoms, proved largely ineffectual.⁷⁰ It is perhaps surprising that quarantine measures do not appear to have been considered for Ireland, as an island nation.

Major epidemics often challenge healthcare systems and sometimes provide the impetus for long-needed reform, casting, as Paul Slack has suggested, a 'peculiarly sharp light' on medical and political assumptions and attitudes.⁷¹ Despite being the biggest disease event to affect Irish society since the cholera epidemic associated with the Great Famine, no direct mention was made of the pandemic in the 1920 report of the Irish Public Health Council (the council had been appointed in October 1919, in the immediate wake of the influenza crisis, to advise the chief secretary on the need for healthcare reform).⁷² And yet, from a close reading of the report, it would appear that the influenza crisis, having highlighted malfunctions within the healthcare system, did indeed inform many of the recommendations.⁷³ The report noted that there was 'considerable lack of

⁶⁶ N. P. A. S. Johnson, 'Influenza in Britain in 1918–19', in *The Spanish Influenza Pandemic of 1918–19 – New Perspectives*, ed. H. Phillips and D. Killingray (Oxford, 2003).

⁶⁷ S. Tomkins, 'Britain and the influenza pandemic of 1918–19' (unpublished University of Cambridge Ph.D. thesis, 1989).

⁶⁸ I. Lowy, 'Influenza and historians: a difficult past?', in *Influenza and Public Health*, ed. T. Giles-Vernick and S. Craddock, with J. Gunn (2011), pp. 91–100. S. Tomkins, 'The failure of expertise: public health policy in Britain during the 1918–19 pandemic', *Soc. Hist. of Med.*, v (2002), 435–54.

⁶⁹ E. Engberg, 'The invisible influenza: community response to pandemic influenza in rural northern Sweden 1918–20', *Våria Historia*, xlii (2009), 429–56.

⁷⁰ B. Echeverri, 'Spanish influenza seen from Spain', in Phillips and Killingray, *The Spanish Influenza Pandemic*, pp. 173–90.

⁷¹ P. Slack, in Ranger and Slack, *Epidemics and Ideas*, p. 3.

⁷² *Report of the Irish Public Health Council on the Public Health and Medical Services in Ireland* (Parl. Papers 1920 [Cmd. 761], xvii).

⁷³ *Report of the Irish Public Health Council*, pp. 4–5.

co-ordination, and a certain amount of overlapping, both in the central control and local administration of the public health services', and that several departments within the Irish government structures were dealing 'more or less independently' with issues to do with health. It observed that few people, apart from the officials directly involved, understood the 'enormously complicated system of local health administration'. The report was quite blunt in its reflections on the shambolic nature of the top-level administration of the existing systems, describing it as 'uneconomical and unsound', because of the lack of co-ordination and overlapping of duties between the various structures. The council recommended that there should be complete co-ordination in the central administration of the mental and public health services in Ireland. In a clause that seems to be directly aimed at the L.G.B.'s constitutional failure to communicate with other stakeholders, highlighted during the influenza crisis, the council observed that it was essential to the successful administration of any central health authority that it should be in close communication with the public authorities, medical profession and the various semi-official and voluntary organizations that are interested in the health conditions of the people. The report added the rider that the council considered it an urgent matter to establish a central health authority which was 'in close touch with public opinion and with the various interests concerned'.⁷⁴

The council's astute findings and recommendations for a comprehensive overhaul of the country's complex healthcare systems met with the approval of the medical profession.⁷⁵ It advised that all the various medical services should be co-ordinated centrally on a county basis. It further advised that the dispensary medical system should be completely removed from the Poor Law administration, and remodelled with the area of local control extended from the union to the county, unified with the suggested general county medical and hospital system. It proposed that the new system would then cater to both the poor and insured workers. It noted the financial difficulties that the voluntary hospitals were experiencing, and suggested that they should be given some financial assistance to enable them to continue functioning.⁷⁶ In what was probably an oblique reference to the influenza crisis, it described the 'permissive nature' of the various enactments relating to the notification of infectious disease as constituting 'a danger to the public health of the country that calls for an immediate

⁷⁴ *Report of the Irish Public Health Council*, p. 7.

⁷⁵ See, e.g., T. Hennessy, 'The report of the Irish Public Health Council', *B.M.J.*, 26 June 1920.

⁷⁶ *Report of the Irish Public Health Council*, p. 6.

remedy' and recommended that the relevant acts be made mandatory.⁷⁷ Again probably in an oblique reference to the crisis, it criticized the lack of research facilities in Ireland and recommended that funds be provided to carry out a comprehensive system of medical research under the direction of an Irish Ministry of Health. The proposed establishment of an Irish medical service with opportunities for promotion, entitlements to superannuation and a formal pay structure can also be seen as an oblique comment on the unsatisfactory nature of the existing ad hoc system administered by the boards of guardians.

Much-needed changes to Irish healthcare systems were, however, deferred once again as changes in governance took precedence. In 1920, Dáil Éireann, the revolutionary parliament set up after Sinn Féin's successes in the December 1918 election, established a new Local Government Department which co-existed with the L.G.B. until 1922, with an increasing number of boards of guardians opting to align with the Dáil department. Although many of the recommendations of the Irish Public Health Council were eventually adopted over a period of years, the slow pace of change was to have significant consequences for the Irish population.

⁷⁷ *Report of the Irish Public Health Council*, p. 6.

II. The roots of regionalism: municipal medicine from the Local Government Board to the Dawson Report

Sally Sheard

A quotation from Sidney and Beatrice Webb's 1910 book *The State and the Doctor* provides a useful way in to what is a rather complex and under-researched area of British medical and economic history. The Webbs' frustration at their inability to obtain information on municipal hospitals is clear:

It is somewhat remarkable that there is neither systematic governmental inspection nor central audit of ... municipal hospitals. In the absence of this inspection and audit the Town Councils are in practice, quite free. Beyond sanctioning the loans for hospitals under the Public Health Acts, the Local Government Board, we understand, has no other official knowledge of this branch of civic activity than it can glean from its own Local Taxation Returns, and from reading the Annual reports of the 1800 Medical Officers of Health with which it is supplied but which it does not for publication summarise or review statistically. There appears to be no official statement of how many sanitary authorities, or what proportion of the whole, either maintain their own hospitals, or make arrangements to use other hospitals, or make no provision at all.¹

Yet by 1915 there were over 1,148 municipal institutions containing 39,541 beds.² This number is comprised of 755 'fever' hospitals with 31,149 beds; 363 smallpox hospitals with 7,972 beds; and 30 Port Sanitary Authority isolation hospitals with 420 beds. This position had been achieved after several decades of rapid expansion – a survey conducted in 1879 showed that out of the 1,593 sanitary authorities in England and Wales, only 296 had isolation hospital provision.³

¹ S. Webb and B. Webb, *The State and the Doctor* (1910), p. 158, n 2.

² Local Government Board, *Return as to Hospital Accommodation in England and Wales* (1915).

³ *Tenth Annual Report of the Local Government Board, Supplement on the Use and Influence of Hospitals for Infectious Diseases* (Parl. Papers 1880–1 [C. 2982], xlvi, pt. 1), p. iv. The 296 comprised 185 urban, 85 rural and 16 port sanitary authorities in England. The corresponding figures for Wales were seven, two and one respectively.

The genesis of nineteenth-century British municipal medicine, and its subsequent gradual regionalization, is evident in the pioneering work of towns such as Liverpool in the eighteen-forties. Their initial response was the essence of ‘localism’ – temporary and geographically constrained policies, which did not challenge national laissez-faire ideologies. Liverpool’s pioneering 1846 Sanatory Act [*sic*] became the blueprint for the 1848 national (but permissive) Public Health Act, which some historians have seen as the trigger for a progressive consolidation of public health. From 1855 central government in Britain took an increasing interest in public health, through the appointment to the Privy Council of John Simon as the first chief medical officer. The 1866 Sanitary Act articulated the first principles of municipal medicine, providing legal authority and financial support for removing infectious patients from their homes into designated isolation facilities, but their adoption was piecemeal.

This essay uses the earliest forms of municipal hospitals – those specifically for isolation of infectious diseases – as a lens through which to examine how towns and their hinterlands began to collaborate on the funding and provision of services. It draws on research conducted on the local taxation returns, which as the Webbs note, were the only source of information to address such questions. It also uses Liverpool as a case study to test hypotheses on the pressure exerted by the Local Government Board and the willingness of local authorities to collaborate with one another. Further, it begins to illuminate the complex relationship between public and private sector medicine (at least the component delivered through ‘voluntary’ hospitals). This has been extensively researched for the inter-war years, but little has yet been said about the earlier period.⁴ Here, it is the relationship between two types of public hospital – the municipal and the Poor Law – that is scrutinized. The picture that emerges is of a very complex ‘mixed economy’, which is essentially locally negotiated and primarily driven by economic demands.

Development of the principle of isolation

The terminology applied to isolation hospitals was often confusing, with the use of a variety of names such as infectious diseases hospitals, municipal hospitals and fever hospitals. For the purposes of this essay the term ‘municipal hospital’ has been used throughout to make a clear distinction from the other main categories of hospital accommodation provided by Poor Law boards and ‘voluntary’ enterprises. Private sector hospitals –

⁴ A. Levene, M. Powell, J. Stewart and B. Taylor, *Cradle to Grave: Municipal Medicine in Interwar England and Wales* (Oxford, 2011).

The roots of regionalism

those usually labelled 'voluntary' which were initially founded and funded through philanthropic donations – rarely admitted patients suffering from infectious diseases. They were a common group that were excluded, along with the insane, children and pregnant women, partly because the cure rates were so low that it could have a negative impact on the hospital's reputation and success in attracting donations.

The basic principle of municipal hospital provision was first articulated in the twenty-sixth section of the 1866 Sanitary Act, which allowed a medical practitioner to:

direct the removal to such hospital or place for the reception of the sick, at the cost of the nuisance authority, of any person suffering from any dangerous, contagious, or infectious disorder, being without proper lodging or accommodation, or lodged in a room occupied by more than one family, or being on board any ship or vessel.⁵

However, the 1866 act did not require local authorities to establish or maintain their own municipal hospitals; it recognized that the institutions already in existence could be used. This was the preferred option for many, and arrangements were often made with the Poor Law authorities to use their infirmaries. Yet relationships between the different branches of local government were often strained.

The 1875 Public Health Act also required compulsory isolation of infectious diseases and provided the power to erect hospitals for the treatment of such patients.⁶ The precise phrase used was 'hospitals or temporary places for the reception of the sick'. Many local authorities used this act to open small, poorly staffed and equipped hospitals. The actions of local authorities at this time need to be seen in the context of the contemporary advances in the knowledge of disease transmission. During the second half of the nineteenth century, as progress was made in identifying the mode of transmission of diseases, particularly cholera, there was a gradual acceptance of new theories.⁷ The new knowledge, while maintaining a focus on sanitation policies, increasingly emphasized the importance of isolation as a controlling mechanism. After the decline of cholera, other infectious diseases were in the spotlight. The smallpox epidemic of 1870–3 killed over 44,000 people in thirty months, and further major outbreaks in 1881–2,

⁵ 1866 Sanitary Act., 29 & 30 Vic., c. 90. In 1863 a report was produced on the Hospitals of the United Kingdom, which Sir John Simon found useful for identifying the facilities available for treating diseases.

⁶ 1875 Public Health Act, 38 & 39 Vic., c. 55, sect. 131.

⁷ M. Worboys, *Spreading Germs: Disease Theories and Medical Practice in Britain, 1865–1900* (Cambridge, 2000), pp. 234–76.

1884–5 and 1893 all increased the demand for the provision of isolation hospital facilities.⁸ Scarlet fever was equally significant in promoting the creation of municipal hospitals. Eyler has shown, however, that the medical profession was often divided on the potential benefits to be gained from isolation of this disease.⁹

The second factor in the development of municipal hospitals was the restructuring of public health services in the late nineteenth century. The appointment of medical officers of health, which was made compulsory through the 1871 Local Government Board Act, provided a medically qualified spokesperson in each district to campaign for health services. Pickstone also identifies in the eighteen-eighties a growing disenchantment with the 'ultra-sanitarians' who focused exclusively on the removal of dirt and the improvement of the urban environment.¹⁰ This approach ignored the benefits of treating diseases which would respond to careful nursing, good diet and experienced medical attention – conditions that could best be fulfilled in a hospital environment.

It was the advent of the L.G.B. in 1871 that facilitated the expansion of municipal medicine, through a system of grants and loans. These were linked into a system of inspections, undertaken by staff with varying degrees of medical and sanitary expertise, who assessed existing provision and demand. Many local authorities were compelled to upgrade or establish services against their own wishes. The early annual reports of the L.G.B. from the eighteen-seventies make frequent reference to isolation hospital provision and usually the tone of these references leaves the reader in no doubt that the inspectors felt they were fighting a hard battle:

We still however too often find that the pressure of an epidemic is required to induce Local Authorities to incur the expenditure which the provision of such buildings entails, and we have frequently had to point out that the most essential requisite with regard to a hospital for infectious disease is that it should be ready beforehand.¹¹

There were other solutions, such as the transfer of Poor Law infectious diseases wards to local sanitary authorities. Section 139 of the 1875 Public Health Act further empowered the L.G.B. to force local authorities to act

⁸ A. S. Wohl, *Endangered Lives* (1983), p. 133.

⁹ J. Eyler, 'Scarlet fever and confinement: the Edwardian debate over isolation hospitals', *Bulletin of the History of Medicine*, lxi (1987), 1–24.

¹⁰ J. V. Pickstone, *Medicine and Industrial Society: a History of Hospital Development in Manchester and its Region, 1752–1946* (Manchester, 1985), p. 4.

¹¹ *Sixth Annual Report of the Local Government Board* (Parl. Papers 1876–7 [C. 1865], xxxvii, pt. 1), p. xciv.

together in providing hospital accommodation where they considered it appropriate, and to make the necessary financial arrangements, but this strategy does not often seem to have been used.

The 1882 report

The proposed location of infectious diseases hospitals was frequently the stumbling block for local authorities, who were under pressure not to site them in residential areas, despite reassurances from the L.G.B. that there was no increased risk of disease to the surrounding neighbourhood.¹² The smallpox epidemic of 1876–7 provided an opportunity for the L.G.B. to conduct an investigation into the arrangements for infectious disease isolation in London. Then, because of an outbreak of cases of smallpox close to the Metropolitan Asylums Board's hospital at Fulham, the inquiry was widened in 1880 into a national study, directed by Dr. Richard Thorne Thorne, assistant medical officer at the L.G.B. This investigated the arrangements made by individual towns for infectious diseases cases, and the effect (if any) of the hospital on disease rates in its locality.

The *Report on the Use and Influence of Hospitals for Infectious Diseases* was presented to the L.G.B. in 1882. It made use of the 1879 return that showed that only 296 of the 1,593 sanitary authorities in England and Wales had some arrangement for hospital isolation facilities, either of their own, or shared with neighbouring authorities.¹³ Thorne Thorne had subsequently selected a range of examples from the return and inspected sixty-seven hospitals. He found that where good hospitals had been provided they were well used by the local population, but that most of the ones he visited had been the outcome of panic from anticipated or actual epidemics. Thorne Thorne cited a number of hastily and poorly built hospitals. He also criticized the lack of co-operation between some authorities, most notably Bradford, Leeds, Manchester and Middlesbrough, where surrounding sanitary authorities did not use the centrally provided hospitals.¹⁴

Costing the solution

The cost of hospital sites frequently gave grounds for local authority opposition to their development. Some authorities used their own land, if it was suitably situated, but others had to include the purchase of sites in their applications for L.G.B.-sanctioned loans. Authorities were encouraged to plan 'well-appointed' hospitals with good facilities,

¹² *Sixth Annual Report of the Local Government Board*, p. xcvi.

¹³ *Tenth Annual Report of the Local Government Board, Supplement*, p. iv.

¹⁴ *Tenth Annual Report of the Local Government Board, Supplement*, p. 8.

ambulances, disinfecting stoves, administration blocks and space for future expansion. In a clearly comparative analysis, the 1882 report detailed the cost of establishing the hospitals, expressed as cost (excluding site) per bed provided. The number of beds per 1,000 population was also calculated to indicate the range of provision existing in England and Wales in 1879. The establishment (capital) cost ranged from £116 per bed in Tonbridge to £347 in Cheltenham (although further planned beds would reduce the cost to £224). The number of beds per 1,000 population again showed a wide range, from Sheffield with 0.2 beds per 1,000 to Darlington at 1.3 beds per 1,000 population.

There were other solutions to providing infectious diseases accommodation, such as the transfer of Poor Law infirmary infectious diseases wards to local sanitary authority control. This was achieved with great success at Goole, Settle and Warwick, although the inspectors noted that where the workhouse was adjoining the hospital there was a deterrent to its use unless a separate entrance could be found to the building.¹⁵

A measure of the success of isolation hospital provision was considered to be the number of patients admitted, the fewer following the first notification of an outbreak the better, although the 1882 report admitted the difficulty of gaining an accurate number of cases. Various methods of notification were discussed, including a compulsory system as in place at Leicester and Warrington. The system at Alcester was praised, where the Rural Sanitary Authority paid a sum of 2s 6d for each notification received. However, it was difficult to use hospital mortality rates as measures of success. Often the milder cases of diseases such as scarlet fever were treated at home, with the more serious ones sent to hospital, thus pushing up mortality rates. All this gave the L.G.B. little useful data with which to coerce other authorities to build hospitals.

The patients' fear of payment may have also been a deterrent to the effective use of some municipal hospitals. The issue of financing the admission of non-pauper patients was addressed in section 132 of the 1875 Public Health Act. Such expenses incurred 'shall be deemed to be a debt due from such patient to the local authority, and may be recovered from him at any such time within six months after his discharge from such hospital, or from his estate in the event of his dying in such hospital'. There was evidence that recouping the cost from the patient was difficult, and that sliding scales of charges did not work because of problems of accurately establishing patients' incomes.

¹⁵ *Tenth Annual Report of the Local Government Board, Supplement*, pp. 20, 21.

The roots of regionalism

There was a wide range of charging policies operating within municipal hospitals. For example, at the Bradford Fever Hospital during the three years 1878–80, of the 812 patients admitted, 443 were treated free of charge.¹⁶ Pauper patients were normally treated in Poor Law infirmaries. If there was an arrangement for paupers to be admitted to municipal hospitals their costs were recouped from the Poor Law authorities. Relationships between Poor Law guardians and local authorities were often strained over the provision of isolation facilities, with the two systems failing to work together to plan an integrated service for the same geographical area.¹⁷ The majority of patients who were admitted to municipal hospitals were from the working classes, who could not provide isolation facilities at home, and paupers who were transferred from workhouses. Yet, a more fundamental argument for universal free treatment was increasingly made:

There are also instances where it is felt that since the entire cost of constructing the hospital and also maintaining both it and the staff, and all the patients occupying the public wards, is defrayed out of the public rates, any member of a ratepayer's family is entitled to use the means of isolation provided, free of cost. In other places it is further felt that all isolation carried out is for the benefit of the community at large rather than for that of the individual patient, and hence that the cost of it should in every case be borne by the community. This latter practice is indeed becoming more and more common.¹⁸

The 1882 report coincided with the report of the Royal Commission on Metropolitan Hospitals, which stated (erroneously) 'that large smallpox hospitals in populous neighbourhoods have "proved appreciable sources of infection to their neighbourhoods"'.¹⁹ The Royal Commission prompted the revision and reissue of the 1876 L.G.B. memorandum on hospital provision to all local sanitary authorities, and undoubtedly stimulated a new wave of hospital construction in the eighteen-eighties.²⁰ The interest in isolation hospitals was maintained throughout the decade by persistent outbreaks of smallpox around some of the London hospitals.

Despite these crises, the L.G.B.'s attitude towards isolation hospitals remained comparatively restrained. There were few references in the main L.G.B. reports or in the annual reports of the chief medical officer. Yet as

¹⁶ *Tenth Annual Report of the Local Government Board, Supplement*, p. 29.

¹⁷ A good case study of the rivalry thus induced can be found at Salford in the 1890s, as narrated by Pickstone, *Medicine and Industrial Society*, pp. 166–9.

¹⁸ *Tenth Annual Report of the Local Government Board, Supplement*, p. 29.

¹⁹ *Eleventh Annual Report of the Local Government Board, Supplement Containing the Report of the Medical Officer for 1881* (Parl. Papers 1882 [C. 3337-I], xxx), p. xi.

²⁰ This memorandum was based on one issued by the medical officer of the Privy Council in 1871.

Hardy has noted, a huge change did occur, particularly in London after the de-pauperization of Metropolitan Asylums Board Hospitals following the 1883 Disease Prevention (Metropolis) Act Disease (Notification) Act. Whereas in 1880 most of the sick had been kept at home, by 1890 there was so much demand that the Metropolitan Asylums Board could not take patients from outside its area.²¹

1889–1914

The creation of county councils in 1888 helped to ease the administrative complexity of local government in England and Wales, and in 1894 sanitary administration was reorganized into Urban and Rural Sanitary Districts (to cover the county areas) and separate arrangements for county boroughs. These were able to exploit the recent Infectious Disease (Notification) Act of 1889 which provided medical officers of health with more complete information on the incidence of infectious diseases in their districts. 1893 also saw the publication of a hospital survey conducted by the British Medical Association which concluded that a ratio of ten beds per 10,000 population was the basic requirement for isolation provision. The Isolation Hospitals Act of the same year allowed the new county councils to make provision for their areas by cutting across sanitary district boundaries to form joint hospital boards. These were funded by loans adopted by county councils who had the authority to use the county rate to fund capital projects, and to recover this cost, with interest, from the local rate of the contributing local authorities.

The requirements for hospital design and construction were by this stage so well prescribed that the L.G.B. in effect would not sanction loan expenditure for anything that did not meet its blueprints. This frequently involved the local authorities in building more elaborate (and expensive) hospitals than they may have wished. The L.G.B. also for the first time acknowledged that these isolation hospitals might be used for other general medical patients when not required for infectious diseases, a trend which increased during the first decade of the twentieth century. But the issue of location remained paramount. The persistence of smallpox cases in the vicinity of isolation hospitals prompted a revision and reissue in 1895 of the Memorandum on Hospital Accommodation. It advised against placing a smallpox hospital within half a mile of a populous district but there was still no clear policy within the L.G.B. on how to cope with this problem.

²¹ A. Hardy, *The Epidemic Streets: Infectious Disease and the Rise of Preventive Medicine 1856–1900* (Oxford, 1993), pp. 277–8.

The roots of regionalism

The period 1900–14 has been identified by Pickstone as a third era, during which the smaller rural authorities were ‘prodded and pushed’ by county councils into providing isolation hospitals.²² There was certainly a clear upturn in capital and recurrent hospital expenditure. Yet the smaller authorities were at a financial disadvantage. They were unlikely to have the same number of infectious diseases patients as the larger towns, and also did not have the same rating ability to pay for permanent isolation facilities, which the L.G.B. strongly recommended. The changing disease panorama, as displayed in the annual reports of the registrar general, also suggested that smallpox was presenting less of a threat, and that separate isolation provision for it could be scaled down.

A further L.G.B. memorandum was issued in August 1900: On the Provision of Isolation Hospital Accommodation by Local Authorities.²³ This again stressed the importance of having facilities ready at all times, and the advantages for smaller sanitary districts of joint hospitals, where the local topography allowed. The following year another Isolation Hospitals Act was passed, which allowed the transfer of hospitals from local authorities and joint hospital boards to county councils, and gave permission to recoup patient costs and make agreements to take patients from other districts. It also permitted county councils to contribute to the cost of local authority hospitals which were formed under the 1875 Public Health Act.²⁴ The regulations for the repayment of loans taken out by county councils were also relaxed, so that districts which benefited did not have to pay directly, thus allowing poorer and smaller areas to join hospital boards. For those loans already in progress, the interest rate at which repayments were due was made flexible, instead of the fixed 4 per cent per annum, which had proved difficult for some authorities at a time of national economic decline.²⁵ The changes initiated through this act formed the backbone of the local authority system, which was subsequently seen as an alternative to the voluntary hospital system in discussions about the arrangement of British medical services in the nineteen-thirties.²⁶

²² Pickstone, *Medicine and Industrial Society*, p. 160.

²³ *Thirtieth Annual Report of the Local Government Board, 1900–1, Supplement Containing the Report of the Medical Officer for 1900–1* (Parl. Papers 1901 [Cd. 747], xxvi, pt. 1), p. 228.

²⁴ They were already permitted to contribute to local authority hospitals formed under the 1893 act.

²⁵ An Act to Amend the Isolation Hospitals Act (1893), 1 Edw. (1901), c. 8.

²⁶ S. Cherry, ‘Before the National Health Service: financing the voluntary hospitals, 1900–39’, *Econ. Hist. Rev.*, 1 (1997), 305–25, at p. 307; A. Marwick, ‘The Labour Party and the welfare state in Britain, 1900–48’, *American Historical Review*, lxxiii (1967), 380–403.

Variation in municipal hospital provision

Most research to date has used hospital bed numbers as an indicator of service, as this information is relatively easy to obtain. However, bed provision does not accurately reflect operating costs. It fails to recognize that some hospitals may be more efficient than others, and that economies of scale are significant. It also fails to identify local authorities which had contracts with Poor Law or voluntary hospitals to treat patients, and those local authorities that had taken advantage of the terms of the 1875 Public Health Act to own hospitals jointly. Thus a financial rather than physical analysis is also desirable, permitting examination of the political economy of municipal hospitals as part of the wider local authority public health strategy.

One rich source of data that has rarely been used is the local taxation returns, although recent work on the inter-war period has demonstrated its potential.²⁷ From 1871, under the conditions of the Local Government Board Act, all local authorities had to make annual financial returns which recorded their income and expenditure, and further separated annual recurrent expenditure from loan expenditure. The returns for a sample of thirty-six towns for the forty-three-year period from 1871 to 1914 have formed the basis for a broader study of local government finance.²⁸ The local taxation returns, as the Webbs correctly identified, are the only solution to the problem of investigating the development and extent of municipal hospital provision before the Ministry of Health and Nuffield Provincial Hospitals Trust surveys of the late nineteen-thirties.

Between 1871 and 1914 there was a sustained increase in total local authority expenditure, both annual recurrent and capital. In fact local authority investment accounted for 90 per cent of all public investment during this period.²⁹ Sources of income were variable, but the basic split was 60 per cent from local rates, 30 per cent from central government in the form of fees and grants, and up to 10 per cent from municipal trading activities, such as waterworks, gasworks, electricity and tramways. An analysis of the local taxation returns shows that county boroughs were more adventurous than the smaller municipal boroughs in their range of activities, and thus could expect to generate profits to subsidize other services. Expenditure on services had both a regional and a category bias. Highest annual recurrent

²⁷ An exception is C. Feinstein, *National Income, Expenditure and Output of the United Kingdom, 1855–1965* (Cambridge, 1972). Levene and others, *Cradle to Grave*.

²⁸ R. Millward and S. Sheard, 'The urban fiscal problem 1870–1914: government expenditure and finances in England and Wales', *Econ. Hist. Rev.*, xlviii (1995), 501–35.

²⁹ C. H. Feinstein and S. Pollard, *Studies in Capital Formation in the United Kingdom, 1750–1920* (Oxford, 1988).

expenditure per capita was in the north of England and lowest in the south. County boroughs spent most per capita, followed by London, the municipal boroughs and then the county areas. Demand for services was sensitive to the costs facing the local authorities, independent from all other factors such as housing conditions and mortality rates.

While the recurrent expenditure for municipal hospitals shows a steady rise, capital expenditure is marked by a 'boom' period between 1897 and 1907. When expressed as a percentage of total local authority spending, recurrent hospital costs averaged less than 0.5 per cent per annum in 1885, rising to a small peak in the early nineteen-hundreds at around 1 per cent per annum and then falling back slightly by 1914. Meanwhile, hospital capital expenditure expressed as a percentage of total local authority capital expenditure moved from 0.5 per cent in 1885 to a plateau of 1.4 per cent between 1895 and 1906, before falling to between 0.4 and 1.2 per cent.³⁰ It is clear that there was a major period of municipal hospital construction between 1897 and 1907. Total annual hospital capital expenditure for England and Wales rose from between £100,000–200,000 in the eighteen-eighties to a peak of £543,288 in 1903–4. Total capital expenditure by all local authorities in England and Wales shows a similar pattern, with a rapid rise in expenditure in the eighteen-nineties and nineteen-hundreds. This is mainly accounted for by investment in water, sewerage and road projects.

From a town-based study it emerges that the largest towns were not always the biggest spenders on hospitals in terms of annual recurrent expenditure, which represents the actual running costs of hospitals. From a sample study of thirty-six towns of varying sizes there are some interesting cases. Large towns with a high provision of municipal hospital services were consistently spending below the national averages during the period 1885–1914. Good examples of this include Bradford (1 per cent) and Manchester (1.5 per cent). Conversely, middle-sized towns like Nottingham, Plymouth, Norwich and St. Helens spent more than the national average, allocating 2–3 per cent of their total annual recurrent expenditure to municipal hospitals. Presenting hospital expenditure in this relative way gives some indication of the potential importance of the supply/demand issue at a town level. Hospital costs must be seen in the context of competing costs of other municipal services, and also the availability of alternative accommodation for infectious diseases in local Poor Law and voluntary hospitals (although most voluntary hospitals had exclusion policies for these types of patients).

³⁰ Capital expenditure data for hospitals is only available as a national aggregate, not for individual towns. However, the annual reports of the L.G.B. provide a list of projects approved for capital expenditure, giving the name of the authority concerned, the purpose for the loan, the amount and the repayment period.

The Local Government Board and capital expenditure

The L.G.B.'s attitude to and influence on capital expenditure forms an integral part of the explanation of the varying provision of hospitals by local authorities. Yet financing capital projects was easier for some local authorities than for others. Analysis of the local taxation returns identifies a number of conflicts between the L.G.B. and the large local authorities. The L.G.B. held the 'trump card'. It had to authorize all projects which required capital finance, and to fix the loan terms. It favoured longer repayment periods of up to sixty years as stipulated in the 1875 Public Health Act, but this was at odds with the Treasury's determination to restrict loans to a thirty-year period, effectively capping the borrowing ability of local authorities.

Once permission had been obtained for a loan the local authority had a number of choices. It could apply to the Public Works Loans Commissioners, but the interest rate was fixed at a relatively high 5 per cent and the maximum period of repayment was only twenty years. There were more cost-effective options than the commissioners, particularly for large local authorities. There was considerable diversity in the types of loans which could be arranged, including mortgages, bonds, annuities and debentures. The large county boroughs could also issue stock which gave them added flexibility in gaining loans. In an attempt to assist the smaller local authorities the Treasury restricted access to loans from the Public Works Loans Commissioners after 1900, by excluding large towns from this source of finance.

However, it seems that for the whole period 1870–1914 all local authorities were able to raise loans for capital expenditure easily, although the terms were relatively better for the larger authorities who could 'shop around'. The ultimate limitation for all local authorities, irrespective of size, was the ability to repay the loan capital and interest. This repayment could only be met through rate income, which financed the majority of local authority expenditure. There was a rise in the average rate charge levied during the period, from 3s 6d in the pound in 1885 to 6s 9d per pound in 1914.³¹ There was also a rise in rateable values, which increased rate income for England and Wales from £19.3 million in 1875 to £71.3 million in 1914. Thus larger towns with a bigger rateable income should have been in a comparatively better position to fund the provision of municipal hospitals, and this is substantiated by Preston who found a correlation coefficient of 0.86 between rate fund expenditure per capita and local wealth.³²

³¹ P. J. Waller, *Town City and Nation* (Oxford, 1983), p. 257.

³² B. T. Preston, 'Rich town, poor town: the distribution of rate-borne spending levels in the Edwardian city system', *Transactions of the Institute of British Geographers*, x (1985), 77–94.

The Liverpool experience

Pressure from above to implement a municipal hospital building programme was only one part of the equation, in that the influence of the L.G.B. could be diffused at the local level. No amount of inspections, orders and memoranda could produce services in a town which did not have the necessary financial ability or political inclination. Liverpool is a good example of how national pressure was translated into local action.³³ It was very active in the creation of new public health policies in the nineteenth century, starting with the Liverpool Sanatory [*sic*] Act in 1846 and the appointment of the country's first medical officer of health in 1847.³⁴ As a large and prosperous urban area it should have been able to meet the financial requirements to fund investment in municipal services. Yet municipal hospital investment was persistently delayed in the face of considerable pressure from the L.G.B..

Throughout the eighteen-seventies the Town Council's response continued to be the erection of temporary accommodation during epidemics. This triggered a letter from the L.G.B. in 1883 urging the council to make adequate provision for infectious diseases. In 1885 the L.G.B. again wrote to the council, urging it to make immediate provision.³⁵ It even went as far as to specify the ideal number of beds required – 750 – to supplement the Poor Law infirmary accommodation, but when the matter went before the full Town Council it was decided that the most it would provide was 160 beds split between two small hospitals.

In 1888 the Poor Law guardians in Liverpool attempted to force the council's hand on the issue of bed provision. They had traditionally taken infectious patients referred by the medical officer of health, thus averting several threatened epidemics. However, they increasingly saw this as an abuse of the Poor Law system, and they gave notice that from the end of 1888 they would not accept municipal patients. The council's planning was tested very soon afterwards. A measles epidemic early in 1889 forced the council to beg for emergency cover and the Poor Law guardians reluctantly agreed. Again in 1890 during a scarlatina epidemic patients had to be kept at home because there were no beds for them in the temporary accommodation provided.

The L.G.B. was well aware of the problems Liverpool was experiencing, but it was not until 1894 that a public inquiry was held. The outcome was

³³ For an excellent municipal hospital case study, see John Eyler's analysis of the facilities at Brighton (J. M. Eyler, *Sir Arthur Newsholme and State Medicine 1885–1935* (Cambridge, 1997), pp. 85–118).

³⁴ The 1846 Sanatory Act [*sic*] formed the basis for the later national Public Health Act of 1848.

³⁵ Liverpool Record Office, 352 MIN/COU, council proceedings (1884–5), p. 1336.

the decision of the council to extend the hospital at Netherfield Road, and to devise a longer-term strategy to cope with the planned expansion of the city, rather than relying on the traditional practice of crisis management which had consistently failed during the previous twenty-eight years.³⁶ A change of medical officer of health in 1894 to the ambitious and entrepreneurial Dr. Edward William Hope also increased the impetus for expansion. In 1903 the Fazakerley Hospital and sanatorium was opened. The capital cost for this 510-bed establishment was estimated at £130,000. In the same year the L.G.B. also authorized Liverpool City Council to spend £53,000 on extending the facilities at Mill Road Municipal Hospital.³⁷ The number of beds thus increased from 540 in the five municipal hospitals in 1895 to 1,074 in 1907. By 1911 Liverpool was recognized as having one of the best municipal hospital provisions in the country.

Can Liverpool be seen as a representative example of municipalization of hospital services? Certainly the negative attitudes of Dr. Trench (medical officer of health in the eighteen-sixties) must have handicapped the early efforts of public health campaigners in the council, yet his opinions were logical in the context of contemporary views on disease, poverty and personal responsibilities. However the facilities offered by the Poor Law guardians in their workhouse infirmaries, with the stigma of pauperism they brought upon the patient, could never be a comprehensive service for all infectious disease in a community. A visibly separate provision was necessary. Liverpool's financial capacity also partly explains the council's delaying tactics. In the eighteen-seventies the city had to start the construction of a second costly waterworks project after an earlier failure and a significant component of its income had been lost when the Mersey docks separated from the City Estate in 1857. Yet Liverpool, as did several towns, chose to offset some of the cost of isolation hospital provision through instituting a variable patient charge: 42s per week in first-class wards, 21s per week in second-class wards and 10s per week in third-class wards.³⁸ The full cost of isolation was therefore never borne by the council.

Conclusion

This essay has used the development of municipal hospitals to illuminate how national and local authorities negotiated the creation of essentially

³⁶ An additional example of this can be seen in the fact that there was no full standing committee of the council to deal with hospital affairs until 1893.

³⁷ Liverpool Record Office, 352 MIN/HOS/1/5, p. 241.

³⁸ *Return of Isolation Hospitals for Cases of Infectious Diseases* (Parl. Papers 1895 (xxvii), lxxxiv).

geographical policies. To date they have not been the subject of many studies, yet they form an important part of the genesis of regional healthcare, and significantly pre-date Bertrand Dawson's better-known 1920 *Interim Report on the Future Provision of Medical and Allied Services*, which presented the concept of a hierarchical regional health service that differentiated between primary and secondary care.³⁹

Many of the studies of the L.G.B. have portrayed it as a significant determinant in the course of local authority development. It certainly wielded the threat of being able to withdraw the block grant on which so many local authorities depended to supplement rate income and provide basic services.⁴⁰ Yet the example of Liverpool shows that it took many years of repeated criticism to achieve an expansion of the municipal hospital system. It is interesting that there are no references to financial sanctions being threatened in Liverpool. Perhaps the explanation lies with a lack of a clear policy on municipal hospitals within the L.G.B. itself.

The mortality rates for infectious diseases such as typhus, smallpox and scarlet fever, which had been the *raison d'être* for the creation of the municipal hospitals in the eighteen-seventies, were beginning to decline in the first decades of the twentieth century, showing in part the success of isolation and hospital treatment. By 1915 there were over 39,000 beds available in England and Wales for infectious diseases patients. Medical officers of health increased the range of diseases which they would admit to include measles, whooping cough, meningitis and poliomyelitis, as a strategy to keep their wards full. Some wards were also converted into tuberculosis sanatoria after 1898.⁴¹ The 1911 National Health Insurance Act also changed the public perception of rights to medical treatment dramatically. Some of the new municipal hospitals which were constructed in the nineteen-tens and nineteen-twenties were not justified by their infectious disease provision, but were explicitly general hospitals. This occasionally gave rise to concerns from ratepayers and the medical profession that some health services were being 'put on the rates' as part of a wider 'municipal socialism' movement.⁴²

The period 1870–1914 was one of unparalleled reorganization within British bureaucracy. It coincided with and to a degree assisted the transition from an era of sanitarian responses to infectious disease epidemics to a

³⁹ B. Dawson, *Interim Report on the Future Provision of Medical and Allied Services* (1920).

⁴⁰ See, in particular, C. Bellamy, *Administering Central-Local Relations 1871–1919: the Local Government Board in its Fiscal and Cultural Context* (Manchester, 1988).

⁴¹ Worboys, *Spreading Germs*, pp. 272–3; B. Abel Smith, *The Hospitals 1800–1948* (1964), p. 127.

⁴² H. Fraser, 'Municipal socialism and municipal policy', in *The Victorian City: a Reader in British Urban History, 1820–1914*, ed. R. J. Morris and R. Rodger (1993), pp. 258–80.

phase of 'personal prevention' during which the focus of attention was isolation and treatment of the individual. The creation of the L.G.B. in 1871, and subsequent linked legislation, provided a good opportunity for central government to influence and manipulate local activities. However, as the analysis of the development of municipal hospitals indicates, the board's attempts at coercion had only limited success. It was effective in providing guidelines for the design and construction of hospitals, and thus required a certain level of expenditure from participating local authorities. Yet it could not insist on a timetable for hospital provision. The result was a gradual introduction of municipal hospital facilities across England and Wales which was determined by other factors than the pressure exerted by the L.G.B. These factors were often financial, reflecting the increasing levels of debt of all local authorities, who were obliged to invest in new services yet had limited financial resources to pay for them. In some places the decision to recoup the hospital costs from patients resulted in such high fees that the hospitals went virtually unused – a clear example of financial expediency outweighing public health considerations.⁴³

The chronology of hospital construction must therefore be integrated into a larger financial model, which recognizes the priorities for huge capital investments such as waterworks and sewerage systems. These projects were easier to justify to the ratepaying electorate, particularly if they provided commercial benefits. Research has shown that there was a peak of capital investment in these large projects in the eighteen-eighties and eighteen-nineties.⁴⁴ This undoubtedly would have had implications for other potential projects. The L.G.B. and the local medical officer of health would have had a hard time putting the case for further public services. Yet they were aided by national legislation, especially the Infectious Diseases (Notification) Act of 1889 and the Isolation Hospitals Act of 1893, that made it easier to identify patients and funding respectively. Spreading the financial burden over a wider geographical area also facilitated the construction of new municipal hospitals, which drew patients across local authority boundaries, with the new agreement that their costs could be recovered from sub-district level.

An analysis of the development of municipal hospital services therefore illuminates a number of debates in late nineteenth-century England and Wales. It can be used to investigate the increasingly sophisticated local

⁴³ *Royal Commission on the Poor Laws and Relief of Distress* (Parl. Papers 1909 [Cd. 4499], xxxvii), p. 942 (minority report). The minority report was also issued separately as S. Webb and B. Webb, *The Break Up of the Poor Law* (1909).

⁴⁴ R. Millward, 'Urban government, finance and public health in Victorian Britain', in *Urban Governance: Britain and Beyond Since 1750*, ed. R. J. Morris and R. Trainor (Aldershot, 2000), pp. 47–68.

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financial markets and the development of regional systems of service provision through the formation of joint hospital boards. It further highlights the complexity of intra-urban socio-medical arrangements between local authorities, the Poor Law authorities and the voluntary hospital sector. This essay has shown that the extent of municipal hospital provision was considerable from the mid eighteen-nineties onwards, and was found throughout the local authority system, from small rural sanitary authorities to the largest county councils. With the decline in infectious diseases such as smallpox, many authorities found themselves with a well-constructed and staffed hospital which had the potential to form the foundation for general hospital services, although not all exploited this opportunity. The transition to a fully fledged public hospital system could not have been achieved so easily if this significant ideological tension between Poor Law, municipal and private provision for infectious diseases had not already been resolved.

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This volume explores developments in health and social care in Ireland and Britain during the nineteenth and twentieth centuries. The central objectives are to highlight the role of voluntarism in healthcare, to examine healthcare in local and regional contexts, and to provide comparative perspectives. The collection is based on two interconnected and overlapping research themes: voluntarism and healthcare, and regionalism/localism and healthcare. It includes two synoptic overviews by leading authorities in the field, and ten case studies focusing on particular aspects of voluntary and/or regional healthcare in Ireland and Britain.

Cover image: The Rotunda and Lying-in Hospital with busy street life, Dublin. Etching, 1842 (The Wellcome Library, London).