Central and local government and the provision of municipal medicine, 1919-39

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Central and Local Government and the Provision of Municipal Medicine, 1919-1939

In this article we explore the extent to which local authorities in England and Wales, during a period described as the 'zenith of responsible local government'[1], were able to assert and carry through their own agendas. In doing this we examine, by way of the expanding role and provenance of municipal health services, the tension between responsibilities and autonomy. Of necessity, we thus also engage with the nature of the 'centre' and in so doing are informed by, and contribute to, broader discussions of the nature of central-local relations. We highlight the importance of disaggregating 'central government', as well as the nature of individual ministries at different stages in their history – in this case the Ministry of Health (MoH) and its regional off-shoot, the Welsh Board of Health. We further show that 'autonomy' or 'influence' must be seen as complex, shifting, and often contradictory, with local authorities simultaneously both resisting and exploiting Whitehall influence as the occasion demanded as well as being themselves internally divided over policy formation and implementation.

The article so contributes to both the history of local government and to the pre-history of the National Health Service (NHS). As we have variously argued, historical writing on health care provision has tended to highlight the NHS and the medical services of the Poor Law, but to neglect the municipal services of the inter-war period, their scale and scope notwithstanding.[2] At a time, such as the present, when the so-called 'command and control' model of the health service governance is subject to widespread criticism, a fuller understanding of what public sector services preceded the NHS has contemporary as well as historical significance. This piece is

part of a wider project, funded by the Wellcome Trust, which analyses in both quantitative and qualitative terms the great geographical and temporal variations in the municipal health sector in the 1920s and 1930s. The aim is to provide a more nuanced understanding of municipal medicine than is currently available, using both statistical data and local and national archival material.[3] The project has involved two distinct, but inter-related, stages. Quantitative analysis has identified four English and Welsh County Boroughs – Barnsley, West Hartlepool, Eastbourne and Newport (Monmouthshire) – as representing a spectrum of rich-poor, low Labour representation-high Labour representation areas. The intention here has been to select case studies which could be taken as representative of a whole range of county borough types.[4]

In this article we focus on the relationship between the County Boroughs and the Ministry of Health. The former were the top tier of the local authority hierarchy and had significant heath service powers and duties. It is notable that local government experts of the 1940s such as William Robson and J.H. Warren singled County Boroughs out for praise. The former found them the 'most enterprising type of council'[5] while the latter similarly described them as 'the most highly developed type of English Local Government administration'.[6] In the wake of the First World War, and particularly with the passing of the 1929 Local Government Act, County Borough health powers and duties significantly expanded.[7] The 1929 Act allowed, for instance, for municipal authorities to 'appropriate' Poor Law institutions and in places like London was used in an attempt to build up a comprehensive hospital and health care system free of any Poor Law association.[8] As we shall see, it also had other implications for the governance of municipal health services.

Choosing case studies based on statistical analysis, rather than the more usual method of locating a rich body of local archival material, has its pitfalls as well as its advantages. Two of the areas – Eastbourne and Barnsley – have not yielded the same quantity of correspondence with the centre, nor the same depth of issues, as West Hartlepool and Newport. This may, naturally, be the result of relevant files having been destroyed, or simply lost. Equally, however, the very distinct possibility that such correspondence never existed in the first, suggests that our methodology has revealed something that a less systematic approach might have ignored: namely that the lack of tension between the centre and certain localities was as an important feature of central-local relations as conflict.

Discussing the nature of the relationship between local bodies and central government, Lowe and Rollings suggest that historians, unlike political scientists, have tended to accept the 'Westminster narrative'. This, they claim, has an implicit assumption about 'the unproblematic nature of the policy process', with a 'neutral' bureaucracy implementing, the wishes of a unitary state characterised by parliamentary sovereignty and strong Cabinet government. In fact, they argue, the first decades of the twentieth century saw the 'the brittleness of the accommodation between government and governance…fully exposed…through the evolving relationship between central and local government'.[9] Local authorities had traditionally enjoyed 'considerable scope for initiative, but this was rapidly eroded' for although local authorities had increased duties this was not matched with an increase in independent income. Between 1920 and 1938 the percentage of local authority income from central government grants rose from 30 per cent to 44 per

cent.[10] Increased revenue from central government meant, in principle at least, greater central control over how that money was spent – hence the tension we identified earlier, between greater responsibility and potentially declining autonomy.

The block grants system, created by the 1929 Act, exemplified this trend, and further reinforced the lack of flexibility inherent in the rating system of revenue generation.[11] Ashford places such developments in a longer term context of, in welfare terms at least, the centre subordinating localities, a process dating back at least to the Whig reforms of the first half of the nineteenth century.[12] A further twist in this complex historical narrative is highlighted by Davis, who points out that in the wake of the post-1918 'flurry of social measures' central government in fact became more cautious 'about imposing further duties upon local authorities in the 1930s', and that the trend, even before 1939, was heading towards national solutions for what were increasingly perceived as national problems.[13] Some accounts of the origins and development of the NHS stress this very point.

And while the inter-war era may have been the period where local authorities enjoyed the greatest powers, this does not mean that their position was seen by all contemporaries as unassailable, or indeed justifiable. Influential critics, such as the Fabian Society and the think-tank Political and Economic Planning, argued that local authority boundaries no longer reflected current conditions; that local government finance was built on shaky foundations; and that service provision varied widely from area to area. This in turn led to proposals encapsulated in the health field by Fox's notion of hierarchical regionalism.[14] As Dupree has recently suggested, health services were the 'prime example of the inefficiency of the existing system', and it

was these, and particularly the hospital services, 'which were seen to gain most from reorganisation along regional lines'.[15] Local government thus appeared to be threatened from a number of different, and superficially conflicting, directions. Yet, as we show, the reluctance of the Ministry of Health to assert itself, even with recalcitrant authorities, indicates a picture much more complex than might at first appear.[16] For Wales, the picture is further complicated by the Welsh Board of Health which simultaneously acted as an intermediary between the localities and Whitehall while of itself seeking, often successfully, to exert a degree of autonomy. Tensions between the centre and the localities were, moreover, attributable not only to financial constraints.

Before moving to the main body of the paper, however, it is important to ascertain more specifically what the Ministry was trying to police or implement. The period around the end of the First World War saw the introduction of measures aimed at improving specific aspects of the nation's health – notably the 1917 Venereal Diseases Act, the 1918 Maternity and Child Welfare Act, the 1921 Tuberculosis Act.[17] There were further additions to local authority services throughout the period, but in general terms the 1920s was the decade of the rapid expansion of clinics and dispensaries while the 1930s saw both expansion and consolidation. The 1929 Local Government Act was significant here, for in essence what it sought to do was improve the administration and delivery of services by taking health out of the remit of the Poor Law and coordinating it with both other council services and voluntary provision. The Act also replaced the system of percentage grants to the local authorities, which had matched local government expenditure on specified services,

with the block grant system. The latter was not tied to particular spending patterns, and was based, inter alia, on the degree of local need.

We now turn to an examination of the Ministry of Health. We explore how the optimism of its early days dissipated through the loss of key individuals and the impact of economic retrenchment, and how this reinforced the famously conservative tendencies of its antecedent body, the Local Government Board (LGB). Next we assess how this affected its self-image, its role in relation to the localities, and its national vision for health provision.[18] In so doing we consider the tactics and mechanisms used by the Ministry to forward its aims, as well as its policy objectives. We then move on to argue that, since local authorities were not in fact passive recipients of Ministry advice and government policy, it is important to consider agency at the local level.[19] Just as the impact of individuals at the national level was vital in shaping the Ministry, so too at local level were certain people instrumental in determining how those policies were received. In particular we examine the role of the local Medical Officer of Health (MOH), members of the Public Assistance Committee (PAC) and Public Health Committee (PHC), and the Town Clerk. In different ways, each had an important role to play in relations with the Ministry. In the final section we discuss, through two case studies, situations where Ministry influence was particularly successful.

The establishment of the Ministry of Health in 1919 was heralded by George Newman, Chief Medical Officer (CMO), as a major health advance. It was, he claimed, indicative of Parliament's decision that 'the national health is of supreme and vital importance' to both the individual and the nation as a whole.[20] The

Ministry's creation must, however, be placed in a wider context. Rhetorically at least, post-war reconstruction was to embrace not only health but also housing, education, and employment. Nor was this simply altruistic. The Coalition government was concerned to forestall industrial and political unrest and saw social reform as one way of doing so. Nonetheless, the formation of the Ministry of Health was more than a sop to revolutionaries and its genesis suggests that it was taken seriously by the Lloyd George government. Addison, the first Minister of Health, although a 'dull' figure, nevertheless 'commanded much respect for his energy and enthusiasm, for his long connection with welfare policies…and for his close political association with the Prime Minister'. He was a key figure in the post-war drive for the creation of a 'developmental state', as was Sir Robert Morant, the Ministry's first Permanent Secretary. Both Morant and Newman were seen as highly competent and dynamic administrators and among that 'most creative civil servants of the age'. [21] However the very way in which the Ministry was set up was later to cause problems in that the apparent equality of status enjoyed by the Permanent Secretary and the CMO became a considerable source of tension after Morant's death, something which did little for the department's effective functioning.

Initially, though, the Ministry got off to a vigorous start, backing up its strong vision to improve the nation's health with a commitment to spend, for example on the development and expansion of clinics and dispensaries. In material in the public domain, the Ministry continued throughout the inter-war period to assert a positive message, even during the years of retrenchment. For example, following the cuts of 1921, the Ministry optimistically described this as an opportunity to survey the whole field of health services, so that when the economic circumstances permitted fresh

progress to be made, policies would be based upon 'a mature and deliberate plan'. [22] To an extent, the Ministry had cause for its optimism over the inter-war period in that in some ways its approach appeared to be vindicated. Not only were central government and local authorities spending more on health and developing services, there was also as steady improvement in the nation's health.[23] Citing the improvement in housing, the better 'personal habits' of individuals and the expansion of personal services supporting the health of population which 'between them embrace the seven ages of man, from cradle to grave', the 1937 Annual Report noted that most of the 'the chief killing diseases take year by year a smaller toll of the population, especially of the young'. Consequently both adults and, especially, children now enjoyed 'a healthier and fuller life than at any time since the Industrial Revolution'[24]

But behind the almost relentless optimism propagated by the CMOs through the Annual Reports, the reality was much more problematic. As Welshman notes, contemporary voices raised doubts about the Ministry's efficacy. Sir Arthur Newsholme, the ex-chief MO of the LGB, observed in 1925 that the Ministry was 'seriously hampered by the inchoate condition of the local medical work under Insurance Committees and Poor Law Guardians'. And the local government expert Robson wrote disparagingly of the Ministry's 'insipid aspirations', remarking that on many questions it was 'discreetly and demurely silent'.[25] None of this was helped by the spending cuts of the early 1920s – the Geddes Axe – which not only impacted on services but also caused the numbers of civil servants employed in the Ministry to be cut by a third from 6,500 to just over 4,000.[26] This meant that not only was the scope to expand services drastically curtailed, but also that the Ministry's ability to enforce

existing policies was reduced. As one senior official put it, work had to be 'delegated to an increasing degree, more and more responsibility being thrown onto the junior staff'. He acknowledged that this was probably a common experience in all government departments but that, nonetheless, the impact had been most profound at the Ministry of Health.[27] In such circumstances, it is understandable that local authorities, if determined to pursue their own agenda, could hold out against the centre.

The result of the Baldwin–Fisher administrative reforms, and the position and influence of the chief finance officers in government departments in relation to retrenchment, have been widely debated. Lowe argues that they gave the Treasury the 'means to impose from within the control which it previously striven to impose from without'. Peden, on the other hand, uses evidence from the Ministries of Labour, Transport, and Health, and the Board of Trade to suggest that chief finance officers were 'not obstructive, although naturally they urged financial prudence, and warned colleagues when proposals were unlikely to receive Treasury sanction'.[28] Savage adds an important further dimension by suggesting officials at the Ministry of Health did not in fact need any such policing, as they saw the state rather than the poor as their constituency. Consequently they were inclined to see fiscal prudence rather than extravagant social reforms as their primary role.[29]

Indeed, the very structure and inheritance of the Ministry tended to work against innovation and expansion. Although named the 'Ministry of Health', one of its major legacies from the LGB was the responsibility of anything related to local government and its interaction with the central state. This not only meant that the Ministry

inherited a large part of the Board's heavy case load but also, as Stacey observes, that 'the system of local government acted as a filter on the vision of the Ministry's staff.'[30] For some observers, even at the point of creation the Ministry was an unhappy marriage of the old and the new and prompted largely by the impact of the Haldane Report.[31] The latter had promoted the idea of a new administrative functionalist school of civil servants who were to be characterised by 'long term thinking'. In some departments this had created 'exclusive cadres of officials (who) sought to rise above the day-to-day business of departmental work and plan for the future'. Morant himself 'had no patience with the view that inefficient local authorities ought to be left to wallow in their inefficiency in order to preserve some sacred principle of autonomy.'[32] For the newly created MoH he wanted to 'bring in new blood, give a "lift" to the whole corps, develop dynamic energy throughout it, and infect the secretariat too, and generally give enhanced prestige to the whole Ministry.'[33]

But as Stacey argues, Morant's unexpected death in 1920, coupled with Addison's political demise and the more general context of renewed administrative and fiscal conservatism, dealt a fatal blow to plans for a dynamic and forward looking Ministry of Health; rather, the ethos and inheritance of the LGB were to dominate. This was reinforced by Arthur Robinson, Morant's successor, who was a generalist of the old school and who remained in post until 1935. Furthermore, many of the talented individuals brought in by Morant either left the Ministry or were passed over for promotion. In short, as Webster asserts, from its early promise the MoH became, by the mid-1920s, a 'career backwater staffed by second-rate minds suitable to act only as instruments of regulation'.[34] The dominance of the LGB's way of working within

the Ministry was thus, by the mid 1920s, crucial in informing its relations with local government. Rather than the top-down, centrist approach promoted by Morant and his allies, the Board's approach had its roots in the practices of nineteenth century administration. The early twentieth century system of English government was noted by contemporaries for the absence of any legal hierarchy in the different levels of government, despite the constraints of statute and central government supervision of the localities.[35] As Davis observes, it is important to remember, 'the extent to which Victorian government depended on negotiation rather than decree to implement its wishes in the localities'.[36]

The main tools at the Ministry's disposal were the powers of veto over Local Acts and over local schemes requiring loans for capital expenditure; the publishing of model bylaws; and, after 1930, the ability to with-hold a percentage of an authority's block grant. However the Ministry tended to stress its position as adviser and arbiter, promoting a view of itself as a font of national expertise and thereby adopting an advisory and supervisory role in relation to local authorities. As Newman himself had noted, relationships with local authorities were 'built on the basis of assent and consent rather than on compulsion'.[37] This point was reinforced by Ministry official Sir Gwilym Gibbon in a way says much about the departmental mindset. Gibbon noted that the Ministry had 'no general powers to step in on a Local Authority and require it to do this, that, and the other at its will'. To do so would be 'rash' and would result in the central body being told 'to mind its own business – fortunately, for the last thing we can afford to weaken in this country is the spirit of local government'.[38]

The vision of the Ministry as a centre for knowledge and expertise was to some degree accepted at local level. The Town Clerk for Birmingham, for instance, wrote favourably of the expertise and national vision the Ministry was able to provide.[39] One way in which the latter tried to advance information sharing among local authorities was through the annual league tables of costing returns pioneered by Gibbon.[40] These covered Poor Law institutions, maternity homes, tuberculosis hospitals and other municipal services, and showed how much it cost to maintain the institution expressed in per patient per week terms.[41] The Ministry promoted these tables as an important means of allowing local authorities to gauge the financial value of the services provided to their citizens through comparison with other localities. While in general the Ministry believed they demonstrated that 'good value for money was received', the tables also 'brought into clearer light the advantages which could be secured by such measures as regular local scrutiny of costs, centralized contracting for supplies, and amalgamation of medical and nursing staffs sometimes separately employed in cognate services'.[42] In fact the tables reveal the wide disparities in the cost of services. So, for instance, in 1935 the national average cost per patient per week in a municipal maternity home was £4.18s.2d. In West Hartlepool's the cost was £4.5.4 ½ d while in Eastbourne it was £7.9.10d.[43]

It is clear that these tables did have some impact, at least in council debates. In Eastbourne, for example, the costs of the municipal maternity home in relation to other homes listed in the costing returns were avidly compared and justified: 'The cost of the external midwife is included in our return, and not in most of the others. Fees are paid in practically every case, reducing this cost by about 42%.'[44] However, the fact that there continued to be wide variations in costs throughout the period

suggests that the tables had less impact than Gibbon either anticipated or acknowledged. It would appear that in this context, the MoH saw its role simply as a facilitator of information sharing, rather than as actively pushing greater equality between the localities. As Gibbon's junior, Ross, observed, 'I was not myself convinced at the time that the results were worthy of the labour involved…Good results can be obtained only if there is close supervision from the centre'.[45]

The Ministry also tried to use its influence to push greater co-operation between individual councils and voluntary hospitals, not least by way of commentary in its Annual Reports. Although Stewart identifies the strong hostility of Labour in London towards voluntary hospitals,[46] the picture elsewhere reveals a much more complex mixture of attitudes which could embrace both ideology and pragmatism. In Barnsley, for example, the Labour council remained keen to work with the local voluntary hospital, perhaps unsurprisingly given that it was primarily funded by local miners throughout the inter-war period and was seen as forming part of the long tradition of miners' self-help schemes.[47] The complexity of the local authorities' attitudes towards voluntary organisations was compounded by the wariness voluntary hospitals felt towards the state sector, with many fearing that their individual characters would become subsumed by an impersonal municipal bureaucracy. In this context, it was the Ministry's task to bring these sides together and it stressed the importance of 'the mental attitude to be adopted by the local authorities and the voluntary hospitals towards this question of consultation'. The MoH thus noted with disapproval that in some areas 'consultation was regarded as a somewhat unpleasant statutory duty which could be performed once and for all by a formal meeting without any practical measures for consideration'.[48] Similarly, the Ministry saw part of its

duties as encouraging local authority cooperation with other voluntary agencies operating in the health field. As one Annual Report pointed out, local authorities did not as yet realise 'how many and varied are the services which they might well accept from voluntary agencies in the matter of organisation, in detail of administration and in general support'. There should be 'mutual aid and cooperation' between statutory and voluntary bodies. Any criticism 'should be accompanied by practicable suggestions for remedying the defects and should be offered with sympathetic appreciation of the difficulties involved'. It was only by such an approach that 'supervision' could be effective and a 'friendly cooperation' established.[49] There is a strong sense here of both the desirability of a mixed economy of welfare and, within that, of the leading role to be played by public bodies.

Although Ministry officials, and particularly those with an LGB background, tended to emphasise the positive aspects of their advisory relationship with local government, the fact remained that the Ministry had very little real power. The majority of health legislation during this period was permissive rather than compulsory. As a result much actual policy decision making, as well as implementation, was left to local discretion. In many circumstances, the Ministry's only options were persuasion and guidance. Consequently there was a palpable sense of frustration among at least some civil servants at the degree to which petty squabbles and local particularism could inhibit health development. Officials complained, for instance, of the 'antagonism arising either as a result of vested interests or mistaken sense of so called civic pride' which often came in the way of central attempts to encourage the pooling of resources and the creation of joint schemes.[50] Even Gibbon, that public exponent of local authority independence, in private was much more ambivalent. 'Theoretically' he

supported local authority 'liberty and independence', but in practice 'when he dealt with particular cases he was something of a bureaucrat' on those rare occasions, such as the sanctioning of loans, where he had full authority.[51]

Equally, it is apparent that some localities, at least, felt that the Ministry was far too willing, despite its protestations to the contrary, to interfere in the minutiae of daily service provision. Reports, and ensuing correspondence, by MoH inspectors could become caught up in almost absurd levels of detail. The Ministry engaged in lengthy correspondence with Newport over whether or not it was appropriate for the MOH to also act as police surgeon, and with West Hartlepool on the question of the positioning of the door of its Venereal Diseases clinic.[52] Clearly, both sides had cause to feel frustrated and to be involved in an apparently endless round of arguments, negotiations, and all too often inaction. There was also no guarantee that attempted interference from the centre would even be consistent. In Newport, a proposal to turn over part of the workhouse to accommodation for families of ex-servicemen received conflicting responses from the officials in Whitehall and at the Welsh Board of Health in Cardiff. While the resolution of Newport Housing Committee was approved in Wales, this decision was over-ridden by the Ministry. The latter sent a telegram to the Town Clerk stating baldly that 'Ministry informed by General Inspector that scheme for conversion of workhouse is impracticable.' The leader column of the local newspaper was quick to point out the inconsistencies: 'Is the Ministry of Health a house divided against itself? Does one department veto what another department approves?'.[53] We shall encounter further instances of differences between London and Cardiff below. It was the high degree of attempted interference into the running of services that led one Town Clerk to assert there was 'a danger of the central

machinery being clogged'. Local authorities should be entrusted with 'with greater executive powers without central control in matters of local government'. Such a course would be to the benefit of both central and local government.[54] The contradiction between Gibbon's vision, at least as publicly stated, and the reality perfectly exemplifies the ambiguous position of the centre in relation to the localities during the period. The MoH, while apparently pro-local independence, was trying to push a national agenda. Paradoxically, though, through its lack of coercive powers it was forced to focus on the petty details of local administration. We next consider how this tension played out in its working relationships with local authorities.

It was one thing for the Ministry to use Annual Reports and circulars to point the general directions in which they expected local authorities to act, but quite another to actually initiate action in an unwilling authority and here the survey reports of the 1930s are extremely rich source.[55] They reveal the varying tactics employed by the Ministry in its attempts to improve local health care provision without upsetting local sensibilities. The surveys show that the central authority, while often internally critical of local services, did try to take a 'hands off' approach wherever possible. Newport's survey revealed that the borough was making progress in service provision. Although civil servants felt that there might be a need to make further enquiries, Dr Bruce Low, an Inspector with the Welsh Board, argued that these should be 'cut down to the minimum and Newport left to work out their own salvation'. The council's own documents, he continued, showed that it was 'taking their health services seriously'. Matters would further improve, Low suggested, 'as a result of the survey and the appointment of a new MOH'. Dr Low felt vindicated in his approach when a further communication from Newport appeared to indicate that the council

had ‘dealt faithfully with the points raised in the survey letter’. He thus concluded that ‘Newport town council wish to improve their health services without any pressure from the department’. [56] In this instance the Ministry’s approach of reasoned guidance and low key monitoring was apparently effective. Yet, closer examination shows that this worked with councils who were broadly amenable to suggestions for improvement, and or for improvements which were uncontroversial, it failed completely to deal with intransigent authorities or in any advocacy of unpopular schemes.

Again to begin with an example from Newport, we find that the council’s willingness to act on suggestions such as increasing the number of visits by health visitors to children under five notwithstanding, when it came to the larger issues of appropriation and greater cooperation with the voluntary hospital - the Royal Gwent – and with Monmouthshire County Council, a different story emerges. It was from this point on that the Welsh Board ran into difficulties with this particular County Borough. What followed was a low level bureaucratic battle which demonstrated both the ultimate weakness of the Board’s position and the key role of a few determined individuals in shaping council policy. In April 1934 the Welsh Board convened a meeting with council representatives. The Board sought to press the points noted above and, further, to urge closer cooperation with the Welsh National Memorial Association, a voluntary body set up in the Edwardian era to campaign on Welsh health issues and which was, from the early 1920s, responsible for the Principality’s tuberculosis services; and between the Health Committee and the School Medical Officer. However it soon became apparent that council representatives’ ‘interest in these other matters appeared to be rather overshadowed by their interest in ...appropriation’. At

the meeting the Town Clerk insisted on knowing the advantages of appropriation, 'apart from the sentimental ones of dissociating the treatment of sick from the stigma of the Poor Law'. There then followed a 'long discussion in which very considerable objection was raised' to appropriation, mainly due to the 'influence of some of the stronger members of the PAC'. [57]

Following this meeting the council decided to reject appropriation on the grounds that it 'would not give any additional benefits…and would only result in additional expenditure in administration and be, in fact, a change in name only'.[58] And, despite promptings from the Board, the council continued to refuse to consider appropriation, 'as they were hoping to obtain definite examples where appropriation had been effected without additional expenditure'. This had been promised by the Board at the meeting in April and asked for in two subsequent letters.[59] The Board was obviously needled by this recurring challenge to their position, and sent back a rather testy letter stating that 'the Department do not understand why the enquiry is repeated'. This further observed that five years after the passing of the 1929 Act the council should 'be in a position to indicate the general policy of institutional provision they have in mind'.[60] It should also be noted that the claim, often made by local authorities, that appropriation would bring increased expenditure was to a large extent erroneous as the process for the most part involved shifting resources from one account to another.[61]

Yet the council continued to stonewall and the question of appropriation was dropped by the Board, which seemed to accept that it was fighting a losing battle and therefore needed to shift its ground. Consequently, it then pressed for improvements in the

relations between the voluntary hospital and the council, and between Newport and Monmouthshire over the development of a joint laboratory. However, here too it was stymied, although in fact this was not solely the fault of the local authority. The Royal Gwent appears to have been as unenthusiastic about the prospect of coordination as the council. In July 1935 a Board of Health official observed that 'I'm afraid we can do nothing but wait another month or so', and this month stretched to five as they waited for the council to reach a decision. However, when an answer came it was simply that the MOH has been asked to 'report generally upon the question of the establishment of a (joint) laboratory (with Monmouthshire County Council)'.[62] By the beginning of 1937 the Welsh Board was resigned to the position: 'Perhaps in all circumstances it would be as well not to continue this rather protracted and indefinite correspondence, and to note this area as one for re-survey'.[63] In fact Newport was not re-surveyed, and although some moves were made to improve the Poor Law hospital, it was never appropriated and cooperation with the Royal Gwent remained limited.

If Newport had seemed dilatory to the Board, then its response to the survey was overwhelmingly enthusiastic compared to that of West Hartlepool, which refused to show interest even in the most minor recommendations. The Borough Council conducted a generally successful war of attrition with the MoH throughout the 1930s, despite being subject to two surveys. Although appropriation once again was a main bone of contention, there was also the wider issue of the council's almost total lack of investment in its health services. As with Newport, it is worth noting that despite the council's unwillingness to act on Ministry suggestions the MoH did not retaliate with a threat to reduce the council's block grant. West Hartlepool's basic position was

that, owing to the depression and thus 'having regard to the urgent need for economy in local administration, which has arisen since the submission of the Inspector's report, the present time (1932) is not opportune for putting into effect the Health Committee's recommendations.'[64] The internal response of the MoH was that '(we) can hardly accept this – but I am not sure how far the Department will wish to press the local authority'.[65] Here was the Ministry's fundamental problem. While it did not believe it could 'let the matter rest', it was equally unclear as to how to move forward. This was despite its belief that West Hartlepool's 'health services were starved in the days when the town was prosperous'. In a passage which again highlights the significance of the composition of the council, this memorandum continued that 'judging from one's general knowledge of the Council, I imagine that the Council passed their resolution to defer consideration of any improvements without any regrets'.[66]

Following communication wherein it became clear that 'the Council still refuse to do anything of any amount', the Ministry decided that '(there is no) use pursuing these matters further at present', except to write once again indicating that they were 'dissatisfied' and that they proposed to hold another survey 'fairly soon'.[67] The borough was re-surveyed in 1935, and despite the lack of progress made since the last survey, and the continually obstructive attitude of the council, the resurvey did not suggest any punitive measures. The relevant passages are worth quoting at length as they illustrate precisely what the Ministry was up against, and the constraints upon it:

> (There) is an almost complete lack of coordination of medical services owing to the Council's dilatory methods, and so far as West Hartlepool is concerned the Local Government Act, 1929, might never have been

> passed…(The) dilatory and feeble response of the Borough Council in the past would seem at first sight, to call for a letter of severe censure with an emphatic demand for them to amend their ways. But a letter of this sort would in all probability fail in its object… If the letter on the re-survey is very censorious, it might be discouraging to the members of the Health Committee and result in some of the less progressive councillors siding with the reactionaries. It is important to encourage the PHC to adopt a coordinated hospital scheme… I would therefore recommend that the letter should begin with some acknowledgement of the few advances which the Council have made.[68]

Here, as in Newport, the MoH appears to have been unable, and unwilling, to force the council to act when it did not wish to do so. Despite the fact that the Ministry was able to withhold a proportion of a block grant if it did not feel that a local authority's health services were efficient, this option is not even considered. Indeed even the much weaker option of a letter of censure is rejected, in favour of a more positive communication. This suggests that the Ministry felt that positive encouragement was the more effective tool, and that with-holding grant money was ultimately counter-productive; or that it favoured a quiet relationship with local authorities, even reactionary ones, over implementing policy objectives, a position reinforced by its own culture and ethos; or even that by the mid-1930s bitter experience and the accumulated impact of living with retrenchment had brought home to officials just how difficult any progress could be in the face of an obstinate local body.

Both the foregoing examples point to the importance of the internal dynamics of local authorities when considering their relationship with the MoH. The questions of appropriation and cooperation were obviously much more politically sensitive than the kind of small scale improvements asked for in the surveys. The former not only raised issues which recalcitrant councils construed as involving large scale expenditure on their part but also, in seeking to improve health services on a broad front, challenged entrenched sectional and parochial interests. It is worth examining this point in more detail, to show how individual or group interventions could have more immediate impact than anything suggested by the Ministry.

The political make-up of a council naturally had an impact on policy, although it should not be assumed that there was a simple correlation between, for instance, the presence of a significant Labour Party representation and 'progressive' policies such as appropriation. Rather, local and sectional politics clearly played a major role. In West Hartlepool this was manifested in the dominance of the 'business party' and so, thereby, the local political scene being the preserve of believers in 'financial orthodoxy'. Hence it was not need, but what 'economy and efficiency would allow', that shaped local policy making.[69] This approach was, moreover, strongly endorsed by the local Member of Parliament, Howard Griffen, a Conservative with a strong dislike of spending ratepayers' money. Writing to the Ministry on its survey's recommendations, Griffen found it 'really amazing that, when economy is so vehemently preached, your Ministry should send out instructions of this sort'. This sort of behaviour was, he continued, 'the old tale of officials making work for themselves. Our town is very badly hit and in financial straits, and so cannot afford the luxury of humouring officialism'.[70]

The 1935 re-survey showed a greater awareness of the importance of internal council politics in the provision of health services. This suggests that the MoH was becoming sensitive, or possibly resigned, to the fact that it was not simply enough to send a council a list of recommendation. Rather, if it wanted change then it had to work through certain interest groups and individuals, or simply wait until internal changes shifted the dynamics of the council itself. It was thus noted of West Hartlepool that there could be 'little doubt that the Council has been dominated by a few small minded but influential members' whose sole aim was to keep rates down at all costs, 'regardless of the efficiency of the health services'. On the other hand, the 'baleful influence of these members appears to be on the wane, and the Council appears to be rather less reactionary. The members of the Health Committee, according to the Medical Officer of Health, have much greater influence than formerly'.[71]

This comment reveals a further aspect of the complexity of the situation with which the Ministry had to deal – the relative position of committees, individuals on those committees, and officials. Jones remarks on the importance of local authority committee chairmen. Such individuals could run their committees as their own 'petty empires', a tendency emphasised by the fact that once elected to the post, they tended to hold it until retirement.[72] Again, the West Hartlepool re-survey showed a greater sensitivity to this issue than previously. The surveyor, Dr Donaldson, took the trouble to interview and actively solicit the support of 'a very influential member of the Health Committee, Capt. Farmer, who is also Chair of the House Committee of the Hartlepools (voluntary) Hospital'. He also had an interview with the Chairman of the Public Health Committee, a Mr Bloom, at which Donaldson stressed the importance

of cooperation with voluntary hospitals; the understaffing at Howbeck (the Poor Law Institution); and the need for its appropriation. Bloom 'promised to do all in his power to see that the recommendations of the Ministry should be complied with'.[73]

Here, then, we have the issue of the importance of personality and of individuals in the policy process, a point which was acknowledged in the journal for public administrators at the time:

> There are some matters on which there is a conspiracy of silence. Everybody knows they are of supreme importance, but they are not mentioned except in conversations of unusual intimacy over bottles. One of these is personality, and the part played by it…(We) know that there are councillors who govern the public life of their own town for a generation and town clerks who can speak with confidence for their councils because as a matter of fact what they advise is done. And no doubt the same kind of thing happens in the civil service.[74]

In both West Hartlepool and Newport, despite the prevailing anti-appropriation climate, individual councillors could and did speak up in its favour. During one Newport council debate on the issue Councillor Mrs Hayward argued that no one, however poor, wanted to think that 'your baby must be born in the workhouse'. While this was 'no reflection on the hospital or the treatment… it was time it was called a Municipal Hospital'. Councillor Ryan also spoke in favour of appropriation noting, correctly, that this could take place 'without expense'[75]

However, such councillors were often lone voices, or out of tune with the dominant influences on the Committee.[76] As an internal MoH minute observed for West

Hartlepool, there were still further barriers to progress, as the sixty eight year old Master of Howbeck Institution was anti-appropriation: 'So long as he continues at Howbeck I am afraid he will be a formidable obstacle and his opinion will carry much weight with the local councillors.'[77] He was not alone – Institution Masters and ex-Guardians, who often formed the bulk of the new PACs, were frequently anxious to guard what little remaining influence they possessed. In Newport, for instance, Dr Low from the Welsh Board noted in 1934 that 'it is obvious that the PAC are strongly entrenched and do not wish to hand over any of their authority to the Health Committee. This is an undesirable situation and contrary to the spirit of the Local Government Act, 1929'.[78] It is significant that Barnsley, which did appropriate its hospital, had ensured that when it formed its Public Assistance Committee it contained none of the old Guardians.[79]

It was not, of course, simply the council's elected members who influenced the direction of policy - local authority growth was 'accompanied by the expansion and consolidation of an elite of municipal officials, many with the status and power of their political masters'.[80] The position of Town Clerk offered much potential for the energetic and ambitious official. As Jones observes, this official could 'become the leader of the Council, directing and energising all its activities, or he can be its servant in the background, confined strictly to his legal duties'.[81] The Newport Town Clerk clearly leaned towards the former position. He actively spoke up at meetings for his own anti-appropriation agenda, and it was he who continued the correspondence with the Welsh Board, in a direct and personalised manner. His method was to reply to any enquiry of the Board about appropriation with a letter insisting they furnish him with examples of where appropriation had occurred without additional cost. Only

then would the council reconsider the position of their Poor Law institution.[82] His key role was acknowledged by the civil servants in Cardiff: 'it seems clear that the TC hopes that nothing will be done. The clerk himself does not appear to be helpful.'[83]

We should also acknowledge another key player, the Medical Officer of Health. MOsH were often keen to cooperate with the Ministry not only so as to improve public health, but in order to enhance their own status and to extend the remit of the health department as widely as possible. Newport's Dr Catto, for example, invested considerable energy in promoting appropriation and the coordination of the health services generally. He wrote a lengthy and considered report on total hospital provision in the borough, concluding unreservedly that appropriation was the way forward.[84] He kept separately, and 'unofficially of course', in touch with the Board of Health, updating them on the possibilities for progress.[85] He also used his Annual Report to publicly outline his position. In 1936, for instance, he declared that the coordination of medical services was improving as all were now under his supervision. Furthermore, such coordination would be finally completed when 'the appropriation of the Public Assistance Hospital is approved'.[86] As a Roman Catholic, he was also key to ensuring that the campaign to extend birth control, popular among sections of the Labour party at the time, made no headway in Newport.[87]

Dr McKeggie, the MOH for West Hartlepool, was similarly energetic and did everything he could to push for reforms. At the time of the first survey he had only been in the job ten months when perhaps little could be expected of him. But at the time of the re-survey he did all he could to cooperate with the Ministry, for example through supplying a confidential list of the improvements he felt were necessary and

the background to the internal politics of his Health Department and the council. He was described by the surveyors as an energetic officer with, nonetheless and as might be predicted from what we have already seen of this particular local authority, an 'uphill fight to get improvements'. It was thus unsurprising that in the period between the first and second surveys 'he had not made much headway'. Furthermore, and in a comment which also shows the frustration of Ministry officials with some local councillors, it was also noted that although McKeggie's 'energy has abated to some extent, he has kept to his programme of reforms, and seems to have had sufficient determination to wear down the ('stupid and' crossed out) obstinate resistance of a powerful section of the Council, and has succeeded in getting some of the reforms which he set out to obtain when he was first appointed'. These reforms included an increase in number of sanitary inspectors and office staff, better premises for the school clinic, some improvements in the venereal diseases clinic, and better office accommodation. And while he had 'not succeeded, as yet, in persuading the Council to adopt a reasonable hospital policy, he seems to be getting them in a better frame of mind'.[88]

Our analysis of the Ministry's effectiveness in pushing for major reforms in health service administration in two of our case study areas raises the broader question of what it actually achieved. As one internal document noted, it had generally been the case that 'local authorities are slow to act upon the recommendations made to them, due very possibly to the lack of financial resources, but the general result of the surveys has been increased activity in Public Health matters'.[89] However it was often the case that the 'activity' referred to here took the relatively low-level form of changing the times of venereal disease clinics, increasing the number of Maternity

and Child Welfare clinic sessions, or perhaps increasing the number of X-rays taken to detect tuberculosis. While not wishing to undermine the importance for patients of these improvements, they were not of such importance to have required protracted correspondence and attention from Whitehall civil servants. This reinforces the point that there was an emphasis on such detail precisely because the Ministry was unable to adequately influence the bigger picture.

At a result, at the local level what emerges is not the overbearing influence or control of the Ministry of Health, but rather its essential weakness, camouflaged by its public commitment to local autonomy. Whitehall civil servants were too far removed from the daily reality of policy formation and implementation - periodic letters couched in polite bureaucratic language were of little use when not backed up by any actual action. Instead what is revealed is the importance of prominent local politicians and the role, positive or negative, of officials such as the Town Clerk and the MOH. Analysis of this kind is further reinforced by the evidence of some of the witnesses to the 1938 Welsh tuberculosis inquiry who expressed 'dissatisfaction with the MoH and with the Welsh Board of Health in that these bodies do not exercise their powers of supervision and control sufficiently strongly, firmly or quickly against the local authorities who are backward or neglectful'.[90]

The foregoing suggests that the Ministry, despite the assertions of the CMO, actually had very little impact on the actions of the localities, while immersing itself in the petty details of health service provision. Indeed this may have been something which solidified over time as officials made a show of seeking innovation and expansion while, in a climate of financial retrenchment, being content to see particular local

circumstances as obstructing or constraining positive change. There is, as we have shown, sufficient evidence to make this a tenable interpretation. However qualifications do have to be made. In this section we explore attempts by the Ministry to foster regional and national institutions, and to encourage councils to develop relationships either with other local authorities or with voluntary institutions. The broader context here, alluded to above, is the debates taking place, particularly in the 1930s, about the virtues or otherwise of 'regionalism'.[91] While the Ministry once again liked to appear to be taking a 'hands off approach', in the case of fostering inter-agency cooperation it was more willing to push its agenda of cooperation, claims of central impartiality notwithstanding. This approach was thus heavily veiled with bureaucratic formalism and, once again, an official commitment to local autonomy.

Such a case was the prolonged development of the Poole Joint Sanatorium, which was finally established in the late 1930s to serve the tuberculosis patients of six County Boroughs in the north-east. The north-east in the 1930s was noted as having a combination of high death rates from tuberculosis and a lack of institutional accommodation for sufferers. Lack of provision was partly due to the poor economic situation of the region, but also to the fact that the demand in any one County Borough was not sufficient to justify establishing an institution. As a remedy there evolved the idea of a regional joint sanatorium to which all contributing authorities could send patients. In June 1931 a conference was attended by representatives of the councils of Darlington, Gateshead, Middlesbrough, South Shields, Sunderland and West Hartlepool; and of the Ministry. The intention was to discuss provision of a joint tuberculosis institution 'but difficulties were felt by certain of the Authorities on the question of joint provision and no definite action was taken'. The proposal was

revived in 1933 to try and make more progress, helped by fact that Middlesbrough Town Council had received gifts of a house and large estate for their own treatment of TB sufferers. The Ministry stated in its Annual Report that the case highlighted 'a matter of public health importance which can be solved only by the co-operation of several Authorities'. Although not wanting to minimise the difficulties of joint action, the Minister felt 'confident that he (could) rely on the good will and commonsense of local authorities to make the machinery of Local Government subservient to the end to be attained'.[92] The public face of this scheme, as presented by the Ministry, was one which, while there may have been some organisational difficulties, was essentially a project by and for the County Boroughs concerned.

But the image of a local authority driven scheme belied the delicate and complex negotiations conducted behind the scenes by the MoH. In fact, the scheme was not even originally a local authority proposal, but instead 'the result of persuasion by the MoH over a period of years.'[93] In December 1930, following an enquiry from South Shields, which was suffering from a shortage beds for tuberculosis patients, the Ministry had conducted a local survey. This found that the region as a whole needed a sanatorium of about two hundred beds. Civil servants, however, realised the constraints facing them and saw purportedly local initiative as one way round these. One astute official observed that 'I doubt…whether in this period of industrial depression which especially affects these local authorities the Ministry could urge the local authorities to establish a joint sanatorium although the need for this provision is sufficiently clear'. Nor was this the only anticipated problem, for 'the rivalry existing between these different local authorities' was 'a bar to effective cooperation'. On the other hand, it would be 'another matter' if the local authorities came up with the

proposal themselves. This would then give the Ministry the opportunity to encourage such a plan, which of course was what it wanted all along. So, it was suggested, 'we might invite the Medical Officers of Health to a purely informal conference' when the possibility of the authorities bringing forward a proposal for a joint sanatorium 'might be explored'.[94] Although employing the cautious approach typical of the civil service, the intention and desired outcomes are clearly evident here.

Consequently the Ministry set about convincing the local authorities that a joint sanatorium was a scheme which they should take on, with some support coming from the centre. The aim here was, as one civil servant put it, to get 'sufficient local authorities in the north-east area to express sympathy with the idea of a joint scheme' and whose combined needs would justify a financially viable sanatorium, although it was also recognised that prevailing economic conditions might impede immediate progress.[95] In a letter to South Shields, the Ministry thus outlined its position as follows: 'if the Town Council, after consultation with the other local authorities, are of the opinion that a conference to consider the question generally would be of advantage, then the Minister would willingly be represented at it'.[96] In private, however, officials were less disingenuous. While they did appear genuinely concerned to make an attempt to transfer the initiative to the localities, this equally did not mean that they were willing to give up ultimate directorship of the project. In a classic example of civil service circumspection, it was suggested that

> we must leave the numbers of admission (to the joint meeting) entirely to the LA, though you might take the opportunity of suggesting that small numbers are perhaps likely to be more conducive to practical business. Though the Ministry have, in fact, invited members to take part in this conference, it is not

> initiated as a conference summoned by the Minister, and I would prefer it to be regarded as a conference of local authorities to which the Ministry are sending representatives to assist them.[97]

Such convoluted thinking and writing demonstrates the delicate balancing act central officials felt obliged to perform in their quest to encourage local authorities to follow suggestions stemming from the Ministry. They give substance to Ross's claims, cited earlier, about the attitude of Sir Gwilym Gibbon. Equally, they also suggest that behind the public face of the Ministry, with its acceptance of local authority independence, there was a propensity for officials to see policy in national as much as in local terms. Another way of interpreting this tension is in the context of the relative strength of central and local government in the policy process. On the one hand the documents show that the Ministry was able to push specific policy proposals on councils, but on the other, the roundabout manner in which they had to go about the task again brings to the fore the ultimate weakness of their position.[98]

Yet at the same time the local authorities themselves seem, in certain circumstances, to have appreciated the role taken by the MoH, which was able to negotiate and use its status to push local authority cooperation. South Shields, in their reply to the Ministry over the possibility of an initial meeting, claimed that 'the probability of the local authorities concerned agreeing to attend such a conference <u>is much greater if the conference is called by the Ministry rather than by my council</u>'.[99] And this was not an isolated example. In West Hartlepool the suggestion of increased cooperation between council health services and local voluntary hospitals led Captain Farmer, whom we encountered earlier, to argue that if the recommendations came from West

Hartlepool Corporation then they 'would be resented, and would be rejected at once. But, if it came from the Ministry, he felt sure that it would be considered'.[100] Clearly then, the Ministry was valued at some level, giving weight and prestige to certain proposals and perhaps able to generate a degree of momentum denied to a single authority. In this sense it did succeed in performing one of the roles envisaged by its creators, although again it clearly falls short of what some of its more radical founders would have wished.

But it is important not assume that was always the case that the MoH, in pushing their concern for national or regional schemes, always had the 'right' answer, nor that local authorities were necessarily the backsliders or unreconstructed reactionaries. The case of tuberculosis service provision in Wales provides an example of a conflict of interest between different groups. The Ministry, through the agency of the Welsh Board, favoured a regional structure; the councils, on the other hand, were proponents of local provision. This case should not be seen as central innovators versus local backwoodsmen, but rather as demonstrating how there were different interpretations over the best means for taking forward health service organisation, with both sides presenting valid arguments to support their respective cases. In 1921 all Welsh County Boroughs and County Councils entered into an agreement with the Welsh National Memorial Association for provision of all care for persons suffering from tuberculosis.[101] This meant that, unlike in England where local authorities were directly responsible for dispensaries run by Tuberculosis Officers as well as in many cases sanatorium or hospital treatment, in Wales the Association provided the full spectrum of services apart from after-care. It had its own sanatoria, Tuberculosis Officers, hospitals, and research facilities, all integrated components of the

Principality-wide organisation. While it was technically a voluntary body, the local authorities were the major contributors to its funds and had majority representation on several of its key committees. At the end of the inter-war period the Report of the Enquiry into Tuberculosis in Wales (the Davies Report) praised the Association for the quality of its sanatoria while also remarking upon its failure to provide a full tuberculosis service and to fully co-ordinate with local authorities.[102] Yet this issue of the organisation of the clinical and preventive services, and the respective roles of the local authorities and the voluntary Association, was not new. While local authorities were largely blamed for the failure to keep their side of the bargain, it was they who had first highlighted the problems they faced in providing a coordinated tuberculosis service.[103]

In 1922 both Cardiff and Newport Borough Councils voted that the work of the Tuberculosis Officer and his staff, rather than being part of the Association, should come under the direct control of the Health Committee through the MOH.[104] Invited by the Coordination Committee of Newport County Borough to give details of the lack of coordination in the health services, the local MOH, Dr Howard Jones, prepared a detailed document enumerating the shortcomings of the local medical service. He complained that medical work in the borough was divided between his own department, the School Medical Service and the Welsh National Memorial Association. It was his belief, Jones continued, that in no other English or Welsh County Borough was there three separate organisations doing public health work. In Newport the outcome was that there was 'much overlapping of efforts in many directions, a large amount of unnecessary clerical work… ignorance on the part of one dept in reference to the work of others, and much unnecessary work in the visitation

of homes by different officials'. Jones believed that in order to create an effective department, he needed all health services centralised under his control, and quoted the CMO at length in order to justify his position. He was thus of the opinion that Newport's decision to hand over control to the Association - whose object was to deal with tuberculosis throughout Wales – was 'contrary to the principle upon which local government is based in this country'; had reduced sensitivity to local tuberculosis problems; had unnecessarily constrained medical staff; and, overall, had led to inefficient provision. Thus while the Welsh National Memorial Association was efficient in providing institutional treatment, 'better progress would take place if local authorities carried out the detailed work themselves apart from the provision of sanatoria and Training Colonies'.[105]

In short, here was a clear and systematic consideration of the failings of his authority's health service to properly coordinate the discharge of its duties. Jones saw existing tuberculosis care as one important component part of the wider problem of coordination, and gave similar consideration to the organisation of other services under his control. He was a local official who had a thoughtful approach to the administration of local services, and their coordination, and thus someone who would seem to have been pushing for the kind of coordination that the MoH purportedly sought to promote in the 1930s. Despite the carefully thought out nature of these proposals, however, the Welsh Board of Health put considerable effort into preventing the suggestions of Howard Jones being put into practice. As with Poole Sanatorium there was a concerted attempt to present the central authority as an impartial arbiter and dispenser of advice. But behind the scenes we can discern a very clear sense of a rather different agenda. In a meeting between the Welsh Board and

Newport and Cardiff councils the Board stated that they 'had an open mind and held no brief for the Association'. Despite this assertion, it was admitted that recently the emphasis had been on pressing local authorities to 'support the comprehensive scheme…(and) to carry out their own obligations as to notifications and urging them to cooperate wholeheartedly with the Association and the Tuberculosis Physicians'. The Board thought that the first line of attack should be to concentrate on the 'best means of surmounting difficulties rather than to find Authorities breaking away from the comprehensive scheme before making a real effort'.[106]

This statement only hints at the level of commitment the Board actually felt towards the national nature of the scheme run by the Association. An internal minute admitted that: 'We are hoping that some kind of compromise will ultimately be arrived at which will preserve the comprehensive character of the scheme, but at the same time give the Councils a rather more direct interest in the work, particularly as regards Health Visiting'. Failure to achieve this goal would almost certainly result in councils terminating existing agreements with the Association and appointing their own TB Officers. In turn, this would mean 'the beginning of a process of breaking up the scheme by which Wales is regarded as a unit for this purpose. We are anxious to avoid this…'.[107] The Board also consistently defended the importance of having Tuberculosis Officers employed nationally through the Association, rather than by individual local authority schemes. In this way, it asserted, they could be part of a specialist service with 'all the resources and experience' of the Association at their command, and poorer and sparsely populated areas had as much access to a comprehensive and specialist service as the towns.[108] Throughout the inter-war period the Association itself also set great store by the specialised professional status

of their Tuberculosis Officers, stating categorically that they would not like anything which would 'weaken the sense of corporate responsibility that at present exists among the medical staff of the Association in their national scheme'.[109]

The unswerving defence of the Association's role in the provision of tuberculosis put forward by the Welsh Board of Health must, however, be distinguished from the Ministry of Health. The latter adopted a rather more nuanced approach. So, for example, while it was against the idea that the councils should break entirely from the Association (in fact, this was not what councils such as Newport and Cardiff were arguing) the MoH also felt 'some sympathy with the desire of the Councils to have their own dispensaries and appoint their own Tuberculosis Officers'. It acknowledged the difficulties and inefficiencies of working under the present scheme, not least because of the 'large amount of overlapping' between council and Association officers. Indeed, this particular correspondence continued, 'it would seem to be impossible for the councils to have any adequate control over TB in their areas so long as the work of those officers is carried out independently of the MoH'.[110] The Ministry suggested, perhaps inevitably, a messy compromise. This was found 'very helpful' by the Welsh Board, which took it up with a few alterations.[111] Tuberculosis nurses at the dispensary could come under the control of the council, as could an amount of administrative work, both of which were to be paid for by the Association. The central issue of the status of the Tuberculosis Officer however, was not resolved, as they were to stay in the employ of the Association, much to the disgust of the Medical Officers for Newport and Cardiff.[112]

The question then remains, why did Newport and Cardiff acquiesce to this arrangement, given the fact that their principal demand had not been met? One reason can be found in the records of the final meeting. Once again the role of individuals in the policy process comes to the fore, as the Newport Town Clerk was key to the borough's ultimate decision. He had been at the forefront of the discussions with his attitude being that, 'if a service was not obtained for the money contributed, then it was a very important factor for consideration. They (the council) were only going to consider the question as it concerned them as a County Borough'. Fundamental to his position was value for money, and his belief that the council were contributing more to the scheme than they received from it. He gave no indication that he had any interest in the administrative structure of the Health Department, but simply that he wished to safeguard his council's finances. Both the Board and the Association had done some research into the relative contributions to and benefits from the scheme of Newport, which they presented at the meeting. Although the two sets of figures differed, both showed that the council was a net beneficiary of the scheme. And while the Town Clerk protested that these figures had not been checked by the Borough Treasurer, this data and the compromise whereby the Association would cover certain costs swung him behind remaining within the latter's scheme. As a result both Newport and Cardiff agreed to accept the terms offered and agreed to defer their decision on the Tuberculosis Officer for twelve months. This decision was in fact deferred indefinitely, and their position remained the same until 1939.[113]

The case once again points to the importance of unpicking the dynamics of internal council politics when analysing relationships with central departments. A lack of unity on the part of council officials and members could essentially result in a

continuation of the status quo. It also suggests that ultimately the influence of the Town Clerk was greater than that of the MOH, who wished to improve the administrative structure of his department, and not simply to save money. Here the inertia of the council worked against its own proposals, just as it could work against central attempts to instigate change. This example also suggests the that the decisions of the Welsh Board could be filtered and diluted by the MoH, raising the possibility of that an already weak ministry could be further weakened by the extra layer of local bureaucracy. Certainly the Welsh Board was criticised by contemporaries for its ineffectual nature. Clement Davies, following his Tuberculosis Inquiry, described it as a 'useless moribund organisation', and as a 'National Waste Paper Basket' where reports of medical officers and sanitary inspectors were discarded.[114]

This article has shown that there is no simple narrative of dependence/independence when considering the position of the Ministry of Health in relation to the local authorities during the inter-war period. Different stories emerge, with outcomes dependent on a variety of local and national contextual factors. If the Ministry was weak, it did not start out that way, containing as it did some of the best administrators of the day and a prominent role in the process of reconstruction. However historical chance, in the death of Morant and the removal of Addison, combined with the LGB's particular legacy, ensured that the Ministry's relationship with the local authorities was governed by caution and reinforced by a lack of real power. Therefore, despite the enthusiasm of the CMO, the Ministry was unable to coerce recalcitrant authorities into making what it deemed to be necessary improvements. While civil servants felt that they were acting in the best tradition of guiding and informing rather than coercing local authorities, individual officials expressed frustration and did their best

to direct policy from behind the scenes. For Ministry officials this lack of power could also result in an over-concentration on the minutiae of health service provision within an area, as they were unable to force movement on bigger issues such as appropriation or cooperation with voluntary hospitals.

It is important, though, not simply or automatically to attribute the Ministry's commitment to a 'hands-off' advisory relationship with local authorities to the weakness of their position: even when they were in principle able to enforce punitive measures, as in West Hartlepool, they shrank from doing so. Civil servants actively believed that persuasion, encouragement, and information sharing, and not heavy handed coercion, was the best means of getting things done. Perhaps it is fortunate for Ministry officials that their administrative ethos tallied so neatly with the level of power they were able to exert. Furthermore, over time the difficulties of working in an atmosphere of financial retrenchment almost certainly added to what we might now perceive as civil service caution. Adding to this complex picture, it is also clear that the Ministry did have standing in relation to the localities. As their role in the Poole Sanatorium case demonstrated, there were clearly times when the weight of central involvement could also add the necessary prestige to a scheme to ensure that it did not degenerate into inter-council bickering. Both this case, and that of tuberculosis care in Wales, demonstrate the Ministry's commitment to producing regional structures to counteract the limitations of local authority provision. But, as the stance of the MOH for Newport showed, this was only one vision of health service organisation current in the inter-war period. The balance between regional and local service provision was a dialogue which was to be interrupted by the Second World War, and pushed to one side by the arrival of the NHS.

In this article we have also stressed the importance of certain key roles within a local authority for mediating its relationship with the centre, and the progress or inhibition of a scheme. It is therefore vital to disaggregate the monolithic categories of both 'the council' and 'the centre'– we need a more sophisticated understanding and analysis of roles taken by council representatives and officials, as well as a deeper understanding of how the agency of councils was expressed in its relationship with the centre.

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Notes:

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[1]J.M. Mackintosh, *Trends of Opinion about Public Health* (London, 1953), p.131

[2] See A. Levene, M. Powell and J. Stewart, 'Patterns of Municipal Health Expenditure in Interwar England and Wales', *Bulletin of the History of Medicine,* lxxviii (3), (2004), 635-669; and idem, 'The Development of Municipal Hospital Care in English County Boroughs in the 1930s', *Medical History*, (forthcoming 2006).

[3] It would be wrong to suggest that interwar municipal medicine has been entirely neglected by historians. See, and their references, S. Cherry, *Medical services and the hospitals in Britain, 1860-1939* (Cambridge, 1996), A. Hardy, *Health and medicine in Britain since 1860* (Basingstoke, 2001), C. Webster, *The Health Services since the War, i: Problems of Health Care. The National Health Service before 1957* (London, 1988).

[4] The data utilised are the Local Government Financial Statistics - Annual Local Taxation Returns up to 1936 - which form an almost continuous series of financial information on local authority expenditure by service over the period. The Labour leanings of a borough were determined by the number of serving Labour councillors – the annual results of which were published in *The Times*, following the November elections. For a discussion of municipal expenditure, and a guide to sources, see Levene, Powell and Stewart, 'Patterns of Municipal Health Expenditure in Interwar England and Wales'.

[5] W. A. Robson, *The Development of Local Government* (London, 3rd ed., 1954), p. 269.

[6] J. H. Warren, *The English Local Government System* (London, 1946), pp. 45-6.

[7] All county boroughs were cities with large populations (the minimum threshold was 50,000 with a few exceptions based on ancient charters up to 1926, when it was raised to 75,000). Their characters varied from large metropolises like Liverpool and Birmingham (with populations in 1922 of 826,400 and 945,100 respectively), through industrial satellites such as Bootle and Oldham (populations 79,750 and 148,300), to county towns and seaside resorts like Canterbury and Eastbourne (at 23,680 and 53,700). The health services provided by County Borough in this period covered maternity and child welfare, tuberculosis, venereal diseases, mental deficiency, infectious disease hospitals, mental hospitals, general hospitals, vaccination, medical salaries, and miscellaneous health.

[8] On London, see J. Stewart, ''For a Healthy London'': The Socialist Medical Association and the London County Council in the 1930s', *Medical History,* xxxxii (1997), 417-436.

[9] R. Lowe and N. Rollings, 'Modernising Britain, 1957-64: A Classic Case of Centralisation and Fragmentation?' in R. A. W. Rhodes (ed.) *Transforming British Government, i: Changing Institutions* (London, 2000), p.99.

[10] M. Dupree, 'The Provision of Social Services' in M. Daunton (ed.), *The Cambridge Urban History of Britain, iii, 1840-1950* (Cambridge, 2000), p.388.

[11] Lowe and Rollings, 'Modernising Britain', p.103.

[12] D. Ashford, *The Emergence of the Welfare States*, (Oxford, 1986), pp.126, 117.

[13] J. Davis 'Central Government and the Towns' in Daunton (ed.) *The Cambridge Urban History of Britain* pp. 279-281.

[14] D. M. Fox, *Health Policies, Health Politics. The British and American experience, 1911-65*, (Princeton, New Jersey, 1986). Here we are referring specifically to the

third aspect of what he defines as hierarchical regionalism, which is that health policies, 'should stimulate the creation of hierarchies in regions that lack them and make existing ones operate more efficiently' (ix). See also C. Webster, 'Conflict and Consensus: Explaining the British Health Service', *Twentieth Century British History,* i, 2, (1990), at 142-7.

[15] Dupree, 'The Provision of Social Services', p.390.

[16] See for example T. Simey, *Principles of Social Administration* (London, 1937).

[17] Examples of studies of the specialised services include L. Bryder, *Below the Magic Mountain: A Short History of Tuberculosis in Twentieth-century Britain* (Oxford,1988); J. Pickstone, *Medicine and Industrial Society: A History of Hospital Development in Manchester and its Regions, 1752-1946* (Manchester, 1985); J. Lewis, *The Politics of Motherhood: Child and Maternal Welfare in England, 1900-1939* (London, 1980); L. Marks, *Metropolitan Maternity: Maternal and Infant Welfare Services in Early Twentieth Century London* (Amsterdam, 1996); J. Welshman, *Municipal Medicine: Public Health in Twentieth-century Britain* (Oxford, 2000); and G. Rivett, *The development of the London hospital system, 1832-1982* (London, 1986).

[18] Welshman, *Municipal Medicine,* p.252. Chapter Six provides a thorough analysis of the position of the MoH in relation Leicester County Borough Council. For these wider discussions see M. Beloff, 'The Whitehall Factor: The Role of the Higher Civil Service,1919-39', in G. Peele and C. Cook (eds), *The Politics of Reappraisal, 1918-39* (London, 1975), pp.209-32; R. Davidson and R. Lowe, 'Bureaucracy and Innovation in British Welfare Policy 1890-1945', in W. J. Mommsen (ed.), *The Emergence of the Welfare State in Britain and Germany, 1850-1950,* (London, 1981), pp.263-95

[19] For a discussion of the 'partner or agent' relationship between central and local government see R. Rhodes, *Beyond Westminster and Whitehall* (London, 1988).

[20] *Annual Report of the Chief Medical Officer*, P.P. 1921, xii, p.7.

[21] K. O. Morgan, *Consensus and Disunity: The Lloyd George Coalition Government, 1918-22* (Oxford, 1986), pp. 82, 84

[22] *Second Annual Report of the Ministry of Health, 1920-21*, P.P. 1921, xiii, p.1

[23] While most indicators of health – infant mortality rates, deaths from infectious diseases, life expectancy – showed an improvement over the period, maternal mortality was the major exception. This however, is not the place to enter into the debate over the standard of living and health in inter war Britain, on which see C. Webster, 'Healthy or Hungry Thirties?', *History Workshop Journal*, viii, (1982), 110-29, also his 'Health, Welfare and the Unemployed during the Depression', *Past and Present*, cix (1985), 204-230.

[24] *Eighteenth Annual Report of the Ministry of Health, 1936-1937*, P.P. 1936-7, x, p.viii.

[25] Quoted in Welshman, *Municipal Medicine*, p.253.

[26] J. E. Pater, *The Making of the National Health Service* (London, 1981), p.10.

[27] I.G. Gibbons, 'The Ministry of Health', *Public Administration*, iv (3) (1926), 243-266, at 259.

[28] G.C. Peden, *The Treasury and British Public Policy, 1906-1959* (Oxford, 2000), pp.186-7, and quoting Lowe.

[29] G. Savage, *The Social Construction of Expertise: The English Civil Service and its Influence, 1919-39* (Pittsburgh, 1996), chap. 6.

[30] S. R. Stacey, 'The Ministry of Health, 1919-29: Ideas and Practice in a Government Department', (unpublished D.Phil. thesis, University of Oxford, 1984), p.1.

[31] Gibbons, 'The Ministry of Health', p.243; the Haldane Report – *The Report of the Machinery of Government Committee* – can be found in P.P. 1918, xii.

[32] Stacey, 'The Ministry of Health', p.77

[33] The National Archives (hereafter TNA) MH78/89, 'Morant to Addison', 10 May 1919.

[34] Webster, 'Conflict and Consensus',142-7.

[35] See for example J. Redlich and F. W. Hirst, *Local Government in England* (London, 1903), who stressed the equality of central and local authorities before the law.

[36] J. Davis, 'Central Government and the Towns' in Daunton (ed.), *The Cambridge Urban History of Britain*, p.263.

[37] *Supplement to the Forty Eighth Report of the Local Government Board, containing the Report of the Medical Officer for 1918-19*, P.P. 1919, xxiv, p.vi.

[38] Gibbons, 'The Ministry of Health', p.254. He also prepared the evidence submitted by the Ministry of Health to the Royal Commission on Local Government, where he made similar assertions.

[39] F. Wiltshire, 'The Appellate Jurisdiction of Central Government Departments', *Journal of Public Administration*, ii (1924), 370-80.

[40] W. A. Ross 'Local Government Board and After: Retrospect', *Public Administration*, xxxiv (1956), 17-25, at 22.

[41] These tables can be found in TNA MH96/1114.

[42] *Eighth Annual Report of the Ministry of Health, 1926-27*, P.P. 1927, ix, pp.xvii-xviii. Poor Law costs had been collected since 1918-19, tuberculosis patients and maternity homes from 1923-4, and street cleaning from 1925-6.

[43] TNA MH96/1114.

[44] Of the 17 Homes containing 11-16 beds the Eastbourne Home was ranked seventh, the average cost of the homes was £4.18s per patient per week, whereas Upperton House was £5.4.2d. East Sussex Record Office, DE/A7/13, 'Minutes of the Maternity and Child Welfare Sub-Committee, 1918-37, 15 May 1933'. West Hartlepool was equally interested in the comparative costs of maternity homes throughout the period – see for example West Hartlepool Health Committee, 27 April 1936.

[45] Ross, 'Retrospect', p.22.

[46] Stewart, 'For a Healthy London'.

[47] Interview with Cllr Michael Stokes, Barnsley Metropolitan Borough Council, 11 Aug 2004.

[48] *Fifteenth Annual Report of the Ministry of Health, 1933-34,* P.P. 1933-34, xii, p.56.

[49] *Annual Report of the Chief Medical Officer,* (London, 1934), p.89.

[50] TNA MH96/1064, 'Anti-Tuberculosis Inquiry Report. Brief Prepared by the Welsh Board of Health for the Minister', 20 March1939. Although this was flagged up in relation to smaller sanitary authorities it is quite clear that the same problems also existed between larger authorities.

[51] Ross 'Retrospect', 24.

[52] TNA MH96/387 for Newport; and TNA MH66/991 and MH66/995 for West Hartlepool.

[53] The Housing Half Loaf", *South Wales Argus,* 13 Sept 1919

[54] Wiltshire, 'The Appellate Jurisdiction of Central Government Departments', p.370-80.

[55] These were conducted by MoH inspectors to determine the degree to which local authorities were carrying out their public health duties in the wake of the 1929 Local Government Act. They can be found in TNA MH66 series.

[56] TNA MH96/388, 'Minute, Dr Low, 9 Aug 1933; minute, 23 Nov 1933, following letter from Newport, 25 Sept 1933; note from Dr Low, 24 Nov 1933'.

[57]TNA MH96/388, 'Report of meeting between Newport council members attended by a Board official (Dr Low) on the coordination of Newport health services, 13 April 1934'.

[58] TNA MH96/388, 'Newport's Health Services: Coordination Proposal Discussed'; *South Wales Echo*, 10 July 1934.

[59] TNA MH96/388, 'Letter from Newport to Board of Health, 8 Nov 1934'.

[60] TNA MH96/388, 'Letter from Board of Health to Newport, 23 Jan 1935.

[61] See Levene, Powell, and Stewart, 'The Development of Municipal Hospital Care'.

[62]TNA MH96/388, 'Board minute, 9 July 1935'. Subsequent letters were sent on 27 Sept 1935, 9 October 1935 and 4 Dec 1935.The reply from Newport was on 5 Dec 1935.

[63] TNA MH96/388, 'Board minute, 27 Jan 1936'.

[64] TNA MH66/991, 'Letter from Town Clerk to MoH, 11 Feb 1932'.

[65] TNA MH66/991, 'Internal MoH minute, 15 Feb 1932'.

[66] TNA MH66/991, 'Minute by Ward, 25 Feb 1932'. The unwillingness of West Hartlepool council to spend on all public services, including health, as a result of the dominance of the 'business party' in the council is discussed in R. Wilson, 'Economy, Housing and Health in West Hartlepool, 1919-39,' (unpublished M.Phil. thesis, University of Teesside, 1998).

[67] TNA MH66/991, 'Internal minute 13 July 1932'; 'Minute by Ward, 9 Feb 1933'.

[68] TNA MH66/993, 'Resurvey of West Hartlepool Public Health Services, 1935, pp. 64, 69' – emphasis added.

[69] R. Wilson, 'Economy, Housing and Health in West Hartlepool', pp.75, 158.

[70] TNA MH66/991, 'Letter from Howard Griffen MP to Chamberlain, 9 Oct 1931'. The reference to 'economy' may simply have been a political point, or it might be an indication of tensions in policy between the Treasury and the Ministry of Health.

[71] TNA MH66/993, 'Resurvey of West Hartlepool Public Health Services, 1935, p.62'.

[72] G. W. Jones, *Borough Politics: A Study of Wolverhampton Town Council, 1888-1964* (London, 1969), p.225.

[73]TNA MH66/993, 'Resurvey of West Hartlepool Public Health Services, 1935, pp.20, 24'.

[74] E. H. Rhodes, 'Personality in Public Administration', *Public Administration*, viii (3) (1930), 250-2.

[75] Newport Woman Councillor's Plea Fails', *South Wales Argus*, 12 March1935.

[76] This was the case with Labour members in Eastbourne council, who although vocal, were in such a minority that their opinions rarely translated into policy.

[77]TNA MH66/ 993, 'MoH minute, 29 Nov 1935'.

[78]TNA MH96/388, 'Report of meeting between Newport council members attended by a Board official (Dr Low) on the coordination of Newport health services, 13 April 1934'.

[79] 'Barnsley under the New Poor Law', *Barnsley Chronicle*, 29 March1930.

[80] B Doyle, 'The Changing Functions of Urban Government: Councillors, Officials and Pressure Groups', in Daunton (ed.) *The Cambridge Urban History of Britain*, pp.287-313.

[81] Jones, *Borough Politics*, p.268

[82] TNA MH96/388, 'Letter from Newport to Board, 9 Jan 1935'.

[83] TNA MH96/388, 'Letter from Newport to Board of Health, 8 Nov 1934, handwritten note on bottom of letter by Board of Health official, 10 Nov 1934'. The point, of course, was that it was very difficult to prove that appropriation cost very little, as it was typically part of a package of improvements to an institution, which skewed any figures over 'before' and 'after' costs from these institutions.

[84] TNA MH96/387, 'The MOH Report to the Health (Hospital Accommodation) Sub-Committee on the question of, "Hospital Accommodation for the County Borough of Newport", 5 Jan 1935, Dr Catto'.

[85] TNA MH96/388, 'Minute following telephone conversation with MOH, 3 Feb1936'.

[86] TNA MH96/388, 'Extract from 1936 Annual Report of the MOH for Newport'.

[87] D. Tanner, *Newport Labour Party: A Brief Introduction to the Microfilm Edition of Newport Labour Party Records*, (Bangor, n.d.).

[88] TNA MH66/993, 'Resurvey of West Hartlepool Public Health Services, 1935, p.5'.

[89] TNA MH96/1064, 'Anti-Tuberculosis Inquiry Report. Brief Prepared by the Welsh Board of Health for the Minister, 20 March1939, p.28'.

[90] TNA MH96/1064 'Report of the Committee of Inquiry into the Anti-Tuberculosis Services in Wales and Monmouthshire, 1938-40'.

[91] This is an issue which deserves further consideration by historians. Existing important discussions can be found in Webster, 'Conflict and Consensus'; and Fox, *Health Policies, Health Politics*.

[92] *Fifteenth Annual Report of the Ministry of Health, 1933-34*, P.P. 1933-34, xii, p.73.

[93] TNA MH61/30, 'Minute from Ward, MoH to Commissioner for the Special Areas,

14 July1937'.

[94] TNA MH67/133, 'Wrigley to Ward, 13 Nov 1930'.

[95] TNA MH67/133, 'Ward to Wrigley, 14 Oct 1931'.

[96] TNA MH67/134**,** 'Treatment of Tuberculosis. Joint Provision by NE local authorities of additional sanatorium accommodation' – emphasis added.

[97] TNA MH67/133, 'Letter from Wrigley in MoH to Batterbury in Newcastle, 29 April 1931'.

[98] It should also be noted that the Ministry was under no illusions as to what joint working could sometimes entail in the way of quality and commitment on the part of local authorities and their representatives. See, for example, the damning remarks on the Lancashire Mental Health Board in TNA MH80/24, 'Memorandum on Quality of Joint Boards, 2 Sept. 1941'.

[99] TNA MH67/133, 'South Shields to MoH, 15 Dec 1930' – emphasis added.

[100] TNA MH66/993, 'Resurvey of West Hartlepool Public Health Services, 1935, p.23'.

[101] TNA MH96/1099, 'Circular 190 (Wales), MoH & Welsh Board of Health, 25 May 1921'. For a more general exploration of the role the Welsh National Memorial Association took in tuberculosis provision in Wales, see L. Bryder, 'The King Edward VII Welsh National Memorial Association and its Policy Towards Tuberculosis, 1910-48', *Welsh History Review*, xiii, 2 (1986), 194-215.

[102] Clement Davies, Chair of the Enquiry, quoted in Bryder, 'The King Edward VII Welsh National Memorial Association', 210-11.

[103] For a discussion of this see Bryder 'The King Edward VII Welsh National Memorial Association' pp.208-11.

[104] TNA MH96/1099, 'Letter from Newport to Board of Health, 19 June 1922'.

[105] TNA MH96/1099, 'Coordination of Public Health Services at Newport - Report by the MOH, Dr J. Howard Jones'.

[106] TNA MH96/1099, 'A Summary of the Proceedings of a Conference between the Representatives of the Cardiff City Council, the Newport Town Council and officers of the Welsh Board of Health, 4 Sept 1922, to discuss certain proposed changes in the administration of the out-patient work of TB in the Cardiff and Newport Areas'.

[107] TNA MH96/1099, 'Welsh Board of Health minute to MoH, 23 Sept1922'.

[108] TNA MH96/1064, 'Report of the Committee of Inquiry into the Anti-Tuberculosis Services in Wales and Monmouthshire, 1938-40'.

[109] TNA MH96/1099, 'Board of Health to MoH, 5 Oct 1922'.

[110] TNA MH96/1099, 'MoH to Board of Health, 3 Oct 1922'.

[111] TNA MH96/1099, 'Board of Health to MoH, 5 Oct 1922'.

[112] TNA MH96/1099, 'Summary of Adjourned Round Table Conference on Proposed Administrative Changes to the out-patient work of TB in the Cardiff and Newport Areas, 24 Oct 1922'.

[113] TNA MH96/1099, 'Summary of Adjourned Round Table Conference on Proposed Administrative Changes to the out-patient work of TB in the Cardiff and Newport Areas, 24 Oct 1922'.

[114] Quoted in Bryder, 'The King Edward VII Welsh National Memorial Association', 210.