The Urban and Local History of Social Policy since the Second World War

Bridging the Voluntarist Gap: Hospitals and the Local State in Middlesbrough, 1890-1950

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Hospital history in early twentieth century Britain is currently undergoing something of a renaissance. This is long overdue as for many years the history of pre-NHS provision has been dominated by pessimistic accounts which have viewed the voluntary sector as uneven, partial and patronising and the work of the municipalities as laudable but inadequate. Popular views paint a picture of patients condemned either to charity or the poor law or worse still, suffering in silence for the want of the cost of treatment. Recent research has, however, begun to challenge this image, with both local and national studies highlighting the degree to which both sectors expanded to widen coverage and access, especially in urban areas. Yet the history of the municipal sector – outside of London and a few other big cities – remains very limited, though this is now being addressed by Martin Powell and John Stewart. The relationship between the municipal and voluntary sector at the local level is even less well covered, although again or understanding is being enhanced by the studies of John Mohan for the national and north-eastern scene, Pickstone for Lancashire, Gorsky for both Aberdeen and Gloucestershire and John Welshman for Leicester. The aim of this paper is to aid this process of uncovering the place of municipal medicine in England before the NHS by assessing the extent to which the local state hospital provision in Middlesbrough, a medium sized industrial town in north east England, helped to meet the gap in provision left by the borough's voluntary hospitals; the degree to which they were able to finance adequate services, especially in a period of severe economic crisis in the town, and the scale of cooperation with the voluntary sector to provide a full acute and chronic hospital service. In the process it will consider the factors which may have promoted and constrained municipal development including the impact of the Labour party, the Medical Officer of Health (MOH) and the Ministry of Health.

Middlesbrough was a product of the nineteenth century boom in heavy industry with all the associated health risks. A village of 300 people in 1830 it grew to over 90,000 by the early twentieth century, many of whom were migrants involved in the making and working of metal. The rapid expansion of the town led to frequent and devastating epidemics of infectious diseases – a small pox outbreak in 1898 resulting in the death of the MOH from over work. The nature of the economy was similarly dangerous. Iron and steel workers were frequently involved in accidents – crushings, burns and eye injuries being particularly common – whilst the conditions exposed them to extremes of temperature and other processes which induced rheumatism, arthritis and back problems. Furthermore, it was not just the workers themselves who were endangered by the works, the smogs and pollution threatening the whole population and, it was believed, producing a particularly contagious chest illness known as Middlesbrough pneumonia. Finally the

nature of the work and structure of the population led to early marriage, with women bearing unusually high numbers of children, a staggeringly large number of whom did not reach the age of one. Although these nineteenth century problems were tempered by changes in the industry and environment, new problems appeared after the First World War as the town was blighted by mass long term unemployment, leading to new health issues such as under-nourishment and reduced access to medical care. Together these issues produced considerable demand for hospital services, some of which was met by the voluntary sector and much by the local state.

By 1890 Middlesbrough could boast two voluntary hospitals – though both were relatively small. These two institutions, which owed their existence in part to enduring divisions within the middle class, provided around 150 beds, with the bulk of their patients accident and emergency cases from local industry. As with most hospitals of their type, they excluded a wide range of conditions, including the infectious, the chronically sick, the destitute, maternity cases, TB, VD and pneumonia. In general they specialised in surgical work and treated few medical cases. In addition to these medical limitations, access was also governed by 'membership'. Unlike the older voluntary institutions, these hospitals drew only part of their income from subscribers, fundraisers, legacies and donations whilst an increasing proportion came from workers' contributions – around half by 1900, 70% by the 1920s. Furthermore, contributing workers increasingly bought the right to treatment for their families as well – and by the 1920s a small additional payment could cover wives and children at both hospitals. As a result, it was claimed that by the outbreak of the First World War, around 50,000 people in the Middlesbrough area were eligible for treatment in the town's hospitals. However, this access was limited to those in manual labour, with the better off workers mostly (though not entirely) excluded, whilst periods of unemployment, a frequent occurrence in the twenties and thirties, could lead to loss of this privilege. Furthermore, the patients treated tended to be skilled and semi-skilled adult males – roughly half of the patients – with wives and children making up the rest. When North Ormesby began accepting paying patients in the 1920s the bulk of these were older, often single, women. Despite the restrictions, the number of patients treated at these two hospitals grew significantly across the first half of the century from 750 a year at North Ormesby and 1000 a year at North Riding Infirmary in 1900 to 3500 and 2500 respectively by the mid-1940s. This growth was facilitated both by the physical expansion of the two institutions – to 150 beds at NRI and 200 at NOH by the 1930s – and by a marked reduction in the length of stay of the patients – down to about 17 days by the 1920s. In part this reflected improved medical techniques, changing illness patterns (the decline of lumbar TB for instance) but also the continued exclusion of most medical cases and the developing emphasis on surgery, especially simple operations for children. Overall, whilst Middlesbrough was fortunate in having a very extensive and efficient voluntary sector – certainly much more extensive than many similar towns – this provision still left many gaps which it fell to the municipal sector to fill.

Prior to 1929 hospital provision by the local state was divided between specialist public health accommodation, which was the responsibility of the municipal borough and general provision for the very poor which was in the hands of the Poor Law Guardians. In

Middlesbrough, the Guardians built a work house in the 1870s which included a separate Infirmary (PLI) with over 100 beds for men, women, some maternity cases (the only hospital maternity provision in the town until 1920) and a number of specialist conditions including skin diseases and VD. Treatment was basic, conditions austere and disciplined, staffing minimal and often inexperienced. Yet the separation of the PLI from the workhouse ensured that it could develop as an effective general hospital for those unable to gain entry to the voluntary institutions. By the early twentieth century it had grown in size, adopted the name Holgate, improved its staff and was gradually expanding into surgical and specialist treatment, especially maternity provision. In addition it had acquired a separate children's hospital, called Broomlands, with 50 beds, though this was never a satisfactory establishment. By the 1920s Holgate was increasingly seen as a public general hospital, and was quickly appropriated by the Borough in 1930. Its patient profile was very different to that of the voluntary hospitals, with the majority of inmates casual labourers and seamen, women, the elderly whilst a great many would appear to have been of Irish extraction. Their stays were long, their conditions mainly chronic the death rate very high. Though not all were paupers, most were the residue from the voluntary sector, condemned to Holgate either because they could not contribute or because their illnesses could not be 'materially improved'. The profile did change a little in the 1920s, especially with the opening up of the institution to paying patients and its growing popularity as a maternity hospital.

Borough provision before 1929 included West Lane Infectious Diseases Hospital, the first of its kind in the North-east of England, the rural small pox sanatorium at Hemlington – which also treated TB cases – and a substantial Asylum, opened in 1898 to accommodate 500 patients. Together, these institutions (along with the PLI) reflected the local state's nineteenth century function as the protector of public safety. These were exclusionary institutions designed to protect the population from physical and moral contagion. Yet in the twentieth century the borough expanded its services extensively under the leadership of the MOH, Dr Dingle. Dingle not only managed to acquire a senior management role at the PLI in the 1920s, he also oversaw the opening of a maternity hospital in 1920 and the gradual expansion of ID accommodation so that Middlesbrough became the de facto sub-regional centre for infectious diseases, adjacent boroughs buying beds in West Lane and Hemlington. At this point municipal provision filled the gaps left by the voluntary sector by handling infectious diseases (which, though on the decline were still a significant occasional menace) caring for the mentally ill and providing increased hospital provision for maternity cases. But Dingle's main contribution was the appropriation of Holgate and the gradual development of a general hospital service in the 1930s. This municipal general hospital built on developments at the PLI by gradually expanding specialist and surgical treatments, improving the professionalism of the staff and reorganising the arrangement of the accommodation to provide a clearer focus for the hospital's work. Admittedly, the patient profile did not change greatly, with the bulk of the patients still on very low incomes and still largely drawn from the labouring classes and those without access to the voluntary sector contributory schemes (unmarried women, wives and children of labourers) and those with diseases the voluntaries would not treat – the death rate remaining very high and the length of stay long. Dingle was able to complete his reign by establishing a TB

sanatorium at Poole (in a property donated by a leading town councillor), and expanding West Lane ID to include a substantial new block. By the time he retired in 1936, Middlesbrough's municipal provision ran to six institutions caring for a wide range of specialist and general – though not really surgical – conditions.

Central to the policy of Dingle and his successors was a vision of municipal provision as complimentary to that of the voluntary sector, with efficient organisation, rather than grandiose projects at its core. It is conceivable that Middlesbrough's municipal doctors adopted this pragmatic position as a result of the rather straightened financial climate of the interwar years in the town. The 1920s saw little building in the municipal sector – except for the small maternity hospital – whilst the capital projects of the 1930s were modest, and focused on reorganisation rather than expansion. Thus, following appropriation, Broomlands children's hospital was closed and a children's hospital opened in a converted building on the Holgate site. Similarly, provision for a men's TB ward was fashioned out of existing accommodation and at a fairly minimal cost. Local politicians seem to have been guided in their decisions by the Ministry of Health, whose inspectors invariably adopted a cautious approach on the grounds that what was really required was a complete rebuilding project but that was not possible in the present time due to economic weakness and uncertainty. However, where the Ministry seemed to be attempting to cut costs simply for the sake of economy, as with the West Lane extension, the Hospitals Committee supported the plans of Dingle for a more expensive scheme. Thus capital expenditure was concentrated on consolidation in the areas the municipality already controlled – maternity, children, infectious diseases, TB – whilst little was done to expand the general as a general hospital to compete with the voluntary sector.

Expansion was partly constrained by staffing problems. The general was a training hospital for nurses, yet it invariably had trouble getting decent applicants and keeping those it recruited. Failure on the course was common and discipline weak. The situation seems to have been even worse with junior medical staff, though there is evidence that the pay and conditions offered were below national standards, whilst the local BMA was vigorously opposed to any expansion into domiciliary work. The failure to develop surgical specialism also caused unrest amongst the medical staff, the Medical Superintendent Britain Jones, bidding successfully to do consultancy work within the voluntary sector. He also appears to have had considerable problems with Dingle, frequently appealing to the Hospitals Committee to establish his authority within the institution. Following Dingle's retirement there were some changes and a more aggressive stance was taken towards the development of the general, yet even here progress was slow, with wartime prosperity weakening the pull of the general in the face of buoyant income in the voluntary sector. Overall, policy seems to have been determined by financial constraint, Ministry of Health dictat and the views of Dingle, rather than the active intervention of the politicians. There does appear to have been a slight change once Dingle retired, which coincided with the expansion of the number of Labour representatives on the committee. Yet their impact was low key, largely restricted to using their visits to the hospital as an opportunity to recommend minor improvements rather than wholesale expansion. Labour members were also significant in encouraging the development of a more unified system of patient distribution and payment, the trades

council securing both a reduction in the fees charged to paying patients and the development of reciprocal agreements with the voluntary hospitals to avoid contributors paying twice.

Up to 1936, and especially in the years following the appropriation of the PLI, Dingle as MOH appears to have followed a policy of cooperation, not competition, with the voluntary sector. Throughout his period in office, he concentrated on developing the services which were specific to the local state, claiming in 1933 that this had led to de facto co-ordination between the voluntary and public hospitals:

> The Voluntary Hospitals are established as the General Hospitals of the district while the Public Authority take on the responsibility for particular sections of hospital work, e.g.
> The duty of providing medical treatment for those unable to maintain themselves, to treat chronic cases, Infectious Diseases, Venereal Diseases, Tuberculosis, Maternity and School Children.

However, more formalised cooperation may have been hindered in the early 1930s by the fact that Dingle remained wedded to the idea that the Municipal Hospital and the Municipal Service should be at the centre of the borough's hospital system on the lines suggested in the Dawson Report. In his opinion, the voluntary hospitals would remain independent but subsidiary to a local state run patient management system which would direct patients to the most appropriate institution for their condition. Whilst this may have been eminently sensible (and probably owed much to similar thinking within the powerful local Guild of Help which attempted to manage welfare services on similar lines) it was anathema to the management and medical staff of the voluntary hospitals. Joint working did develop slowly, for example in radium treatment, whilst the war saw the first tentative steps towards the more efficient management of acute patients. Yet even here, the plan was for the general to provide a complimentary, rather than a competitive role.

Hospital services provided by Middlesbrough's local state would thus appear to have been designed to bridge a voluntarist gap. Owing their origins to Victorian public safety ideals, they gradually developed under Dingle into a wide ranging public health hospital service addressing the needs of all but acute patients. Whether more could have been done is unclear at this stage. Certainly the Medical Superintendent wanted to embark on more ambitious plans for the General by the later 1930s, though the MOH and the politicians appear to have reigned him in. Certainly cost was a very important factor in the slow expansion of municipal services, as was the attitude of the Ministry of Health, especially in the early 1930s, whilst party politics was of only minor importance. But of equal significance was Dingle's acceptance of the fact that the voluntary hospitals were the best providers of acute medical services in the town. His vision was to concentrate on the efficient organisation of his specialist institutions to ensure the delivery of a complete and ultimately integrated hospital service to the people of the borough