Renewed interest in community hospitals and continuing controversy surrounding NHS finances make an examination of the hospital in modern history both topical and relevant. With the exception of St Bartholomew's and St Thomas's in London, refounded in the 16th century, modern hospitals begin with the Westminster (1720) and Edinburgh Infirmary (1729), with provincial emulation initially in the county towns of southern and western England. Forty voluntary general hospitals were founded by 1800 but the correlation between hospital location and industrial population centres remained poor. The map illustrates how institutions established in Manchester, Leeds and Sheffield were the sole hospital facilities for the burgeoning populations of east Lancashire, west and south Yorkshire respectively.

Nineteenth century hospital expansion also had qualitative dimensions, notably in the emergence of the scientific institution, critical to training of the medical profession and, by 1900, the pinnacle of biomedical effort. Although levels of general practitioner care developed in the early twentieth century, hospitals provided the greatest range of services and consumed most resources, a situation confirmed in the early NHS. Modern hospitals, emphasising distinctive, technical forms of treatment, are increasingly scrutinised on cost-effective grounds and in relation to primary or preventive forms of health care. They have also been presented as avenues for entrepreneurial medical specialists and the domain of professional medical elites, which cared little for other health personnel or for patient concerns beyond the specifics of ‘the case’. [1 & 2] This essay explores the development, typology and role of hospitals, commenting on some key areas of research.

Historical writing on hospitals has been dominated by individual institutional studies. Typically these have paid little attention to background community needs or the hospitals’ relevance to these. Hospitals collectively were often examined to illustrate the value of philanthropic or voluntary effort or the emergence, via poor law and municipal provision, of a pre-NHS public sector. Medical innovations, notably smallpox inoculation, were assigned a positive role in population expansion. Such views overstated medical achievements and facilities, rather ignoring the likely workings of the eighteenth century and early nineteenth century medical market and the importance of background improvements in diet and sanitation. But from 1955 Thomas McKeown’s devastating critique of the role of medical effort in improving health led to other overgeneralised assumptions; for example, that hospital inmates ‘normally died there’. [3] Arguments that hospitals were, on balance, not harmful or might have had a localised, positive impact featured in a brief ‘hospitals debate’, but this had little mileage without its social context. [4 & 5] Mortality data is a crude indicator of medical effort or living standards and the relationship between medical services and health levels is complex. The isolation of medical contribution from questions of nutrition, resistance to disease or the ability of patients to withstand treatments or surgery is unrealistic, given their interdependence in any assessment of life chances. [5] Individual hospital studies became less useful, considering the expansion of hospital numbers or the increased overlap of their functions and patient catchment areas by 1900. As such questions are examined by Simon Szreter in ReFRESH 14 (Spring 1992), we turn to other features of the modern hospital.

Steven Cherry is a lecturer in History and a member of the Wellcome Unit for the History of Medicine at the University of East Anglia. His published work includes Medical Services and Hospitals in Britain, 1860-1939 (1996) and articles on medicine and population growth, hospital funding, and studies of political and health issues in the labour movement.
The organisation of hospital care

Most eighteenth century hospitals were philanthropically founded, with major donors or individual subscribers able to recommend patients and to vote at governors’ meetings, though executive management boards took critical decisions. Admissions policies focused upon the sick, non-pauperised poor, though sufferers from infectious diseases or mental illnesses, pregnant women, infants and small children were often excluded. Male breadwinners, particularly accident cases, were sometimes prioritised initially, notably in smaller institutions in heavy industrial or mining areas, though this aspect can be overstated. Chronically ill patients were admitted for delineated periods of treatment, the average duration of which was high: 40 days was not unusual in late eighteenth century and 30 days in late nineteenth century hospitals.

It has long been recognised that patients, as charity cases, had few rights. They risked discharge for all manner of ‘irregularities’ in breach of hospital rules or upsetting to medical sensitivities. More recent research has also established that the diagnosis of sickness and treatments were increasingly justified on scientific grounds by hospital doctors less inclined to consider the sufferer’s own account of circumstances.[6] Honorary medical staffs provided free services but achieved professional objectives in securing status, access to the hospitals’ wealthy supporters, greater opportunities for practice and research and to take pupils. Their protection of this position produced increasing ratios of patients to medical staffs in hospitals before the proliferation of specialist departments in larger institutions from the 1850s and 1860s. In turn, this feature underlined the authority of the hospital specialist or consultant.

Elevation of the proposed Herbert Hospital, Woolwich, London.

Source: The Builder, April 14, 1866.

Before the introduction of anaesthetics in the middle 1840s hospital or domestic surgery was largely restricted to the surfaces or extremities of the body. Trepanning (sawing) of the skull, resection of strangulated hernia, lithotomy (the process of cutting for a stone in the bladder), amputation of limbs and removal of tumours comprised the most serious operations. However, by 1900 a more sophisticated understanding of the cell structure of the body, the discovery of microorganisms, aseptic procedures and X-ray technology enhanced the claims of scientific medicine.[7] Following the 1858 Medical Act, hospital training and university education were promoted by the General Medical Council, and all were subject to the influence of the Royal Colleges of Physicians and Surgeons. Medical authority in the teaching hospital was replicated elsewhere; the voluntary hospital specialist, the poor law infirmary medical superintendent and the cottage hospital GP, each in institutions developing rapidly in the third quarter of the nineteenth century, could exert professional influence based upon expertise. Larger hospitals became research establishments and their increasing range of treatments impacted upon nursing systems, hospital design and hygiene, patient super-vision and cost effectiveness, each the subject of reform by 1900.[8]

The public association of hospitals with more advanced levels of care increased as general medical practice expanded, notably under state national insurance arrangements from 1911, and as wartime experience 1914-18 confirmed the importance of patient referral to hospital facilities. The interwar period saw the use of insulin in the management of diabetes, the development of kidney dialysis, blood transfusions, skin grafting techniques and radium therapy, whilst the introduction of sulphuric drugs from 1936 heralded control over the processes of infection. Such life-saving capabilities further raised the status of hospital medicine, although rudimentary questions of access and cost, vital to the general public, were often ignored by the chroniclers of medical progress.

A hospital system?

Hospital development in the nineteenth century proceeded along two distinct lines. Voluntary general hospitals existed in most towns, with teaching hospitals in major cities or university towns; twelve in London, twelve in provincial England and Wales and six in Scotland by 1900. Special hospitals, beginning with fever and maternity institutions, also expanded rapidly. Twenty eye hospitals were established before 1840, 38 children’s hospitals were founded before 1890, and 60 assorted specialist hospitals existed in London by 1865. Some 300 cottage hospitals, including ex-dispensaries with beds, village, small district and suburban institutions, were founded between 1859 and 1900, with 300 more by 1939.

The proportion of voluntary hospital beds per 1000 population rose from 0.70 in 1861 to 1.07 in 1911 and to 2.12 in 1939, although their distribution, still skewed towards London and Edinburgh, remained less equitable than poor law or local authority equivalents.[9] Their focus upon acute treatments of shorter duration and increased bed occupancy rates meant that voluntary hospitals treated one third of all hospital patients by 1938, compared with one fifth ill 1861. Yet, as Table I shows, the proto-public sector provided most hospital beds.
In poor law hospitals standards and organisational principles, rather than increased basic provision, have preoccupied historians. Roughly half of hospital beds for the physically sick were in separate infirmaries, rather than workhouse sick wards, by 191 1. All were open to the chronic sick and infirm, whose ill health produced destitution. The admission of non-pauper patients, direction by medical superintendents and improved nursing systems suggested a proto-public service by 1900, particularly in the main conurbations. Yet the 300 or so English rural infirmaries lacked basic nursing or equipment, as did most Scottish poorhouses, and twentieth century improvement was patchy.[10] By 1939 most public assistance infirmary beds were separate from general accommodation and municipalisation of ex-poor law institutions proceeded under the 1929 Local Government Act. Other local authority hospital provision reflected successively concern with sanitary arrangements, community isolation procedures and specific provision for individuals suffering from infectious diseases or tuberculosis from the 1860s to the 1920s.[11] Hospital facilities were also added to emergent maternity and child care services from the early twentieth century, either directly or via arrangements with voluntary hospitals.

Integration of rivalry?

Thus some co-ordination of services is apparent, though its extent remains a matter of dispute. The Ministry of Health, established in 1919, did not take an interventionist role or provide financial inducements until the 1929 Act, which enabled rather than compelled matters of hospital service Organisation. Area studies have established that the Voluntary Hospitals Commission adopted a conciliatory attitude to the London County Council (L.C.C.), seeking contracts or grants for services and to avoid direct competition with the latter’s uprated hospitals. Hospital consultants in Manchester, aware of professional opportunities in both private and public sectors, promoted their co-ordination. More generally, patient transfers from voluntary to public hospitals relieved waiting lists and facilitated the demarcation of responsibility for acute or chronic and infectious patients respectively, as in interwar Birmingham and Sheffield.

But did such examples constitute a hospital system? Only one fifth of poor law infirmaries were municipalised before 1939, notably by the L.C.C., the larger English urban boroughs and in Glasgow. Missed opportunities to integrate existing public hospital services from 1929, particularly in rural areas, reflected insufficient basic facilities, financial resources or political willpower. Many voluntary hospital authorities remained fiercely independent and suspicious of the public sector, their medical staffs taking isolationist or elitist stances which regarded public institutions as refuges for the chronic sick or convalescent and other patients transferred from voluntary hospitals. Co-ordination of the voluntary sector hardly progressed beyond plans for regionalised services, based on cottage, district general and ‘key’ specialist or teaching hospitals. In the 1935-7 (voluntary) British Hospitals Association Survey, for which 13 per cent of voluntary hospitals failed even to respond, 30 per cent reported no developments in service co-ordination since 1929. Claiming 1.39 million inpatient treatments in 1937, voluntary hospitals had expanded but skimmed on their contribution to integrated hospital services, let alone more general health care. An improving public hospital sector provided two opportunities to integrate existing public hospital services from 1929, either directly or via arrangements with voluntary hospitals.

Table 2: The main categories of hospitals for the physically ill, by sector and type, in England and Wales, 1861, 1911 and 1938

<table>
<thead>
<tr>
<th></th>
<th>1861</th>
<th>1911</th>
<th>1938</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teaching</td>
<td>25</td>
<td>24</td>
<td>25</td>
</tr>
<tr>
<td>General</td>
<td>130</td>
<td>530</td>
<td>671</td>
</tr>
<tr>
<td>Infectious</td>
<td>5</td>
<td>53</td>
<td>108</td>
</tr>
<tr>
<td>Infectious</td>
<td>5</td>
<td>53</td>
<td>921</td>
</tr>
<tr>
<td>TBS (both)</td>
<td>12</td>
<td>8</td>
<td>111</td>
</tr>
<tr>
<td>Maternity</td>
<td>605</td>
<td>625</td>
<td>445</td>
</tr>
<tr>
<td>Total</td>
<td>254</td>
<td>783</td>
<td>1,357</td>
</tr>
<tr>
<td>Total (public)</td>
<td>650</td>
<td>1,404</td>
<td>1,882</td>
</tr>
</tbody>
</table>
| (Public) hospitals include poor law and local authority institutions. All figures exclude convalescent and related institutions; the 1911 figure does not include public TBS hospitals.

Based on R. Finster, English hospital statistics: Table 7, p.57

...sector facilities were more equitably distributed than voluntary, but regional disparities of 50 per cent in bed provision and nursing levels were common, with intra regional variations equally pronounced.[12] London public hospital bed provision per capita was double the provincial averages and quadrupled in rural areas. Beyond the conurbations there were few signs of a hospital system based on features more positive than demarcation or default. In the best voluntary hospitals intensive treatments contrasted with inadequate after care services. In others, GP staffs sometimes performed overambitious, poor surgical work and expensive equipment was allegedly underused. Almost everywhere, the concept of the hospital as a supporting service for community health care remained underdeveloped.

The continued vitality hospitals, public sector potential, signs of co-operation, and links between service improvements and reduced mortality are noteworthy. Yet gaps in service provision and co-ordination, missed remedial opportunities and inadequate attention to positive health were critical deficiencies.

Issues in hospital funding

The expansion of hospital facilities required new sources of funding, a subject much less barren than first impressions convey. Aggregate data before the late nineteenth century is scarce but, in conjunction with individual hospital studies, suggests that some commonplace assumptions require revision.[13] As a service of last resort, poor law medicine was always subject to financial restraint but the growth of separate infirmaries and the influence of their medical superintendents meant rising expenditure. Annual spending on new buildings averaged £2 million and costs per infirmary bed doubled in the period 1899-1914, for example. There were surges in hospital spending by other local authorities, notably on isolation hospitals in the late nineteenth century and on public infirmaries after the 1929 Local Government Act. The latter partly reflected relocations from ex-poor law to health committee budgets, but public sector hospital income - £19.6 million in 1934 - now exceeded that in the voluntary sector.

Public sector growth did not mean a decisive shift from voluntary to public services, however. Voluntary hospitals, traditionally funded through the donations of the living and the legacies of the dead, became less obviously philanthropic institutions. Their new income - £19.6 million in 1934 exceeded that in public sector.

Cherry, Refresh 26 (Spring 1998)
‘windfall’ donations. They prolonged the independence of the voluntary hospital sector - a mixed blessing but ultimately insufficient for sustained expansion to meet rising standards and costs of care. Meanwhile, the voluntary hospitals’ patient clientele extended beyond the sick poor, who, if they were chronically ill, infirm or infectious, were increasingly dependent on public sector institutions.

**A hospital based service ...**

Financial considerations underpinned calls for an integrated, national hospital service on the eve of World War Two. The deteriorating finances of many voluntary hospitals, particularly in London, undermined their hopes of an independent role within a national health service. Yet uneven local authority facilities hardly satisfied the requirement of uniform provision. A largely tax funded service, with independent status granted to teaching hospitals and nationalisation of most of the remainder, reflected the state response to these objectives and efforts to retain the consultants’ skills within an NHS hospital environment. In planning the NHS wartime experience, changes in coalition government personnel and approach, professional medical influence and Bevan’s post-1945 ministerial role have occupied historians, recent debate focusing upon the role of vested interests or the emergence of an ‘enlightened consensus’ informed by the medical profession.

Much less attention has been paid to grassroots opinion, possibly on the grounds of its insufficient expertise, interest, or influence. This ignores Labour Party or trade union interest in health policy, stretching back before the Poor Law Minority Report of 1911, traditions of self-help and organisation of primary medical services since the early nineteenth century, and interest in hospitals, rather than merely fund raising for hospitals, from the 1860s. By 1900 workers’ funding was a major source of hospital income, notably in heavy industrial areas, and was accompanied by demands for participation and even control of hospital management. In 1938 10.3 million people, generally wage earners or on modest salaries, were members of hospital contributory schemes, securing for themselves and dependents coverage for hospital treatment not addressed under the 1911 National Insurance Act. Their representatives constituted an additional element within hospital authorities, which usually recognized a degree of worker or contributory scheme participation, more pro-active than the images normally associated with philanthropy, self-help and voluntary effort.[14] Similarly with presentations of professional medical practice and politics of public health since 1919 (eds.), The Hospital in History (1989).

Ironically, their opportunities for effective representation possibly diminished rather than increased under the early NHS. The new service, wrestling with a great backlog of deprivation and neglect, was popularly acclaimed. Yet given its technocratic, professionally dominated organisational structures and operative focus upon the hospitals, where these features were strongest and more rigid, the early NHS was a service for sick people, rather than the people’s health service. Matters of community career control were to be neglected both in the NHS and by historians for many years after 1948.

**References**