Barry Doyle’s new study addresses a subject area that has lately attracted much interest from social, political and medical historians. The reasons why Britain’s inter-war health services have become such a hot topic are not hard to discern. With the National Health Service (NHS) a central feature of contemporary political discourse at home, and with its famous attributes – universal, comprehensive and free at the point of use – so widely noticed in health policy circles abroad, it was inevitable that its history, and pre-history, should rise up the agenda. And, as Doyle points out in his opening pages, that history has recently become subject to some fascinating revision.

Put simply two main lines of interpretation dominated before the 1990s. Both assumed that the roots of the NHS lay in developments during the inter-war period, albeit with events set in motion by the Royal Commission on the Poor Laws (1905–9) and the National Insurance Act (1911). One view was that a consensus then gathered among bureaucrats, politicians and leading clinicians in favour of rationalizing a pluralistic but inefficient mix of provision. Another inclined away from consensus to attribute impetus to the progressive left, manifested in the position of the labour movement, municipal socialists and the Labour Party. Both accepted though that reform responded to real problems. These were: the financial difficulties of the voluntary hospitals as need outstripped philanthropic funding; the patchy and sometimes poor delivery of local government public health services; and the administrative incoherence of overlapping arrangements
variously provided through the poor law, charities, local authorities, mutual associations, national
government and the private sector.

The floodgates of reappraisal were opened by Steven Cherry’s analysis of voluntary hospital finance and by
Martin Powell’s social geographies of municipal hospitals. Many others followed, and today’s horizon looks
rather different. The problems of voluntary hospital funding now seem less clear-cut; the spatial unevenness
of local government services now exemplifies local autonomy as much as inadequacy; newly discovered
regional policy networks now show integration working well in places, affirming the claim that a
hierarchical regionalism driven by medical expertise was reshaping governance structures; and municipal
socialists have now been joined by progressive Conservatives and unaligned ‘policy entrepreneurs’ as agents
of change. However no revisionist synthesis has really emerged from all this and, in the hospital field
particularly, it would be difficult to argue that Abel-Smith’s classic 1964 study has been dislodged.

The British debate nestles within a much larger international historiography of the emergence of health
services within welfare states. This too has undergone substantial change. Early ambitions were to anchor
welfarism empirically in the transition to urban industrial modernity. Quantitative comparisons failed to
uncover common processes, though economic growth and the strength of labour organization seemed to
matter. Historical sociology pointed in conflicting directions. Parsons structural functionalists saw welfare
states as the adjustment of social systems to the shocks of modernity, a convergent and broadly consensual
process. Marxists meanwhile read them as the outcome of class conflict, though whether best understood as
capitulation to working-class mobilization, or concession to legitimize capitalist inequalities was uncertain.
From the 1980s the crumbling of these epistemologies and the vogue for political institutionalism ‘brought
the state back in’ to accounts of health policy-making. Emphasis was variously placed on the importance
of structures of governance, on national political cultures, on pressure groups and interest politics, on the active
role of bureaucrats, and on path-dependent processes that constrained or promoted policy options.

This then is the field to which Doyle adds a micro-study of two large cities in Yorkshire, Leeds and
Sheffield. Conceptually he takes a narrow view of the literature in both time and space, concentrating tightly
on hospitals to the exclusion of larger welfare trajectories. He frames the historiography solely in British
terms, identifying ‘pessimist’ and ‘optimist’ schools of thought. The former holds to the earlier
interpretation, assuming the problems of inter-war health care were real and that the NHS was the outcome
of trends underway before the war. The latter though sees inter-war pluralism as responsive, democratic and
effective, thus rendering more problematic and contingent the NHS reforms.

To interrogate these perspectives, his case study focuses on voluntary and municipal hospitals. The other
two elements of urban health systems, primary care and public health (ie. preventive, environmental and
community-based clinical services) are not dealt with, beyond fleeting references. Mental institutions are
also excluded, despite two large West Riding Asylums (High Royds and South Yorkshire) lying just beyond
the cities. However, because their administrative control resided with county councils, Doyle treats them as
‘outside the boundaries’ (p. 37) of the study. Despite the title, the book’s time-span is principally the inter-
war period.

The study first introduces the urban cases, selected for their different social and economic structures and
political characteristics. These, Doyle suggests, outweigh their similarities as classic industrial towns,
geographically close and of similar size. He also mentions ‘their regional role’ as a criterion (p. 8), though
this subsequently figures little. A key contention is that the configuration of local health services was heavily
dependent on social and economic structures, particular the nature of employment and the gender balance of
the workforce. The prime difference was that working-class Sheffield had a more masculine labour force in
its metal trades, with Leeds more ‘prosperous and middle class’, ‘a women’s city’ (pp. 24, 26). The final key
comparator is party political, with Sheffield distinguished by Labour’s persistent, though briefly interrupted,
tenure in office from 1926, and Leeds by Conservative dominance, broken by short periods of Labour
control.

The next section introduces the hospital infrastructure of the two cities. This adds a variant on a familiar
narrative, of the 18th-century birth of voluntary general hospitals followed by consolidation and specialization in the 19th. The inter-war period was one of significant material growth, with the emphasis as much on ancillary institutional factors as medical. In the public sector the story is begun only in the later 19th century with the arrival of poor law infirmaries distinct from general workhouses, and the isolation hospitals and sanatoria built by local authorities under Victorian public health legislation.

In setting up the relationship between the municipal and voluntary sectors Doyle argues that public provision was essentially ‘residual’ (p. 63), in that it accommodated those not served by voluntary hospitals. This reading sits oddly with his data, which show that in 1938 in Sheffield the voluntary sector proved just 30 per cent of the city’s bed complement, and in Leeds 27 per cent. The exclusion of peripheral mental hospitals accentuates this, for if the beds of the South Yorkshire Asylum are added, Sheffield’s voluntary hospital share drops to 20 per cent. In light of this it might have been desirable for the pre-history of public care through the poor law and county asylums to receive the same attention as the voluntaries, and more generally to see the balance of the book better reflecting sectoral shares.

Next Doyle develops his argument about local needs shaping different configurations in patient flows and specialities. Women for example benefitted from increased provision of maternity and specialist beds, and he argues this offset the exclusions from National Insurance many experienced. That this was particularly true of Leeds he attributes to greater female prominence in the job market and public sphere. Similarly in Sheffield he finds that occupational health risks associated with the metal trades determined the commitment to the orthopaedics specialty. In thus teasing out the relationship between service configuration and industrial society he extends further the insights from John Pickstone’s and Hilary Marland’s work on 19th-century Lancashire and Yorkshire.

The chapter on hospital finance treads familiar terrain, documenting the relative decline of traditional charitable modes in favour of mass contribution and user fees. Doyle’s distinctive emphasis is on continuity rather than the change. Thus for example, the standardization of the employers’ payments into workers’ contributory schemes, which (as others have noted) was particularly strong in Sheffield, may be read as a restructuring of the philanthropic subscription. Here, as in previous work with Nick Hayes, Doyle also emphasizes the persistence of small-scale charity at community level. This is not shown to have had great financial significance, but it does matter as social history, adding to the burgeoning literature on the ‘Big Society’ avant la lettre.

Specialists on hospital finance will be interested in two areas where local sources can go beyond intractable national data. The first is the voluntary hospitals’ capital base, for a key aspect of appraising ‘financial health’ is to move beyond current expenditure to establish whether assets were growing or declining. Individual institutional accounts yield this information, and the historiography thus far is mixed, with large investment portfolios that underpinned activity visible in some hospitals, while in others these were rapidly diminishing. This appears to be the pattern in Doyle’s towns too, though his exposition is imprecise, alluding to percentage changes rather than presenting longitudinal data on assets and overdrafts.

The second area is public sector spending. Here too Doyle’s decision not to present statistical series is a missed opportunity, preventing systematic comparison with the voluntary side. He states the methodology is ‘less clear-cut’ (p. 131) despite citing work which shows how this can be achieved, using the borough treasurer’s abstracts. Instead he relies on the Levene/Stewart/Powell rankings of municipal expenditure. These though have limitations because they omit large areas invisible in the national aggregate statistics, particularly hospital spending under the Poor Law (latterly Public Assistance). Interestingly Doyle shows that some of the Sheffield municipal hospital expenditure came from this source, further problematising Levene/Stewart/Powell’s methodology. The question of whether (as we might expect) city patients in the West Riding Asylums were funded by transfers to the county council is not addressed.

The book scores most highly in its exposition of the hospitals’ place in municipal politics. Here a key issue is the rise of Labour in inter-war local government, and Doyle probes the question of whether a unitary left-wing position hostile towards charity and pluralism existed. Close inspection of local evidence thoroughly
nuances this proposition, showing municipal socialism running alongside commitments to voluntarism. This is a helpful addition to the literature, including Ray Earwicker’s unpublished thesis, the Stewart/Powell municipalism project, and Julia Neville’s urban cases (referenced here but not incorporated), which have already disrupted simplistic assumptions. It must be said though that historians who cleave to a ‘labour mobilisation’ explanation of the coming of universalism probably won’t abandon their faith. On the contrary, Doyle has turned up plentiful anecdotes of socialist ardour for statist solutions, notwithstanding all the nuancing, cleavages and ambiguities.

The final section documents the degree of administrative integration across the sectors, and between the departments and units of local governments. Doyle argues that if we look beyond superficial national assessments we can find a great deal of successful joint working documented in administrative records at city, hospital and regional level. His findings are not fully consistent, also containing evidence of tensions and parochialism. On balance though, he suggests it is a canard for historians to claim that hierarchical integration under the NHS was a necessary response to diversity’s confusions.

So where does this study leave the field? There are repeated claims to be filling historiographical lacunae (on, inter alia, infectious diseases hospitals, modernization of ancillary services, free treatment for the sick poor, pay beds, financial pressures and contributory scheme interests as integrative forces, and even the Medical Officer of Health), which may strike specialists as overdrawn. (pp. 44, 62,102, 145) There is also occasional rhetoric implying that because critical appraisals are not borne out by Leeds or Sheffield then by default they are invalid (p. 180). Nonetheless, Doyle has surely given us as full and as balanced a case for (in his terms) an ‘optimist’ evaluation of the pre-NHS system as we are likely to get. His final verdict is that his local actors met changing medical needs ‘in a highly effective manner’ and that historians who overlook this are guilty of the condescension of posterity (p. 209). Does this conclusion hold up?

First, if we reach a positive appraisal of how a local health system functions, then we need clear criteria. Population health gains are the most obvious, but here Doyle’s evidence is at best unclear. Standard health indicators are briefly noted, the key point being that infant mortality rates fell in both cities between 1920 and 1939, with Leeds remaining above the national average and Sheffield below. Crude death rates confirm the picture of Sheffield close to the national experience and Leeds worse, though Doyle does not standardize these for population structure. Had he done so he would have found Sheffield death rates were rather poorer than this, though still not as bad as Leeds, but with neither city at the worst extreme. Otherwise he makes no systematic attempt to relate hospital provision to local trends in morbidity and mortality. This is unsurprising: even today this is fiendishly difficult given the problem of mapping hospital catchments onto civil registration districts. Instead then Doyle follows others in accounting for the gains in infant health particularly through municipal environmental interventions and housing programmes. Attributing health improvement to growing state agency doesn’t obviously help an ‘optimist’ case for pluralist provision. Absent such evidence then, how else might we appraise success in meeting local need? Once again, needs assessment is extremely complex, because demand can follow supply. One of the earliest insights of health services research in the 1970s was that ‘a bed opened is a bed filled’, regardless of underlying morbidity patterns. Nonetheless, local and national health policy-makers were long concerned to strike the appropriate balance of provision and need. Doyle’s case is that responsive localism through joint committees close to the grassroots was the optimal means of achieving this.

So how might we assess adequate provision? We know from the Hospital Survey of 1945 that Sheffield was close to having what experts then regarded as ideal bed/population ratios. However it was the counties and smaller towns of its region where gross shortages were identified. We know from 1960s comparisons of NHS regional data by health economists that the North generally, and Sheffield in particular (region not city) lagged behind in key provision indicators of bed and staffing levels. And we also know that it was only the work of the 1970s Resource Allocation Working Party which slowly adjusted historically inequitable funding flows away from the South-East and towards places like the (renamed) Trent region. An equally plausible evaluation then is that localism in this region (not city) was highly ineffective due to the underlying resource base. Hence it was only centralizing bureaucrats (not to mention political leadership by
This is not the only instance where Doyle’s choice of case studies stacks the cards in his favour. If, on the basis of existing literature, we were to select places where we would expect to find integration working best, then surely they would be large provincial cities with medical schools? Daniel Fox on hierarchical regionalism has given the theoretical justification, Sturdy on Sheffield and Pickstone on Manchester have shown empirically the existence of medical, political and academic networks, and Gorsky, Mohan and Willis have documented other examples in their contributory schemes studies. Would it not have been better to set big city experience against several smaller locations to give the thesis a proper test? There are after all (by my count) 29 metropolitan boroughs, 83 county boroughs and 63 administrative counties from which to draw representative case-studies.

The same criticism of narrow selection that invalidates generalization might be leveled against the book’s principle concentration on acute medicine in general hospitals. Any appraisal of pre-NHS health services surely needs to take on the functioning of primary care under National Insurance, testing historians’ claims about gaps in provision, the two-tier service and the growth of public dissatisfaction? More serious, in a book about hospitals, is the neglect of mental asylums and of long-term care in Poor Law institutions, particularly those not subject to modernizing policies after 1929. With respect to the former, this period was the peak of institutional solutions to psychiatric illness, and of new physical and occupational therapies: we need to know what this meant for health politics. As for the latter, both Alysa Levene on national data, and my own work on the South-West region propose that this was a neglected part of the hospital sector, both in expenditure and policy development. The same point appears repeatedly in the 1945 Hospital Surveys, not to mention in Bevan’s political rhetoric. So from the perspective of system appraisal it is unfortunate to rule these out of consideration due to geographical boundaries.

The final problem with Doyle’s stance is that he makes no attempt at a larger synthesis. If, as he suggests, inter-war diversity, was effective, democratic and financially viable, then how and why did national reform come about in 1945–8? ‘Pessimist’ histories, after all, respond to the need to understand the NHS legislation as a critical juncture in British policy-making. It is hardly unwarranted to hypothesize that perceived problems with existing arrangements in the preceding decades may have led to this. Nor is it unwarranted to suggest that when empirical research affirms the existence of such problems, in some places at least, we may have identified reasons why health reform came onto the agenda. If Doyle wants to argue that this is teleology or personal bias, then he needs to provide his own account, linking his local findings to the broader national trajectory, for the rest of us to interrogate. What, for example, are their implications for theories of universalism as social democratic advance, or of interest group formation within the pluralist arena, or of path dependence and policy options?

One final thought. Let us suppose that Doyle is correct, that the successes of Leeds and Sheffield can be generalized to the rest of the country, and that historians have seriously misjudged the relationship between inter-war trends and the coming of the NHS. This is hypothetically possible, particularly in light of Nick Hayes’ recent reappraisal of public opinion data, revealing how ambivalent contemporaries actually were towards health reform. In that case the research agenda should shift decisively towards the war years, with the imperative of reexamining the Emergency Medical Service, along with the contingent impacts of conflict on policy-making. Post-Doyle, we have surely reached saturation point with inter-war urban micro-studies, but moving the spotlight to the 1940s opens exciting new possibilities.

Notes

1. Social and Spatial Inequalities Group, "Deaths and population 1921–2005" <http://sasi.group.shef.ac.uk/data/index.html> [accessed 16 December 2014]. In 1936–9, the SMR for Sheffield was 107 and Leeds 115 (Britain: 100), the extremes being Eastbourne, 74, and Salford, 133; thus they ranked 39 and 57 out of 83 English and Welsh county boroughs. Back to (1)

2. Ministry of Health, Hospital Survey. The Hospital Services of the Sheffield and East Midlands Area


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