

**The Forgotten 'Cradle to Grave' Welfare State: a re-assessment of municipal
medicine before the NHS**

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Introduction

The British NHS has been seen as the centre-piece of the welfare state, and central to the welfare reforms of the 1945 Attlee Government. Any other way of delivering health care is almost unthinkable. However, before 1948 local or municipal health care accounted for the majority of hospital provision, and was regarded by most commentators as the goal of progressive policy, with a national health service seen as not practical politics (eg Stewart 1999). Indeed, Aneurin Bevan- the founder of the NHS- overturned both Labour party policy and a broad bi-partisan consensus on municipal health care. This was part of a larger view about local government. As early as 1890 Sidney Webb indicated the importance of municipalism in everyday urban life (in Davis 2000: 261). Using a phrase generally linked with the post-1945 'Beveridge' welfare state, Mr Marshall, Labour MP and a former Lord Mayor of Sheffield stated that 'In one way or another, local government touches our lives at all stages from the cradle to the grave' (in Powell, 1995b: 361).

There has been recent increased political support for localism and decentralization (at least in rhetorical terms) (eg Filkin et al 2000; Stoker 2004; Milburn 2003, 2004; Reid 2003; see Peckham et al 2008; Powell et al 2009). Blair (2002) wondered whether Labour took the wrong road historically in downplaying a previous tradition of 'mutualism, localism and devolution'. It may be timely to re-assess the local government provision of health care in the 'high period', 'zenith', 'heyday' or 'golden age' of local government (Laski et al 1935; Loughlin et al 1985; Stevenson 1984: 309; Lee 1988; Pickstone

(1985: 6; White 2004; Mackintosh 1953: 131), and the Bevan-Morrison debate on the nationalization of hospitals (cf White 2004).

While contemporary writers pointed to many problems of municipal medicine (which are reflected in the historical literature) they also pointed to some advantages and policy trade-offs (which tend to be neglected in the historical literature). This paper critically examines historical accounts of municipal medicine, before pointing to a more nuanced contemporary debate.

Historical Perspectives

Many historians have tended to favour centralist over localist arguments, arguing that a local government system was either undesirable or impracticable. According to Dupree (2000: 390-1) local government was not well equipped for provision of health services, because both the local government areas and local government finance were inadequate. It was beyond the capacity of the existing local government structure to administer health and it might lead to the collapse of all government services, particularly education and housing in which local variation was more acceptable. Davis (2000: 282, 285) states that by 1939 the image presented by local government was unedifying, and appeared beyond reform. It was thus unsurprising that Sidney's Webb's heirs abandoned his faith in local government as the agents for the socialisation of Britain.

The most common argument is associated with inequality (eg Thane 1996: 180; Gladstone 1999: 26; Mohan 2002; Harris 2004: 214, 233,235; cf Hunt 1995; Walker 2002). Crowther (1988: 47) stated that 'the economic problems of the time encouraged central control, since local authorities in the depressed areas were in a constant state of financial crisis'. Doyle (2000: 313) notes that centralisation was usually seen as part of a

drive to provide uniform, efficient services, something the local state was felt to have signally failed to do in the interwar period.

There are three main problems with these arguments. First, with some exceptions (eg Powell 1992, 1997b; Mohan 2002, 2003), little detailed empirical evidence is produced for the level of inequalities before the NHS. It is even less clear whether these inequalities were changing over time. In the short term, there is some evidence that inequalities in municipal provision were reducing over time (Powell 1997a; Levene et al 2004) and that municipal provision was reducing or even reversing inequalities in voluntary provision (Powell 1992; Mohan 2003). In the longer term, the extent to which the NHS has eradicated the 'postcode lottery' remains unclear. Klein (1995: 225-6) concluded that 'more than 40 years after its birth, the NHS had yet to offer everyone with the same level of service'. As one NHS manager put it, it appeared 'that 191 different National Health Services existed in the country, rather than one single NHS operating in 191 districts' (in Jenkins 1996: 69). There is a tendency to contrast the actual inequalities of localism with the theoretical- rather than the actual- inequalities of national services. As Stoker (2004: 225) puts it, Walker's (2002) analysis of dangers of localism and his defense of equality of opportunity is mistaken because he ends up defending inadequate and failing methods of achieving that goal.

Second, it can be argued that criticizing a local government system because of unequal geographical provision is almost a vacuous tautology as local government is essentially a system of differentiation that allows local political preferences to flourish. This means that instead of viewing geographical inequality as a 'negative', local differentiation can be seen as a 'positive'. As Chester (1951: 342) puts it, uniformity is the hall-mark of a centralised bureaucracy not a system of local democracy. Rather than simply examining

crude inequalities (in terms of coefficients of variation) it is necessary to analyse more complex issues such as whether all authorities are above a 'national minimum' or whether the grant system allows fiscal equalisation. In other words, a low level of provision that results from political choice is good, while a low level of provision that results from constraint (such as low rateable resources) is bad. One means of assessing local discretion in the grant system is through the structure of grant (Page and Goldsmith 1987). We might expect that a general grant, unhypothecated to any particular service, is likely to offer greater discretion to local authorities than specific or categorical grants- ie with strings attached. This suggests that discretion increased after the 1929 Local Government Act, with the replacement of percentage grants by block grants (Chester 1951; Foster et al 1980; Gilbert 1970). Page and Goldsmith (1987) suggest that one crude indicator of discretion is the variation in spending (ie the coefficient of variation; eg Boaden 1971; Sharpe and Newton 1984). Coefficients of variation on spending generally decreased through the inter-war period (Levene et al 2004) suggesting a greater degree of discretion. As the units of analysis change, it is difficult to compare discretion before and after 1948, but one crude analysis suggests no order of magnitude difference (Powell 1992; cf Sharpe and Newton 1984 for the remaining local authority services). However, another test of discretion is to examine the link between political parties and policy outputs (Boyne 1993). As representative democracy allows the public to influence policies by electing different parties, then the regression coefficient of party - holding other influences such as need and resources constant- should become stronger with more discretion. The data is less clear on this point, but there does appear to be a stronger party effect after the 1929 Local Government Act (Levene et al 2004).

Third, there are other criteria of evaluation beyond inequality. Supporters of local government stress democracy and integration. In terms of representative democracy elected local government is superior to unelected quangos. The historical evolution of local government can be seen in multi-purpose authorities taking over the functions of single function ad hoc bodies, leading to the greater potential for integration.

In short, many of the criticisms of municipal medicine are (usually implicitly) based on centralist rather than localist criteria: the 'Marshall' rather than the 'Robson' welfare state (see below) (Powell and Boyne 2001). Powell (1998) suggests three main criteria that distinguish national from local services. First, a national service should be little autonomy and no democratic input at local levels. There is no clear definition of local government (Cole and Boyne, 1995) but a key characteristic is that decisions should be made by local people through the local ballot box. Local diversity should be the result of the interaction of local political forces: localism tolerates - even celebrates - diversity rather than the imposition of national uniformity (eg Robson, 1953). Local autonomy is deemed more important than territorial justice (see Davies, 1968; Newton, 1980; Page, 1982; Boyne and Powell, 1991). In the words of John Stewart, 'local government is the government of difference' (in Page, 1982, p. 30). Second, there should be national as opposed to local funding. In a purely localist service, with the complete absence of grants, local areas would rely on their own resources: a scenario termed by Newton (1980, p. 12) the 'grantless society'. Such a situation would entail the territorial equivalent of 'to him that hath', in which richer areas would have access to more local resources and where no financial redistribution would take place between areas. In contrast to pure localism, in which localities are totally reliant on their own resources, in a national service the centre allocates money according to central criteria to secure horizontal equity in funding at the national level. Third, central control and funding should lead to provision which is

equitable according to centrally determined standards. National 'Marshallian' social citizenship should mean that equal citizens receive equal treatment irrespective of factors such as location (Boyne and Powell 2001; Powell 2002, 2009a,b). The strategy of equality (Le Grand, 1982) has a spatial component, with the aim of achieving territorial justice (Davies, 1968; Powell and Boyne 2001). There should be horizontal equity in treatment: need should get identical response in different areas. In short, a national service should be based on national as opposed to local citizenship, funded 'from each according to their ability', delivered 'to each according to their need' at the national level. Geographical location should make no difference to contribution or benefit: two individuals of identical income should pay the same amount towards the service and two individuals in identical need should receive the same amount of benefit regardless of location. The aim of a truly national service would be to make geography irrelevant.

Contemporary opinion reveals a more nuanced view of local government, which is more alive to the wider conceptual issues discussed above. Contemporary writers such as Robson (1933) and McHenry (1938) pointed to the rise of centralism, and the growing gap in Labour party rhetoric and reality about localism in the twentieth century (see also Gyford 1985; Rowett 1979). However, while academics, politicians and civil servants identified many problems with local government and municipal health care such as size and financial capacity, these were balanced by the advantages of local democracy and integration of services (eg Chester 1951; Laski et al 1935; Mackintosh 1953; Simey 1937; Wilson 1938, 1946).

Contemporary Perspectives

A belief in local government in general and municipal medicine in particular was a major element in the policy of the Labour Party. Groups such as the early Fabians, the

Independent Labour Party and the Socialist Medical Association were all strong supporters of municipalism. Places such as Sheffield and Bradford were regarded as strongholds of 'municipal socialism'. The London County Council, captured by Herbert Morrison's Labour Party in 1934, was the largest municipal hospital authority in the world, with its Health Committee chaired by SMA President Somerville Hastings.

In the Debate on the Local Government White paper (15 Feb 1944), great tributes were paid to local authorities by speakers from all the main parties. The Conservative, David Eccles, stated that 'what a tremendous task we set ourselves when we insist on using independent local government as the vehicle for the execution of a social policy which is national in scope... [but it] may conflict with blue-printed efficiency and with the attainment of uniform standards. To reconcile those two apparent opposites of decentralization and efficiency is our task' (col 437). The National Liberal, Stanley Holmes (col 469) argued that 'If fundamental changes remove from the people the control of their own affairs...whatever gain there might be in efficiency - and that is a debatable point - is discounted by other and more far reaching consequences'. The Labour MP, Fred Messer (cols 474-5) pointed to two types of service. 'For the impersonal such as electricity, I do not care who administers them so long as they can be carried into every house in the country. However, for human services such as education and health care to get efficiency it may be necessary to have a large unit, but if we do that there is a danger that the unit may be too far removed from the people.... Local administration of all these human service is better' (cf Morrison, col 506). There was a general opposition to unelected, ad hoc bodies. Lord Latham, leader of the LCC, reacted angrily to the idea of non- elected boards in 1941: 'the Fifth Columnists against democracy are planning to steal the people's municipal hospitals.' Labour Secretary of State for Scotland in the Coalition Government, Tom Johnston, attacked ad hoc health authorities as a 'system of continental dictatorships' inconsistent with the principles of

representative government (Webster, 1988: 49). Reflecting the SMA's 'immutable belief' in local democracy, SMA President Somerville Hastings wrote in 1941, 'Above all else, the hospitals after the war must be under the control of the elected representatives of the people through the Ministry of Health and the local authorities.' Similarly, Labour's 1943 policy document, 'National Service for Health' insisted that 'wide powers must be left into local authorities; it is they who must be responsible for the detailed administration of the service.' Initial plans for the NHS from 1938 were based on various forms of municipalism, notably joint authorities. Local authorities played a major role in the 'Brown' Plan of 1941 and Willink's White Paper, 'A National Health Service' of 1944. As PEP put it (1944: 16) a medical service in which local authorities play no part is unthinkable. In the King's Speech Debate in 1945, Morrison announced that Bevan intended to return to the 1944 White Paper. The 1945 Labour Party Conference agreed that 'no scheme is acceptable which does not...give to the local authorities control over municipal hospitals and medical services on statutory Health Councils and Committees.'

The nationalization of the hospitals, Bevan's main innovation, came very late in the day (Foot, 1975; Webster, 1988, 1995). One of the main stated reasons for nationalizing the hospitals was to reduce inequality, which was one of the main criticisms of health care before the NHS (eg Abel-Smith 1964; Eckstein 1958; Powell 1992). In the Debate on the Second Reading of the NHS Act, Bevan (Hansard 1946: cols 48-9) argued that it was not possible to base the hospitals on the local authorities 'if it is our intention to universalize the best, that we shall promise every citizen in this country the same standard of service, how can that be articulated through a rate-borne institution which means that the poor authorities will not be able to carry out the same thing at all?' According to Bevan, in any local government system 'there will tend to be a better service in the richer areas, a worse service in the poorer' (in Klein 1995, pp. 16-18). Bevan claimed that local authorities could not be effective hospital administration units because they were too small and their

financial capacities were too unevenly distributed. As Parliamentary Secretary, Charles Key explained, 'geographically and administratively, functionally and financially, the local government machine is not equal to our task' (1946,col 211). This, it will be remembered, is the same local government machine which the Coalition Government White Paper preserved and which received praise from all sides only some 15 months earlier. Conservative spokesman, and former Minister of Health, Willink pointed out that 'every word he said about the unevenness of finance in different counties and county boroughs would defeat the whole of the Education Act' (1946, col 234). Willink and Law claimed that the main problem was lack of finance. With generous new central grants, the local authorities could do the job.

Bevan argued for national (Parliamentary) rather than local accountability: boards 'will be and they must be the instruments of the Ministry ... The most sensitive instrument in this country for bringing about effective administration is the Question on the Order Paper of the House of Commons....in a good many instances, the relationship between the citizen and his MP is more direct than the relationship between the citizen and his local authority' (Hansard Standing Committee C, 15 May 1946, col 77). He stated that 'When a bedpan is dropped on a hospital floor its noise should resound in the Palace of Westminster'. (Jenkins, 1996: 65; see also Foot, 1975: 192-3). He argued that (col 52) 'by taking the hospitals from the local authority and putting them under the regional boards, large numbers of people will be enfranchised who are now disenfranchised from participation in local government' (ie a democratic gain rather than a deficit)

However, the two main arguments in favour of a local government service were of democracy and integration. Morrison led the defense in Cabinet on behalf of his beloved local authorities. Once Cabinet agreement had been reached, the local authorities and Labour MPs quietly accepted this reversal of party policy: the dog had failed to bark-

including SMA President Hastings, representing the East London constituency of Barking. Bevan's decision to kick over the ballot box prompted surprisingly few problems for Labour MPs in the NHS debate (Hansard, 1946). The only Labour dog to bark was Messer who asked 'why this loss of faith in the elective principle? Why lose faith in what we believe to be democracy?' Messer quoted the Labour Party Conference and 'Tribune' to Bevan, who interrupted the former with questions. (1946,cols 137-144). The Conservatives saw their chance to become the defenders of localism: to support the man in the Town Hall as opposed to Labour's gentleman in Whitehall. Speakers such as Henry Willink (cols 226-36), Richard Law (cols 68-70,75) and Sir Harold Webbe (cols 270-74) taunted the Labour party in general and Herbert Morrison in particular about their part in the demise of local government. Sir Harold Webbe claimed that the NHS Act signed the 'death warrant of local government' (col 274). However, in Standing Committee, the Conservative objections appeared to be not so much on the grounds of appointment as opposed to election, but on central as opposed to local control. They attacked the concentration of power in Whitehall as opposed to the periphery, in the hands of the Minister as opposed to local hands. Willink wanted to increase the autonomy and independence of the RHBs and HMCs from the Minister (col 111) Criticisms stressed the 'top down' approach and advocated the 'bottom up' approach (cols 114-118,199-204). Mr Linstead welcomed the centre of gravity moving away from the centre towards the periphery (col 377). This also appeared to satisfy Messer in the Third Reading. He was critical on the Second Reading due to the remoteness of control, but he was now assured that the HMCs would get the necessary measure of power (cols 427-428). The parameters of the debate, then, appeared to change. The democratic deficit was seen not so much in the principle of election versus selection, but in the locus of control, in the centre as opposed to the periphery. The question of power was more 'where' than 'who'. In 1952 Bevan conceded that 'election was a better principle than selection', and argued that with reorganisation of local government, it might be possible to return the

hospitals to the local authorities. However, 'no local finances should be levied', for this would give rise to frontier problems, and the essential unity of the Service would be destroyed (Bevan 1978: 115).

After the demise of the Brown plan, neither the 1944 White Paper nor the NHS Act planned to secure a unified service. The Society of Medical Officers of Health (1944) criticised the White Paper for splitting the service between local authorities and Joint Boards, stressing the problems of divided responsibility for clinical and preventive aspects of work in areas such as tuberculosis. Sir Harold Webbe (Hansard 1946: col 367) considered that the system of local government that followed the Local Government Act of 1929 allowed public health to be planned as a whole, which gave a complete interlocking of the preventive and curative medical services. The NHS would re-open the gap between preventive and curative public health, and take health back to a position which would be worse than before the 1930s. The lack of unification both within the NHS and between it and other associated services such as housing has been pointed out (Leff 1950: 240-1; McIntosh 1953: 154; Guillebaud, 1956, see especially the note of reservation by former Permanent Secretary at the Ministry of Health, Sir John Maude).

Many assertions were based on the traditional arguments in favour of local government (see Stoker 1996). Mr Wrigley (PRO MH 80/24 Wrigley note 16, 12, 40) wrote that it is more important that the general body of people should be interested in services than they should be provided from above with a mechanically perfect organisation for which they have no responsibility and in which they can take no interest. It was 'unreasonable to require Hereford or Cornwall to produce in the next few years a hospital service equivalent to the LCC.' According to Chester (1951: 23), even if it could be proved conclusively, and so far I have seen no such proof, that local services such as police and education, could be more efficiently managed by central government, it would still be a

mistake to make the transfer. He concludes that 'It is a commonplace among Ministers, politicians, civil servants and publicists to say that they believe in local government. It is possible for a Minister to say this even when, as in the case of the centralisation of the hospital system, he clearly prefers to run local affairs by a series of non-elected Boards' (p. 341).

Localists tended to regard inequality either as a positive dimension of diversity or as an inevitable trade-off in a responsiveness system of local government. As Simey (1937: 117) argued, local autonomy allows local variety to assert itself, and the variations in the services provided are striking, both as regards quantity and quality. This is, of course, by no means a wholly good feature of local administration, for it must be admitted that freedom to experiment must be accompanied by freedom to lag behind. Robson (1953: 52) stated that 'just how or why the Labour Party ceased to believe in local government as one of the instruments for realizing the socialist commonwealth is hard to say. One reason is probably an extreme emphasis on equality: if socialists regard the provision of more or better services in one area than another as indefensible anomalies, if, for example, they become indignant if more grammar school places are provided in Surrey than in Cornwall, or if Labour MP's feel they have a genuine grievance if housing is provided on a more lavish scale in Luton than in Glasgow, they have ceased to believe in local government as regards these services. For nothing is plainer than the fact that local self-government is incompatible with uniformity. It is consistent with the imposition by the central government of a national minimum standard below which no local authority may fall. It is not consistent with the imposition of a maximum standard above which no local authority may rise.' He continued that 'The full realisation of democratic socialism or even the development of the welfare state, demands a reversal of recent trends, a revitalization of local government, an expansion of its functions and responsibilities' (p. 54). Similarly, GDH Cole (1947: 250) states that considerable variation in the ways of

getting things done from one place to another is a vital part of local government autonomy, and is a price worth paying.

Wilson (1938: 227-8) wrote that 'the local authority's right to determine to what extent it shall protect the health of its citizens ...is commonly justified on the grounds that local self-government, which diffuses the sense of affairs and responsibility, is imperative for democratic government.' According to Wilson (1946: 167-9) there are great variations in adequacy and efficiency, and it is tempting to suggest that local authorities should lose their personal health functions to regional administration of the Ministry of Health.

However, 'a nationally uniform health service would, however, be bought too dearly if the cost were the loss to the community of a measure of control larger and more effective than can be exercised through Parliament. Lenin once said that the health of the people is the concern of the people themselves. The nearer the approach to the conception that health services are not provided for people but are provided by them, the more efficient, extensive and developing these services will be. The endeavor should not be to take responsibility away because so many are too indifferent or ignorant to shoulder it, but rather, in the various ways which can be employed, to create an informed public opinion that will not be satisfied with any service but the best. It is therefore of prime importance that the present partnership between centre and locality should continue' (pp. 175-6).

Some writers have suggested that Morrison versus Bevan debate should be reassessed. Foster et al (1980: 58) wrote that Bevan's arguments of variations in size and wealth are not too persuasive at this distance; and also should apply to education (and housing). The most important reason for nationalization - the medical profession's dislike of local authorities- was not explicitly stated. Campbell (1987: 177) writes that 'all the fundamental criticisms of the NHS can be traced back to the decision not to base services on local authorities. The various medical services were fragmented instead of unified; the

gulf between the GPs and the hospitals widened instead of closed; there was no provision for preventive medicine; there was inadequate financial discipline and no democratic control at local level. In retrospect the case for the local authorities can be made to look formidable, the decision to dispossess them a fateful mistake by a Minister ideologically disposed to centralization and seduced by the claims of professional expertise.'

According to Fraser (2003: 256), there was a good case to be made out for local authorities to run the new health service just as they ran the education service. Although there were problems of finance, the overwhelming argument against the primacy of the local authorities was simply that the medical profession would not wear it. White (2004) argues that the NHS objectives of universal or uniform provision and command and control have proved elusive. Universal or uniform provision has never been achieved in the NHS. Of course to a service predicated as 'national', local differences will usually look like failure, but one wonders whether local government would have evolved a less national service than the one we have now. Centralizing power- command and control- has failed, with a democratic deficit and sham local accountability. Again, one wonders whether a service devolved to local government could have brought about less effective control than this?

Some commentators have noted that the loss of health care was a major loss of function to local government (eg Doyle 2000). While local authorities acquired other functions after 1945 and increased overall expenditure (eg Wilson and Game 2002), in terms of health the foundation of the NHS can easily be equated with a major loss of function of local government. Blunkett and Jackson (1987: 64) see nationalization of health as 'Labour's great mistake'. White (2004) argues that the NHS marked the greatest creation of quangos in British administrative history, marking the true beginning of that withering away of local democracy recognised belatedly by the Royal Commission on Local Government in England in 1969. It called the loss of the hospitals a 'great misfortune' that

ought to be reversed, but 5 years later, the remaining local authority health services were nationalized too. It is no exaggeration to talk of the immersion of local government in its present state, with powers largely abdicated to Whitehall at the centre (the Attlee model) and to school governors, urban regeneration companies, housing associations and so on at the periphery (the Thatcher model, still actively pursued). Blunkett and Jackson (1987: 55) wrote that the NHS, for all its sophistication and success, has never achieved the same combination of local accountability, sensitivity and innovation as local government services'. According to Morrison, 'I believe that the LCC is, in many respects, a model of public administration, it is clean, it is upright, and the machine works with precision, good sense and humanity. Whenever I go over Westminster Bridge, I can almost hear it ticking' (p. 63). Doyle (2000: 313) argued that local government achieved an enormous amount in one hundred years, very often shaping local services to local needs in a way the central state could never manage. Gladstone (1999:106) notes that the position of modern local government raises issues of democratic accountability. According to White (2004), in reviving special, single purpose local authorities, we can see that new localism is very old localism indeed. It takes us back beyond living memory, before anything that we would now recognise as local government to 'pure' eighteenth century forms where local magistracies wielded undemocratic power. Nor does history bode well for special purpose authorities in other directions. The main argument against them is that they fragment local democracy and create divisions between services. They were generally absorbed into multi-purpose local authorities in the nineteenth century. It was just this argument that convinced those who welcomed the abolition of the LSB in 1904.

Conclusions

A large proportion of the historical perspective appears to be implicitly based on the central point of view (cf eg CLD 1995; Jenkins 1995; Stewart 2000; Stoker 2004; Wilson

and Game 2002 for political science), and seems not to place much emphasis on earlier political or contemporary perspectives. Localists and centralists tended to favour different criteria of evaluation, with the former pointing to the advantages of participation, responsiveness, integration and diversity, while the latter stressed the problems of inequality.

It is important that current policy debates are informed by historical perspectives. Few policy debates are entirely new. For example, the Layfield Report (1976: xxiii) notes that most of the serious problems uncovered by the review are not new. Many of these were recognised at the turn of the century, and have reappeared at intervals and were last reviewed by the Kempe Committee in 1911-1914. However, there is much scope for simplistic or incorrect views to inform the debate (eg Milburn 2003, 2004; see Mohan 2002, 2003). As White (2004) points out, it is easy for myths to be created: in November 2003 the Blair government was accused in the main local government journal of following through Thatcher's anti-local agenda in contrast to Attlee and Bevan's protection of local democracy in the 1940s! With such dangers, it is vital that contributions to debate are conceptually and historically informed.

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