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Williamson, C. (2014) "To remove the stigma of the poor law': the 'Comprehensive' ideal and patient access to the municipal hospital service in the city of Glasgow 1918-1939.' *History: the Journal of the Historical Association*, 99 (334): 73-99.

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‘To remove the stigma of the Poor Law’: The ‘Comprehensive’ Ideal and Patient Access to the Municipal Hospital Service in the City of Glasgow, 1918–1939

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Abstract

The objective of the newly established Department of Health after the Great War was to ‘remove the stigma of the Poor Law’ from public health policy. Although there was no abolition of the Poor Law in its entirety there were strategies employed to encourage better health, and manipulation of the rules to extend free access to primary health care. This article examines the efforts of the Corporation of Glasgow from 1918 to 1939 to expand patient care to the citizens of the city who either did not qualify for poor relief or had no access to national insurance. The article examines the city’s pioneering work in devising strategies to fulfil these changed priorities through the reorganization of services, building additional health infrastructure and through lobbying the Scottish Office to support legislation to create a legal context in which to expand patient access; this came to fruition in the health clauses of the 1929 Local Government (Scotland) Act. As Glasgow was the largest municipal authority outside the London County Council, its experience is crucial in understanding how changing national priorities were applied at local level and that despite great improvements in the scholarship on the inter-war hospital service the neglect of the city has created a major hole in the study of public health before the creation of the NHS. This article will correct this omission and further add to the existing scholarship on the period.

I

The objective of this article is to examine how the Corporation of Glasgow and the Glasgow Poor Law Guardians dealt with changing national priorities in health care from 1918 to the advent of the Emergency Medical Service in 1939. A key aspect of these reorganizations is the concept of the ‘comprehensive’ ideal. This objective was expressed in the words of the Scottish Board of Health’s (SBH) Consultative Committee report in 1920: that ‘a complete and adequate

medical service be brought within the reach of every member of the community'. (1) It was not to be a national health service in the post-1948 sense of the term but the coordination of the different bodies with a health remit at a local level: the municipal (council) sector, Poor Law Guardians and the voluntary sector. The 1929 Local Government (Scotland) Act would unite the municipal and Poor Law services and permit the expansion of access to hospital treatment to those not covered by the Poor Law regulations but would leave the independents alone. Together they would offer a multi-layered service: paupers in Poor Law hospitals, those covered through National Insurance contributions using the voluntary sector, and the municipal service somewhere in-between treating a variety of infectious diseases and taking care of the Schools Medical Service as well as those who were not insured. In the main the discussion will focus on the local authority services, but where relevant the article will examine the interaction between the municipal service and the voluntary hospitals. Glasgow, with its large population and deep-seated health problems but also a substantial public health infrastructure, offers a chance to measure the ambitions of the SBH against local outcomes. The objective of a comprehensive and unified set of local services coincided with the ambitions of both the City Corporation and the local Poor Law authority in Glasgow, and they were to take this ideal forward in a unique series of experiments. These included stretching the meaning and application of admission criteria to Glasgow's municipal hospitals, which sought to offer care in a manner that would remove the stigma of the Poor Law (2) and extend care beyond paupers to the so-called ordinary ill.

So far scholars of the inter-war municipal hospital services in the United Kingdom have not paid much attention to the rules and strategies for admission and the local variations in them, although a start has been made to address this gap especially in the English context. (3) This is an omission, because the subject touches on a number of key themes in the general study of health services between the wars. It covers the local aspects of provision; it involves the discussion of cooperation between providers; the role of the Medical Officer for Health; and the interaction between local authorities and central government. Therefore it is an important component in the understanding of the character of the health services prior to state control, as well as giving an insight into the nature of localism at this time. It is equally important to understand the formidable health- and welfare-related obstacles to the comprehensive ideal, and this is exemplified by the experience of Glasgow. First, poverty was a major issue: the city, according to the Board of Health had, nearly half of all Scotland's paupers within its boundaries. This placed a major burden on the Poor Law and municipal infrastructure, filling the hospitals with the non-sick poor and foiling attempts to free up bed space

for the sick poor and others. In the main this due to the fact that all of the Poor Law hospitals were also part of the poorhouses and there was a tendency to domicile those that qualified for indoor relief anywhere that could be found for them, this was especially the case for the elderly and children as there were no specialist facilities for them. The second element that was to confound attempts at 'completeness' was the persistence of the serious infectious diseases that required sufferers to stay in hospital, sometimes for a long time. Certainly, there was a substantial fall-off in mortality from influenza, tuberculosis and scarlet fever, but patients with infectious diseases again took up large numbers of beds either as a result of seasonal epidemics such as the flu, or perennially in the case of tuberculosis. This made the Corporation's ambition to offer the ordinary ill the possibility of a hospital service without the stigma of the Poor Law a challenging task. Very quickly after the Second World War the advent of the 'therapeutic revolution' in vaccination and antibiotic treatment was to transform the hospital service by releasing vast amounts of bed space previously occupied by infectious diseases patients. However, prior to this, there was significant pressure on limited hospital beds for both clinical and socio-economic reasons. Any critique of the failings or otherwise of the health services as a whole in Glasgow has to take account of these crucial factors.

II

The study of the pre-NHS hospital service in the United Kingdom has undergone a major transformation in the last decade or so. Scholars have become increasingly interested in the nature and ambition of the public health services, their structure and finances. The main overview of the subject in Great Britain is provided in monographs by Steven Cherry and John Welshman. (4) Of the two Cherry has a broader canvas, but the volume is slim and can only really be regarded as an introduction. Welshman's work is more detailed, but although the book aspires to be a 'national study' it is in truth a local study based on Leicester. His coverage of Scotland is scant to say the least but the chapters on the School Medical Service are the strengths of the work. It is in journal articles that the study of the inter-war service has really matured. (5) These works, as well as providing a general context to the study of the municipal hospital service, identify the key concepts and controversies in the subject area such as finance, service provision, political interference and the role of the Medical Officer for Health. Local studies have provided some important case histories of the inter-war municipal system with studies on the London County Council, Gloucester and Middlesbrough in England, Wales, and Aberdeenshire in Scotland standing out. (6) More recently the monograph *Cradle to the Grave* by Levene, Stewart, Powell and Taylor has augmented the coverage of the municipal sector by adding studies of Barnsley, Eastbourne, West Hartlepool and

Newport. (7) Additionally there is an increasing awareness of the changing legislative context with the passing of the 1919 Board of Health Act and in particular the 1929 Local Government Act – arguably the most significant piece of inter-war health legislation. This study will examine in detail the making and working of the 1929 Local Government (Scotland) Act health clauses, to which Glasgow made a major contribution. (8)

Scottish health history is gradually catching up with developments pioneered in the study of the English municipal service, as the example of North East Scotland has shown. Levitt's *Poverty and Welfare in Scotland*, written more than two decades ago, is still the most substantial monograph on public health in Scotland prior to the NHS. (9) The most recent study of the local and national character of health services in Scotland pre-1948 has come from Morrice McCrae. (10) His focus is for the most part on the Highlands and Islands Medical Service, and the major commissions and surveys from McAlister in 1920 to Cathcart in 1936 as they sketched out the future provision of health care. In these respects it is a very worthy contribution, but it is notably thin on discussion of Glasgow both in terms of provision and in terms of the prominent role played by the Corporation Medical Officers for Health (hereafter MOH): A. K. Chalmers in the 1919 Consultative Committee and his successor A. S. M. Macgregor in the framing of the 1929 Local Government Act Health Clauses and the Cathcart Report. More specialized work by period or sector is, however, patchy. The main work on Glasgow, while reasonably comprehensive on the nineteenth century and also post-1948 services, only episodically covers the inter-war period. (11) Macgregor's own memoir of his time as MOH for Glasgow, although a subjective account, offers much insight. (12) Many of the individual hospitals have had serious study such as the three main voluntary hospitals (the Glasgow Royal Infirmary, the Western Infirmary and the Victoria Infirmary), but they do not reveal the wider context of health care in the city. (13) The Poor Law medical services and infectious disease hospitals, meanwhile, have had almost no serious attention paid to them. (14) The Poor Law general hospitals and mental institutions are a complete black hole as far as scholarship is concerned. This article seeks to advance the study of the municipal and Poor Law hospitals in Scotland, highlighting their place alongside the voluntary hospitals in the promotion of comprehensiveness, and alerting future scholars to the need to close this gap in the historiography.

III

The approach of this article is built on four elements. It will in the first instance place Glasgow's health infrastructure in the context of its health problems. Any attempt to produce a more

comprehensive service would inevitably have to be made alongside existing priorities and responsibilities, especially those relating to the sick poor and treatment of infectious diseases. There will then be a discussion of the health services in Glasgow as the era of 'completeness' dawned, that is in 1919 with the creation of the Scottish Board of Health. This also involves a discussion of the attempts at cooperation between the Corporation of Glasgow and the Poor Law Authority to extend the reach of hospital treatment to the so-called 'ordinary ill': those who did not qualify for poor relief and who did not have access to treatment via the National Insurance Acts. The third part of the article will deal with the role of Glasgow in the framing of the health clauses of the 1929 Local Government (Scotland) Act. This Act was primarily concerned with rates and unification of local authority functions, but it also had important health implications as it saw the abolition of separate bodies in charge of education and poor relief and their responsibilities handed to local councils. This change offered an opportunity to redraw the rules on admission to the municipal hospital service to focus on health status alone; an opportunity that was taken by Glasgow. This initiative allows us to discuss the influence of the MOH in shaping policy both locally and nationally. Recent studies of the inter-war health services have emphasized the role of a powerful patron or insider lobbyist in advancing provision both within authorities and nationally, with much attention focused on the role of MOH or on high-profile party political figures such as Herbert Morrison or lobbying groups such as the Socialist Medical Association. (15) While Glasgow had no comparable political figure to rely on for policy momentum, there were the likes of the Independent Labour Party MP James Maxton and senior Labour councillors such as Patrick Dollan, who made intermittent interventions in the debates on hospital provision. (16) Glasgow did have the proactive role played by its Medical Officer for Health, and as Levene, Powell and Stewart point out in reference to the English municipal hospital service this was a post that 'could exert a strong influence' on policy-making. (17) This influence is also identifiable north of the border and is most notable during the tenure of Alexander Macgregor; in addition, he had the patronage of a senior government figure in Walter Elliot, a minister for health in Scotland, latterly secretary of state for Scotland and a prominent figure in the national governments of the 1930s. Despite being a Labour bastion Glasgow had support at the heart of government, ironically a largely Conservative government. The study of Glasgow allows an insight into many of the factors that were important in the dynamic shaping of inter-war health policies in a local context. The final part of the article examines how the Corporation sought to make the health clauses extend provision for the 'ordinary ill'. In this we will look attempts to restructure provision within the newly expanded municipal sector and at the cooperation between the municipal and the voluntary sector, which has been a much-commented aspect of the inter-war public health experience and allows scholars to see how the comprehensive system worked or otherwise.

IV

The choice of Glasgow is based on a number of key socio-economic factors. First is its population: housing nearly one quarter of all Scots it offers the opportunity for a large-scale study of a system which affected large numbers of people. Second, it had deep-seated health problems related to poor socio-economic conditions: infant mortality was higher than average; life expectancy was lower; and instances of infectious diseases were more commonplace. It was in Glasgow that the last epidemic of bubonic plague took place in the United Kingdom. At the root of many of these problems was poverty. One of the major difficulties facing the Corporation health department was how to transform hospital care amidst such monolithic health problems. In some respects Glasgow seems atypical: its health concerns were out of proportion to the rest of Scotland and the UK. This is another reason why a case study of its approach to healthcare is revealing of wider concerns.

The first report of the newly established Scottish Board of Health in 1920 made a point of contrasting the health picture in Glasgow with the rest of Scotland. It focused on infant mortality, life expectancy and instances of infectious diseases. In all these areas the second largest city in the United Kingdom demonstrated serious health problems. Glasgow had three times the population of Edinburgh but five times as many infant deaths from infectious diseases. Infant mortality statistics were overall worse than the Scottish capital with a death rate of 129 per 1,000 live births compared to 123 in Edinburgh. But this was better than both Aberdeen and Dundee, which had rates of more than 135 per 1,000. The Scottish average was 102 per 1,000 (18) and the rate for the UK was 82 per 1,000. As the inter-war period progressed there was a significant fall in infant mortality: by the start of the Second World War the UK statistic was 61 per 1,000, in Scotland it had fallen to 77, but Glasgow continued to lag behind the rest of the country with 87 per 1,000. (19) The city by 1938 had also fallen behind both Dundee and Aberdeen in its infant mortality rate.

In terms of infectious disease in 1919 the number of notified cases in Glasgow was 12,853 while in Edinburgh it was 3,545. (20) This meant a bigger commitment of resources on notification and treatment than elsewhere in the UK as the whole of the responsibility for treatment was borne by the municipal service, whereas in England infectious diseases cases could be treated in voluntary hospitals. The objective to provide better health care in Glasgow in line with the vision of the PHC and the MOH was therefore seriously compromised by the maintenance of such a large proportion of the medical resources and hospital beds for infectious diseases. It would only be in the post-1945

period when vaccination and antibiotics were in more widespread use that the bed space previously devoted to TB and other infectious diseases was freed up to treat illness and offer domiciliary care.

Further complicating the drive towards a complete municipal hospital services was large-scale pauperism. Scotland, and in particular Clydeside, suffered disproportionately in economic terms during the inter-war period with high unemployment, peaking at 30 per cent of insured workers in 1930 and remaining high throughout. (21) In addition to this was a long-standing problem with poverty: according to the Scottish Health Department annual report in 1938, 40 per cent of all of those on the Poor Law rolls in Scotland lived in the Burgh of Glasgow and 82 out of every 1,000 Glaswegians were classified as poor while the Scottish average was 42. (22) This resulted in larger numbers seeking public assistance and greater demand for Poor Law medical service resources. Again this added to the pressure on the municipal services, taking up more beds and resources than the authorities had hoped, and leaving fewer free for the treatment of the ordinary ill at the time of the transfer from the Poor Law under the 1929 Local Government Act health clause. As a result of the weakness of the job market and low pay for the work that was available, Glasgow in 1938 had only 42 per cent of its population covered by health provisions of national insurance, leaving the majority of Glaswegians without health cover just prior to the outbreak of the Second World War. Although this was proportionally on a par with other cities in sheer numbers, it posed a challenge and a considerable obstacle to completing the vision of a comprehensive service, since these uninsured and poorly paid citizens had little access to voluntary hospitals as alternative health care providers.

V

The inter-war years saw the gradual unification and increased coordination of the public Health Services in Scotland. Although Scottish health policy in the inter-war period evolved side by side with English and Welsh policy there were important differences in health priorities and structure, most notably the Highlands and Islands Medical Services Board, which was according to McCrae the closest thing to a 'comprehensive state medical service' in these years. (23) This began with the creation of the Scottish Board of Health in 1919 'to secure the effective carrying out and co-ordination of measures conducive to the health of the people'. (24) At this early stage the role of the state was primarily as supervisor not initiator of reform. Throughout the 1920s and 1930s the Scottish Office, Scottish Board of Health (from 1930 the Department of Health for Scotland), and Westminster were to introduce a series of reports, commissions and select committees to try to

reach a final position in relation to health care in Scotland. It started with The National Insurance Commission, which reported in 1919 and recommended a specialist body to bring forward proposals for the development of health. Significantly that body, the Scottish Consultative Committee, recommended the principle of 'completeness' as outlined above. However, moves towards a comprehensive service stalled at a national level as the momentum for reconstruction slowed and as the 'Geddes axe' fell and the Conservative-dominated National Government pushed for small government as opposed to state provision. It was not until the Scottish Board commissioned another report into the hospital services in Scotland in 1924, published in early 1926 and popularly known as Mackenzie Report, that the early 'comprehensive service' concept of the SBH was revived. This was followed by The Cathcart Report in 1936, which further promoted an integrated system of provision. (25)

Consideration of role of the state in the provision of health services was undergoing a profound change at a national/UK level in the last years of the Great War via the discussions of the War Cabinet Committee on Reconstruction. Amongst the first of the tangible outcomes of this was The MacLean Report on the administration of the Poor Law in 1918 under the chairmanship of Sir Donald MacLean, a Liberal MP, which looked forward to a growing role for the state in public health and the adoption of a new form of poor relief without its previous social stigma. (26) Although many of the grander visions of the report, especially concerning poor relief, were to be quietly ignored, it did provide for the creation of a Ministry of Health. (27) The original plan was to include Scotland in the Ministry but thanks to intense lobbying it was separated and made autonomous, answering to the Secretary for Scotland. (28) The board amalgamated the Local Government Board, Highlands and Islands Medical Board and National Health Insurance Commission into a single department.

One of the first acts of the Board was to create a special subcommittee to 'consider and make recommendations as to the systematic provision of such forms of medical and allied services as should be available to the community'. (29) The resulting Consultative Committee on Medical and Allied Services was made up of experts from all branches of the service with Glasgow represented by its own Medical Officer for Health, A. K. Chalmers, one of only three representatives of Local Government on the committee. Its interim report encapsulated the major intellectual and political changes in the philosophy and organization of public health and its sixteen recommendations covered all aspects of the welfare system including the 'general principles which in our opinion should govern the development of a comprehensive health service'. (30)

The committee identified a new trend in the provision of health care or, as it termed it, 'state medicine'. (31) This was a shift towards a system which emphasized the overall 'physical welfare of the population'. (32) The committee saw the provision of public health primarily in relation to the 'medical care and treatment of individuals'. (33) Prior to this point public health policy was built around what Morrice McCrae described as 'essentially defensive . . . measures' based on improving sanitary conditions. (34) The committee was critical of how this new emphasis in public health had not been accompanied by a parallel change in the local administration of health. Public provision, it said, had 'not proceeded upon any single well ordered plan'. (35) It was also critical of the incomplete nature of the coverage of health provision. Special attention was given to particular groups: the destitute and disabled poor, insured people, mothers and infants. Within these categories there was a wide variation in provision: the Poor Law hospitals, for example, were attacked for providing a service which was 'limited and defective'. (36) The most serious anomaly was in relation to those who contributed to the National Health Insurance scheme. An insured person was able to get free examinations by a panel doctor but would have to seek alms or pay for access to many inpatient and outpatient services in the voluntary sector. The committee sought a radical change in the system of National Insurance, an extension in the range of treatments available so that the coverage of an individual would also allow his or her family to get access to treatment, and a gradual extension of National Insurance even to those currently subject to the Poor Law.

The committee was unhappy with local divisions between municipal government and Poor Law authorities, which did not correspond to contiguous areas. This issue had been raised previously during the debates on the Scottish Board of Health Bill in Westminster. Despite acknowledgement from the Scottish Secretary it remained unresolved, (37) leaving a multiplicity of small units in local government covering a vast number of individual tasks in public health from the Schools Medical service to the Poor Law. This was seen by the authors of the report as detrimental to the efficient and effective provision of services. Some of the bodies were too small to raise the capital costs for large health projects and were reliant upon central government for grants and loans for development or, as was the case in the North East of Scotland and a number of English municipalities, agreements to share use of facilities. The Committee recommended the rationalization of all health and public assistance bodies at a local level, but it would be nearly a decade before this obvious change was carried out in the 1929 Local Government (Scotland) Act.

The SCC concluded its report by stating: 'The time is opportune for formulating a general plan, whereby the entire health service of the nation may be established on a broad and comprehensive

basis.’ (38) Adoption of what the Consultative Committee described as ‘completeness’ was heavily qualified, however. First, the development of change was to be gradual or through ‘patient perseverance’. (39) The Committee was anxious to stress that the future of health provision would be a partnership: ‘the closest co-operation between government, medical schools, local health authorities and public hospitals’. (40) The state would have a supervisory and advisory role, but the status quo in provision would remain. It is significant to note that there was widespread support in parliament for the maintenance of the voluntary sector. Labour Party members from Glasgow continually acknowledged the important role of the voluntary hospitals, (41) and many unions were active contributors to the hospitals via the National Insurance system, which allowed their members the chance of inpatient treatment. (42) The support for the maintenance of the voluntary sector on the left in Glasgow contrasts with the London County Council Labour Group, which was openly hostile to the preservation of the independents. (43) This cooperative approach in Scotland is a feature of the whole inter-war period, with all advances in public health seen to operate in tandem with the public hospitals. To this end the SBH and its successor after 1929, the Department for Health in Scotland, sought to bring together the different providers via a permanent national Consultative Committee, and also to subsidize pilot schemes such as one in Aberdeen and publicize best practice in cooperation. (44) Despite these initiatives progress across Scotland was less than spectacular – a situation regularly lamented in the annual reports of the department. (45)

The most important principle established by the Scottish Consultative Committee was that ‘a complete and adequate medical service be brought within the reach of every member of the community’. (46) This is the thread by which the entire approach of the city of Glasgow was joined. Bringing this principle to reality was a matter of dealing with each of the components of the interim report in their Glasgow context. It raised several difficult questions: how to gain access to the resources of the Poor Law hospitals? How to manipulate the strategy for admissions to offer access to as many as possible despite being tied by the severe regulations of the Poor Law? The promise of a new approach to public health by the state was not delivered immediately; the emphasis for change fell upon the local authorities and the measures they could adopt. It was therefore necessary in the interim to find imaginative ways to apply the current legislation to achieve these goals.

VI

There was by the end of the Great War a substantial hospital service operated by the Poor Law and municipal authorities in Glasgow. The Corporation had by the start of the twentieth century built five

infectious diseases hospitals. (47) The city made the treatment in these hospitals free in 1881, so that all 'class distinctions within the hospitals should be broken down'.(48) At the same time a permanent Public Health Committee (PHC) was formed by the city council to oversee the work of the MOH. The work of the PHC was strengthened by the 1889 Notification (Compulsory) of Infectious Diseases Act, statutory only in London but open to adoption by any health committee.(49) Glasgow incorporated the Act in 1890, which allowed the corporation to act quickly upon the outbreak of any infectious diseases including in 1900 a short epidemic of the bubonic plague, the first outbreak in the city since the seventeenth century with thirty-six cases and sixteen deaths. As will be seen in relation to influenza the steady rise in the numbers that were included on the list of notifiable diseases added considerably to the workload of the hospitals. The voluntary adoption of the initiative, however, shows how forward-thinking the city of Glasgow was in moving towards as comprehensive a health care system as possible from an early date.

The Parish of Glasgow Poor Law hospital service was divided between two functions: general hospital provision and care for the mentally ill. The description of Poor Law hospitals as 'general' was in many respects accurate since they were not only hospitals in the strictest sense for the sick poor, but also served as children's homes, old people's homes, sanatoria, maternity wards and lunatic asylums. The development of separate infirmary facilities outside the poorhouses dates from the 1898 Poor Law Act, which helped to unify and rationalize the administration of the Scottish Poor Law; the four central parishes of Glasgow were merged to form a single council. Prior to 1898 the Poor Law administration had sent its sick to the voluntary sector for treatment. However unwillingness by the voluntary sector to domicile elderly infirm paupers coupled with their refusal in 1876 to accept any more infectious diseases patients led to a change in the operation of the Poor Law and municipal medical services. (50) First, there was the construction of one local authority fever hospital and then, with the passing of the 1897 Public Health (Scotland) Act, came permission to borrow more capital to build as required. (51) The Parish Council then launched an ambitious programme, building three Poor Law hospitals, starting in 1900 with Stobhill Hospital on the northern edge of the city and adding the Eastern and Western District Hospitals by 1905. South of the river Clyde the Govan Board of Control constructed an infirmary adjacent to the main Poorhouse (subsequently called the Southern General Hospital). The second main function of the Poor Law medical service was to provide asylums for the mentally ill. As with the infirmary service, this suffered from a lack of investment, overcrowding and (as was to be a common problem in treatment for the mentally ill) a lack of general interest. Glasgow's provision of care for the insane and disabled was to remain spartan throughout the inter-war period.

From 1914 to 1918, a large proportion of Glasgow's hospital capacity was earmarked for military personnel convalescing from wounds or disease as a result of active service. The end of the Great War threw up new problems for the city. The infectious diseases hospitals took some time to return to their normal duties and were badly prepared for the pneumonic influenza pandemic of 1918–19. Wartime expansion of the infectious diseases hospitals at Robroyston and Ruchill had helped substantially to improve the system, a windfall which would leave 'their problem of accommodation largely solved'. (52) In 1919 the ratio of ID beds to population was 2.01 per 1,000, a situation which was only bettered by Dundee amongst the big cities of Scotland. (53) The main cause for concern was the inconsistency of provision of tuberculosis sanatoria and hospitals. The Glasgow Chief Superintendent for the TB service recorded that the Sanatoria 'were adequate for adults, inadequate for Children', (54) and the hospitals 'inadequate for adults, adequate for children'. (55) It was estimated that the city needed the provision of 300 extra beds for infant TB patients. (56) The municipal infectious diseases hospitals were evolving in the face of increasing demand; the most significant legislative change was the inclusion in the list of notifiable diseases of pneumonic influenza after 1918. (57)

The National Insurance Commission for Scotland had during 1917 gathered evidence for a report into the hospital and nursing services in Scotland. It was impressed with the three Glasgow Poor Law General Hospitals, whose service it described as 'particularly . . . good'. (58) The city had a far superior ratio of beds to population than any other city in Scotland, with 3.35 per 1,000 compared to 1.84 per 1,000 in Edinburgh. (59) The main drawback of the system was the qualification rules for treatment; according to the Report 'the only provision of public authorities in Scotland of General Hospital treatment bears the stigma of the poor law.' (60) In addition, non-acute sick persons took up much of the accommodation, as one Poor Law commissioner had observed on a visit to the Stobhill Poor Law hospital: 'the majority of non-tuberculosis patients were very old, malnourished bed ridden citizens.' (61) Long-term domicile of the elderly and young able-bodied was an obstacle in the way of releasing much-needed bed space for the chronic sick, although Glasgow Parish Council had a provision of general hospital beds which was not bettered in Scotland, much of its actual usage was confined to those who were not specifically meant to be there. As the decade progressed, the SBH continued to be impressed by the facilities of the Parish Council regarding Stobhill, as the 'ideal standard to be aimed at' for Poor Law General Hospitals and the Eastern and Western District Hospitals was 'wholly and in high degree admirable'. (62)

The provision of care for the mentally ill in Glasgow was under considerable stress immediately following the armistice. Many asylum beds were taken up by ex-servicemen who were only slowly moved either to the Royal Asylum at Gartnavel Hospital or to Bellahouston ex-servicemen's hospital. The National Insurance Commission had detailed its concern at the state of Glasgow's four district asylums, calling them 'scarcely adequate'. (63) They were to be a continual concern for the Guardians of the city Parish Council. (64) The Parish Council, aided by government grants, was able to expand facilities for the mentally ill with a new purpose-built establishment for them at Lennox Castle in 1928. In general, however, the resources devoted to the mentally ill were, and remained, inferior.

It is possible, however, to identify moves towards cooperation between sectors in some of the responses to these problems. To cope with the new responsibility for influenza the Glasgow MOH Alexander Macgregor looked to cooperation with the voluntary and Poor Law authorities to relieve the pressure on the city ID hospital service, for example, and adopt a strategy which would utilize the resources of the service in general. The voluntary sector was unwilling to help, but Macgregor found an unusual ally in his campaign for change in James Motion, the General Superintendent for the Glasgow Parish Council. At this stage – prior to the 1929 Act – cooperation between the municipal and Poor Law sectors was relatively unusual. Motion, according to Macgregor, held strong views on pauperism and the punitive measures needed to deter idleness, but he was 'tender-hearted' in his views on access to treatment for the sick poor. (65) He had been instrumental in the development of the Glasgow Poor Law hospital service and during his period as superintendent had helped to establish three big district hospitals. Macgregor viewed the Poor Law service as the key feature of the hospital system. The main stumbling block to change was created by the regulations on admission: that is, that patients had to be assessed on welfare grounds. Motion was convinced that the regulations 'could be stretched to cover the provision of a comprehensive hospital service'. (66) The Parish Council had attracted much interest over its 'liberal interpretation' of the regulations. (67) The Scottish Board of Health was well aware of this manipulation of the rules and although it expressed reservations about this 'enlightened policy' it felt that criticism in the current circumstances would be 'unreasonable'. (68) It was, however, an approach which was a matter of opinion. To effect real change, legislative action was necessary.

The significance of the 1929 Act lies in the interaction between central (UK), regional (the Scottish Office) and local government. Glasgow played an important role in this because of its early moves towards cooperation, and the vigour of its MOH. Macgregor had set specific objectives for the expansion of treatment in Corporation hospital services but was hamstrung by regulations he looked to national government to remedy this. There were also indicators of a change in attitude in the political parties towards health care provision. A consensus had been reached in favour of a 'comprehensive' system in Scotland; the area of differing opinions was in the means to achieve that end. The MacKenzie Committee set up by the Scottish Board of Health to examine the hospital service in Scotland in 1924 reported in 1926, and furthered the cause of the comprehensive service by recommending that 'the poor law stigma should not attach itself to a poor person who needed hospital treatment', reiterating the parts of the 1920 report which regarded this shaming ritual as an obstacle to better health. (69) The supporters of a 'comprehensive system' now had three main reports that called for change, two of which were distinctive to Scotland: the MacLean Report of 1918, the Scottish Consultative Councils report in 1920, and now Mackenzie, supported by active agitation by key members of the medical and administrative system including Macgregor.

The demand for change in the rules of admissions and rights of access hooked onto the demands for a fundamental reorganization of local government at a national level in 1928. As far back as the MacLean report in 1918 there had been criticism of the large number of small bodies in charge of local government, 1,500 in all according to the Committee on reconstruction. The most significant concern for administrators was the creation of local government units which could be relatively self-sufficient and able to bear the capital costs of administrative change, as well as be involved (in the words of the 1919 Scottish Consultative Committee) in the 'systematic organisation' of health services. The 1928 Local Government Bill did finally act upon the committee report, proposing to unify the health services of the Municipal, School Board and Poor Law authorities. Crucially the Bill failed to include any change in the regulations for admission to local authority hospitals. (70) Macgregor was 'surprised and disappointed' by the omission of health clauses. (71)

He later admitted that he did not know whether the non-appearance of clauses was 'intentional or an oversight'. (72) According to Scottish Office records Glasgow was the only local authority to raise the question of the omission of medical clauses from the Scottish version of the legislation and to offer draft clauses. The MOH's main criticisms of the omission were first that it retained the Poor Law rules of eligibility for medical treatment that he said was 'perpetuating a system that is already discredited'. (73) Second, Scottish and English local authorities would have unequal powers in terms

of medical provision, with councils south of the Border retaining the power to build and maintain general hospitals; indeed section 4 of England and Wales legislation offered the prospect to extend to treatment to non-paupers. Scottish local councils had lost the power to build general hospitals under the 1897 Public Health (Scotland) Act as means to protect the voluntary sector. Now they would fall further behind in terms of provision. The result of this would be that 'progress on the lines of preventative medicine would be harassed and impeded'; (74) also that it would undermine the creditability of the boasts of central government 'that [the Bill] would make it possible to sweep away the Poor Law'. (75)

Macgregor would mobilize not just his department but also the full Corporation of Glasgow to lobby for changes to the act. (76) Glasgow council passed a resolution on 10 January 1929 supporting a request from the MOH to make representations to the Scottish Office in the form of a memorandum to have a new clause inserted into the act. (77) This clause, drafted by the town clerk's Office, would authorize local authorities to offer health treatment to those citizens not covered by the Poor Law and also to allow authorities to recover all or part of the costs of care. (78) These two elements would be included in clause 4 of section 27 and clause 1 of section 28 of the 1929 Local Government Scotland Act.

Macgregor also made good use of his contacts in the voluntary sector and in government. He approached a former colleague in the Army Medical Corps, Dr D. J. Mackintosh, who was a member of the Voluntary Hospitals Liaison Committee in Scotland to speak to the undersecretary of state in Scotland, Walter Elliot, who was a close political supporter of the British minister for health. Neville Chamberlain as Westminster health minister was also anxious to expand the service. (79)

Mackintosh intervened to reassure the minister that the plans for Glasgow were not a threat to the independence or livelihood of the voluntary hospitals. Macgregor knew that he was in a strong position in co-opting Mackintosh and also in approaching Elliot, whom he had known since starting his professional career as a doctor at the Glasgow Royal Infirmary. Elliot supported the campaign for new provisions to bring Scottish Councils closer to the English model and quickly drafted amendments for the third reading of the Bill for Scotland in January 1929. (80)

In the effort to alter the Bill we see the interaction of the local authorities, Scottish Office and Westminster and the municipal MOH for Glasgow in particular in shaping policy through a network of contacts. Macgregor was able to utilize the considerable leverage that came through association

not only with political figures such as Elliot but also through contacts in the voluntary hospitals, which was crucial to the outcome as he understood that preservation of the independence of the voluntary sector was a key policy aim of the Conservatives. In fact, this view was shared across the political spectrum. This prominence in political circles emphasizes the leading role taken by Glasgow in shaping national priorities. Allaying the anxieties over this issue was key to acceptance of a revision of the Bill and the introduction of clauses to allow expansion of access. Also, it is important to acknowledge the role of the town clerk's office in the Corporation of Glasgow. It had drafted the original version of the amendments and had lobbied for them; when Mackintosh had approached Elliot he had taken a copy of them with him. (81) In their 2007 article Taylor, Stewart and Powell included the town clerk's office as an important component in policy-making and implementation in the municipal hospital service in England. Here we see it active in policy formation in the Scottish context. (82)

Although the Scottish Act was essentially a duplicate of a similar piece of legislation for England and Wales relating to the organization of local government and de-rating, the health clauses were a major departure from its Westminster sibling. Arguably in terms of eligibility for treatment and admission to hospitals, it is little short of an attempt to overcome the stigma of pauperism. In fact Walter Elliot declared that the changes were 'the break up of the Poor Law' and a 'wide extension of hospital facilities and provision other than those of the Poor Law'. (83) However, Emanuel Shinwell for Labour was not convinced by the choice of language: 'abolition or does he mean redistribution?' (84) The Parliamentary Labour Party was also concerned that the new clauses would lead to a new means test. John Wheatley, former housing minister and MP for Shettleston, was concerned at the possibility of two separate classes of hospitals inside one municipal authority: 'on the one hand infectious diseases hospitals which serve every one, and on the other the Poor Law hospitals which only serve those covered by Poor Law legislation'. (85) In summing up the debate and recommending the Bill to the House, Sir John Gilmour set out his vision of the service: 'I visualise, in a great city like Glasgow the development in the future of this hospital service. More and more in my judgement there will come into the paying wards of these hospitals the classes of the people of Glasgow who hitherto have not gone to hospital.' (86) Gilmour's view was very much in keeping with that of the Consultative Committee, which had reported a decade earlier that the service would be a partnership between existing providers with government only creating a framework.

Macgregor concluded: 'We expected that we would now be able to treat the sick under the Poor Law acts, and to remove the Poor Law disability.' (87) His main objective had been achieved:

authorization by central government for the new public health authority to reconstruct and expand the general service outside of the regulations of the Poor Law.

The 1920s had seen a considerable shift in the ideology of public welfare in the United Kingdom. Government had come to terms with the redefinition of 'state medicine', had accepted the idea of a 'complete' service, and had eventually acted to unify the parish and county/burgh councils. It did not, however, decide actively in favour of alternative views of social security, between national insurance and the Poor Law. Many insured people and their families were left in a limbo between National Insurance and Poor Law Acts. (88) The health clauses of the 1929 Local Government (Scotland) Act driven through the activity of the Glasgow MOH did allow a concession to the local authorities to treat all classes in Poor Law hospitals, but this was at the discretion of the authority and the sanction of the Board of Health.

VIII

The 1929 Local Government (Scotland) Act came into force on 15 May 1930. With it the Corporation of Glasgow, in addition to its previous responsibilities, took over the functions of the old Glasgow School Board and the Poor Law Parish Council. The MOH in Glasgow, Alexander Macgregor, saw his own department swell with the assumption of responsibilities for the medical inspection of schoolchildren, the general hospital service and the services for the mentally ill. (89) The Corporation of Glasgow took over the running of fourteen hospitals previously the responsibility of the Poor Law Authorities. (90) In all, the 1929 Local Government (Scotland) Act added 6,362 beds and over 2,000 staff members to the city complement of 3,067 beds in the fever hospitals, making an overall balance of 9,429 municipal health beds. (91) The unification of the corporation and Poor Law medical services promised a more coherent strategy for the treatment of the sick in the city of Glasgow. To facilitate even greater cooperation in 1932, a unique partnership was created when the six Glasgow medical societies brought together all the organizations in charge of health provision in the city, including the voluntary sector in the city and formed a 'subcommittee for Hospitals'. (92)

The MOH in Glasgow had with the implementation of the 1929 Local Government (Scotland) Act the authorization to change the approach of the city towards the hospital service. The city could in theory allow almost anyone who desired treatment to gain access to some form of inpatient facility in the municipal service for a modest fee. In 1929 the Corporation did not simply gain access to new buildings but also had to come to terms with a responsibility that increased threefold.

The city had to maintain the service that it had nurtured in the infectious diseases sector, its new responsibility for the Poor Law hospitals and the mental health service. Further to this the council had to balance the achievement of access to new services whilst taking care not to tread on the toes of the politically influential voluntary sector.

To achieve these ambitious objectives four parallel strategies were put in place. First, there was to be a reorganization of the service that aimed to move those who were not chronically ill but who were the responsibility of the Corporation, such as the elderly or mentally ill, to specialized accommodation to free up general hospital bed space. The second strand was to expand the range of treatments available to the so-called ordinary ill, for example non-paupers. The third strand was to put together an admission strategy that was flexible and in line with the new opportunities, but that was realistic enough to recognize the shortcomings of what could be provided in terms of bed numbers and available services. The fourth strand was liaison with the voluntary sector. In each case there were problems that acted to undermine the grand design of Macgregor. Reorganization was to be hampered by the sheer scale of the task and lack of existing alternative facilities, forcing the city to make more capital investment. The expansion of treatment was to be similarly expensive, as there was the need to hire specialist staff, invest in new technology and revamp operating theatres amongst a myriad of other tasks to bring the Poor Law general hospitals up to scratch. The admission system was to be stretched to the limit not just by the new section 27 patients but also by the unexpected numbers of people who literally turned up at the gates of the Corporation hospitals needing treatment. Cooperation with the voluntary sector was also to prove difficult as there was the issue of payment for treatment, as the study of maternity service will demonstrate.

The first task was reorganization, but almost immediately there was an unexpected problem: demand for the municipal health service went up by one third between 1931 and 1933 from 22,142 to 30,384 patients per year. This was a result of increased unemployment in the city and a consequential rise in numbers eligible for public assistance and therefore entitled to free access to the municipal general hospitals. The main consequence of this rise was that the newly acquired general hospitals were seriously overcrowded, making the main preparatory task for expanding admission more problematic. The MOH had to find accommodation for many elderly people and destitute children who were occupying acute bed space. At any one time as many as 2,400 beds were occupied by 'Poor Law non-sick inmates', (93) which deprived the city of the capacity either to use them for the chronic sick or to introduce new working practices. A first step in the relieving of this problem was to shift as many elderly patients as possible to more suitable accommodation.

Arrangements were made to transfer many of the 'main problem' (94) infirm elderly to the 324-bed Barnhill Poor-house (renamed Forresthall Hospital) and the Lightburn Hospital in Carntyne. This was made possible by the opening of the Lennox Castle hospital for the mentally deficient in 1935. (95) For able-bodied children the Corporation benefited from a bequest to build the Marion Reid Children's home on the grounds of Stobhill Hospital, providing 440 places by 1936. But this still left over 1,000 patients in beds that the MOH had hoped to earmark for the specialist treatment of the ordinary ill.(96)

Aggravating the situation was provision for the mentally ill, which in Glasgow was in many respects very poor, both for those who were congenitally disabled (described in the vernacular of the day as 'feeble-minded') and those who became insane through illness. Again overcrowding was the main concern. In 1930 the Corporation of Glasgow took control of the Glasgow Parish Council Poor Law asylums, giving the city in total responsibility for 3,929 domiciliary beds and 188 observation beds (mainly for homicidal or suicidal patients). (97) A report commissioned by the MOH in 1931 outlined the principal reasons for the accommodation shortage. Part of the problem of the mental hospitals was the low turnover of patients: in 1931 only 138 new patients were admitted to the 1,252-bed Woodilee Hospital and fewer than 100 were discharged. (98) Alongside such a low turnover of patients there was also increasing demand as the population grew and those domiciled in mental health facilities living longer, all of which placed a greater strain on the system. The inability to create an effective regime for care in the hospitals was a continual frustration for the administrators. With an acute shortage of space other aspects of care were put under threat. The Corporation had assessed the acceptable bed space for each patient at 90 square feet, but the actual space was less than 50 square feet.(99) The MOH could not oversee the introduction of a more modern care system under such conditions.

In addition to the problems in overcrowding there was the shortage of facilities for nursing staff, especially for females, a situation described by the MOH as 'unacceptable'. (100) The Public Health Committee decided to act as quickly as possible on these two issues. It recommended the expansion of existing hospitals at Gartloch and Hawkhead by 200 beds each and the construction of two 120-bed nurses' homes at the same hospitals. (101) It moved 150 senile elderly from the general hospitals to Lightburn Hospital. The MOH then moved 130 'mental defectives' from Carntyne to Lennox Castle. (102) The Hawkhead expansion was started in 1934 and completed in 1936, but the Gartloch expansion was delayed by financial problems and not commenced until 1937. The nurses' homes were built and in use in the hospitals by 1936.

The Corporation had discovered that it was inheriting a system that had been near to collapse for some considerable time. As far back as 1914 a report by the Glasgow Parish Council had noted that the Woodilee Hospital was 'taxed to the uttermost capacity', (103) and from 1917 'portions of wards not originally meant for hospital wards, and not suited to the purpose, have had to be utilised.' (104) Minor improvements had been introduced in the 1920s by the parish at Woodilee, but with 'No fewer than 259 patients confined to bed [the Asylum] has exceeded the limits of safety' and 'No part of the Asylum or the extensive additions made to it, supply suitable accommodation according to modern ideas.' (105) A similar picture could be found elsewhere. The mental hospital superintendents had to rely upon the boarding out of patients to ease overcrowding; every year around 400 inmates were transferred as far afield as Lochgilphead in Argyll and Kinross in Perthshire. (106)

The first strand in the Macgregor plan for reorganization was therefore hindered by a number of factors: an elderly and dilapidated infrastructure; lack of alternative resources, which meant that fewer Poor Law non-sick inmates were transferred out of the general hospitals; and unexpectedly high growth in the numbers of Poor Law patients caused by the economic slump of the 1930s.

The second strand was the expansion of specialist care. The Poor Law hospitals had dealt with mainly general medical and surgical cases, but in the mid-1930s the Public Health Committee wanted to see greater provision for ear, nose and throat surgery (ENT). An additional priority was to accommodate for the growth in the population of the city and to make the general service grow in combination with it. Help from the voluntary sector did not materialize as anticipated by the government in 1929, as the sector was facing a major cash crisis of its own and extra capacity was devoted to fee-paying patients rather than assisting in the plans of the Corporation. Adding to the demands of expansion was the adoption in 1931 of a maximum 48-hour week for nurses. This would have a significant impact on staffing levels. In Stobhill Hospital alone it would mean a rise in the number of nurses from 389 to 550. (107) So with little in the way of opportunity to gain access to the much-needed facilities of the voluntary sector and new obligations in terms of staff workload, the expansion of specialist care was undermined.

A further factor hindering specialism expansion was the problem of bed-blocking. In 1937 the Corporation MOH had reported that 'the pressure on the general medical beds has made it impossible to give due regard to the growing requirements of the several specialities.' (108) Out of

the 3,356 beds in use over 1,800 were used for general medical and surgical cases. (109) Only 760 were used for specialist areas such as ENT, dermatology and gynaecology. (110) The voluntary hospitals had made great strides in diversifying treatment, as the Victoria Infirmary had opened the first orthopaedic department in Scotland in 1930 and in 1934 a department of urology. (111) The Corporation in 1937 decided to expand the number of general hospitals with the building of a new 1,000-bed hospital to feature enhanced provision for speciality surgery, and to help see Glasgow through the projected growth in both population and the elderly acute sick. (112) Unfortunately it was never started as with war appearing to be likely all capital projects in the city were frozen. Without specialization the municipal service could not hope to move towards a comprehensive service offering treatment for a variety of conditions or attract senior medical staff to operate in them.

The third strand and arguably the key to a comprehensive system was admission strategy. The winning of concessions from the undersecretary of state, Walter Elliot, on admission to municipal general hospitals had been a major coup for Macgregor. But to open up the system also demanded a rationalization of categories of admission. There were three different categories of patients in the Glasgow municipal general hospital service: Poor Law patients, Section 27 patients and gate admissions. The first two were relatively easy to administer, but the variable in the equation was gate admissions – literally those who turned up at the hospital entrance. They were to expose the problems of a semi-official open system. The admission strategy was neither comprehensive nor fully selective; it could offer care to as many as possible but not to everyone, and could not recoup money very easily, as those who went to the municipal sector were quite often those with neither insurance nor employment. The voluntary sector could claim money from national insurance; this imbalance is exemplified by the experience of the municipal maternity services. In the end the admission strategy was confused and patchy, but it did show the potential of the municipal service as a comprehensive provider.

The regulations that governed the Glasgow system were explained in 1932 with the publication of the Notes on Hospital and Infirmary Arrangements in Glasgow:

The General hospitals are intended for the treatment of the sick poor, and applicants for relief under the Poor Law Acts have therefore primary claim on all accommodation. After the needs of those in receipt of public assistance have been met, however, any surplus accommodation may be available for those other than poor persons and their dependants. (113)

This was a significant proviso as it allowed the Corporation to treat almost anyone who could gain a certificate from a GP. Continually the MOH in Glasgow would explain the admission policy of the Corporation by recalling the words of the Consultative Committee on Medical and Allied Services from 1920: 'a complete and adequate medical service should be brought within the reach of every member of the community.' (114) The development of the strategy on admissions is the key to understanding the municipal service in the 1930s and Macgregor's ambition to expand the reach of the Corporation hospitals to those who did not have insurance and did not want to go on the Poor Law roll.

Over 40 per cent of admissions annually to Glasgow municipal general hospitals were through doctors' certificates (10,450 in 1935–6, up to 13,146 in 1937–8). Under the 1911 National Insurance Act, an insured person received the costs of medical examination by a GP, but not the cost of treatment. GPs simply sent poorer national insurance patients directly to the municipal general hospitals; 3,520 patients presented themselves for treatment at the gates of the main hospitals in 1937–8. (115) The Western District Hospital in the north-west of the city and the Eastern District Hospital on Duke Street, both of which bordered some of the most deprived areas of the city, accounted for 80 per cent of gate admissions. The gate admissions cut into the core of the health provision inconsistencies in the 1930s. Ideally, if regulations were enforced they would all have to be turned away, but the health service was more than a simple system dictated by bureaucracy. Professional concern and compassion played its role, as Macgregor explained in his report of 1935: 'These patients are admitted because of a reluctance on the part of medical officers to accept the responsibility of turning away any sick person.' (116)

The fourth strand of the Corporation strategy was cooperation with the voluntary sector. In this it was building on existing arrangements. Before 1930 Glasgow had a number of joint ventures to promote better access; there was the unified admissions strategies between the municipal and Poor Law sectors (already cited), but there was also the arrangement between the Poor Law and voluntary maternity services. In 1925 an arrangement was reached between the Poor Law Stobhill Hospital and the voluntary Glasgow Royal Maternity Hospital. In return for space at Stobhill being used for the overspill of patients from the Royal Maternity, the Poor Law authority was paid for its services from the funds of the voluntary hospital. This was looked upon by the Scottish Board of Health as 'an important step in the development of the hospital service' in Scotland. (117)

The positive coordination seen in the case of Stobhill was only one aspect of the experience of cooperation in the maternity sector. The 1938 report by the Medical Superintendent of the Southern General Hospital pointed out that a large number of gate admissions were women in various stages of labour. (118) The Public Health Authority had as part of its remit both antenatal and postnatal inspection, but neonatal care was the remit of two bodies; the majority went to the voluntary sector, but those who qualified under the Poor Law went to the 450 beds spread around the main general hospitals. The trend in midwifery throughout the 1920s and 1930s was towards hospital-based births and away from women giving birth at home. The Central Midwives Board regulations of 1931 began the development of a coherent approach to antenatal care. Like the admissions system the National Insurance Acts helped to encourage better health but penalized the public sector. The Royal Maternity Hospital took in anyone in labour who presented herself; it knew it could claim back on treatment through provisions for maternity care under the National Insurance Acts and, as at Stobhill, make use of its excess capacity. When it had no space it decanted those patients without insurance to the public sector. This prompted the MOH in 1936 to note that 'true co-operation between the institutions is in practice not at all easy unless they have the same financial basis in their transactions with patients.' (119) The MOH tried in 1937 to reach some agreement over remuneration with the voluntary sector, but nothing concrete emerged. (120)

The MOH in Glasgow in his annual report of 1936 taking account of all of the recent developments in admission policy arrived at an important conclusion: 'The hospitals are thus being used to a very considerable extent by the general public apart from the ordinary poor of the city.' (121) Macgregor saw the system that emerged as near to the ideal of a 'complete hospital service' which he had sought to introduce. (122) The general hospital service could point to the fact that it was treating 1,500 more patients per day than in 1930 through better management of the stock of beds and some increase in capacity. There were arrangements for cooperation between the local authority and the voluntary sector and these had the blessing of central government.

IX

Ultimately Glasgow, despite these great efforts and some notable achievements, was not able truly to bring 'an adequate medical service . . . within the reach of every member of the community'. Despite the ambitions of both the MOH and the Department of Health in Scotland, the municipal hospital service was still largely devoted to the tasks that had been set for it prior to 1929. The infectious diseases hospitals were still almost exclusively for the treatment of the same maladies

that they had been built to deal with in the last years of the nineteenth century. Despite attempts at rationalization and reorganization under municipal control the Poor Law hospitals were still filled with the non-sick poor, their facilities still inadequate and resources limited. There had been some progress towards greater access and better treatment for the 'ordinary ill' with the health clauses of the 1929 Local Government (Scotland) Act and investment by general hospitals in new surgical facilities, but this was still short of expectations as capital investment largely went into remedial efforts to repair the dilapidated infrastructure of the city. There was some evidence that cooperation across the public and private health sectors could work to the benefit of not only the patient but also the financially struggling voluntary hospitals. However, as the example of the coordination of maternity services demonstrated, there were anomalies that put the municipal sector at an economic disadvantage. The persistence of poverty, bad housing and high unemployment in the city created overwhelming demands on its municipal hospitals, while access to the voluntary hospitals was limited, leading to the denial of the sorts of treatment that could offer a better quality of life or relief from chronic pain to the vast majority of Glaswegians. There were no antibiotic treatments and vaccination programmes, which when they became available in the post-Second World War years helped to free up large swathes of capacity of NHS hospitals to treat the ill. For example, in 1930 there were 4,497 cases of scarlet fever which required hospitalization in Glasgow for on average forty-three days; in 1954 there were just 845 inpatient cases with the average stay just eleven days. (123) The ambition of a local authority based health care system without the 'stigma of the Poor Law' was arguably never fully realizable in such conditions.

Irrespective of these considerable difficulties the Corporation of Glasgow made a series of significant contributions to the advancement of the cause of 'comprehensiveness'. First, the very size of the city's health infrastructure made it a major player in deciding national priorities as the intervention of the MOH and the Corporation in 1929 was to demonstrate. Second, it provided evidence that local authorities in Scotland could manage successfully an enlarged public health service. There is no indicator of the system failing, or that a regionally based service was inherently weak. Glasgow offered one model of a comprehensive service, amongst many alternatives. Scotland was arguably unique in that it had such a multiplicity of approaches to provision such as the Glasgow model and the pseudo-nationalized service in the Highlands and Islands, and models of cross-authority cooperation such as in the north-east of Scotland. Third, Glasgow was to demonstrate that successful provision was partly based on effective management of existing resources through centralization of specialties such as paediatric and geriatric services to release bed space and facilities. Finally Glasgow's experience emphasized that essentially future public health progress

could only be assured through a dynamic admission strategy that was fully inclusive to all those who were sick, not just paupers or the well-off.

1 A Scheme of Medical Services for Scotland (1920), Cmd. 1039 Clause 10.

2 Report of the Hospital Services (Scotland) Committee (1926), p. 6.

3 See for example A. Levene, M. Powell, J. Stewart, and B. Taylor, *Cradle to Grave: Municipal Medicine in Inter-war England and Wales* (Oxford, 2011), pp. 13–17.

4 S. Cherry, *Medical Services and the Hospitals in Britain, 1860–1939* (Cambridge, 1996); J. Welshman, *Municipal Medicine: Public Health in Twentieth Century Britain* (Oxford 2000).

5 A. Levene, M. Powell and J. Stewart, 'Patterns of municipal health expenditure in inter-war England and Wales', *Bulletin of the History of Medicine*, 78 (2004), pp. 635–69; M. Gorsky, J. Mohan and M. Powell, 'The financial health of voluntary hospitals in inter-war Britain', *Economic History Review*, 55/3 (2002), pp. 533–57; J. Welshman, 'The Medical Officer for Health in England and Wales, 1900–1974: watchdog or lapdog?', *Journal of Public Health Medicine*, 19/4 (1997), pp. 443–50; M. Gorsky, 'Local leadership in public health: the role of the Medical Officer for Health in Britain, 1872–1974', *Journal of Epidemiology and Community Health*, 61 (2007), pp. 468–72.

6 J. Stewart, '“The finest municipal hospital service in the world”? Contemporary perceptions of the London Council's hospital provision, 1929–39', *Urban History*, 32/2 (2005), pp. 327–44; B. Doyle, 'Competition and cooperation in hospital provision in Middlesbrough, 1918–1948', *Medical History*, 51 (2007), pp. 337–56; M. Gorsky, 'The Gloucestershire extension of medical services scheme: an experiment in the integration of health services in Britain before the NHS', *Medical*

History, 50 (2006), pp. 491–512; M. Gorsky, ‘Threshold of a new era: the development of an integrated hospital system in northeast Scotland, 1900–1939’, *Social History of Medicine*, 17/2 (2004), pp. 247–67.

7 Levene et al., *Cradle to Grave*.

8 A. Levene, M. Powell and J. Stewart, ‘The development of municipal general hospitals in English county boroughs in the 1930s’, *Medical History*, 50 (2006), pp. 3–28; B. Taylor, J. Stewart and M. Powell, ‘Central and local government provision of municipal medicine, 1919–39’, *English Historical Review*, 122 (2007), pp. 397–426.

9 I. Levitt, *Poverty and Welfare in Scotland* (Edinburgh, 1989).

10 M. McCrae, *The National Health Service in Scotland: Origins and Ideals. 1900–1950* (East Linton, 2003).

11 O. Checkland and M. Lamb (eds), *Public Health as Social History: The Glasgow Case* (Aberdeen, 1982); G. McLachlan (ed.), *Improving the Common Weal* (Edinburgh, 1987).

12 A. S. M. Macgregor, *Public Health in Glasgow* (Edinburgh, 1967)

13 J. Jenkinson, *The Royal: The History of Glasgow Royal Infirmary, 1794–1994* (Glasgow, 1994);

L. McQueen, *The Western Infirmary, 1874–1974: A Century of Service to Glasgow* (Glasgow, 1974);

S. Slater and D. Dow, *The Victoria Infirmary 1890–1990* (Glasgow, 1990).

14 The main exception being Rona Gaffney’s study of the Poor Law Hospitals in Checkland and Lamb (eds), *Public Health as Social History*, pp. 44–59.

15 See for example J. Stewart, ‘“For a healthy London”: the Socialist Medical Association and the London County Council in the 1930s’, *Medical History*, 42 (1997), pp. 417–36.

16 Maxton was to feature in a number of the debates on public hospitals in the inter-war period, but his most important contribution was a 1922 pamphlet, *The Labour Movement and the Hospital Crisis*, which was the basis of his contribution to the public inquiry on the hospital services in Scotland that became the Mackenzie Report. See *British Medical Journal*, 1 (1925), p. 280. Dollan, according to Macgregor, was an enthusiastic backer of expanding the hospital admission strategy of the corporation. See Macgregor, *Public Health in Glasgow*, p. 140.

17 Levene, Powell and Stewart, ‘The development of municipal general hospitals in English county boroughs in the 1930s’, p. 13.

18 Scottish Board of Health, *Annual Report for 1920* (London, 1921), p 321.

19 Department of Health for Scotland, *Tenth Annual Report* (1939), pp. 71–2.

20 Scottish Board of Health, *Annual Report for 1920*, pp. 294–316.

21 <http://www.visionofbritain.org.uk/data_cube_page.jsp?u_id=12834676&data_theme=T_WK&data_cube=N_LUI_UNEM_PERCENT&add=N>, accessed 6 Sept. 2012.

- 22 Department of Health for Scotland, Tenth Annual Report, p. 161.
- 23 McCrae, *The National Health Service in Scotland*, p. 1.
- 24 Scottish Board of Health Act (9 Geo. V) (London, 1919), clause 2
- 25 Report of the Committee on Scottish Health Services (1936), Cmd. 5204.
- 26 Ministry of Reconstruction Local Government Committee, Report on the Transfer of Functions of Poor Law Authorities in England and Wales (London, 1918), Cmd. 8917.
- 27 J. Brotherston and J. Brims, 'The development of public medical care 1900–1948', in G. McLachlan (ed.), *Improving the Common Weal*, p. 60.
- 28 *Ibid.*, p. 60.
- 29 A Scheme of Medical Services for Scotland (London, 1920), Cmd. 1032, clause 1.
- 30 *Ibid.*, clause 2.
- 31 *Ibid.*, clause 3.
- 32 *Ibid.*, clause 2.
- 33 *Ibid.*, clause 3.2.
- 34 McCrae, *The National Health Service in Scotland*, p. 102.
- 35 *A Scheme of Medical Services for Scotland*, clause 3.2.
- 36 *Ibid.*, Clause 5.
- 37 For a good commentary on this debate see Brotherston and Brims, *The Development of Public Medical Care 1900–1948*, pp. 60–2.
- 38 *A Scheme of Medical Services for Scotland*, clause 10.6.
- 39 *Ibid.*, clause 10.6.
- 40 *Ibid.*, clause 34.
- 41 Levitt, *Poverty and Welfare in Scotland*, p. 153.
- 42 The role of the working men's committee and union contributions is discussed in Slater and Dow, *The Victoria Infirmary 1890–1990*, pp. 44–50.
- 43 John Stewart, 'For a Healthy London': The Socialist Medical Association and the London County Council in the 1930s', *Medical History*, 42 (1997), pp. 417–36.
- 44 *Third Annual Report of the Department of Health for Scotland* (Edinburgh, 1931), p. 77.
- 45 See annual reports *passim* 1929–39.
- 46 *A Scheme of Medical Services for Scotland*, Clause 10.6.
- 47 J. Bell and J. Paton, *Glasgow, Its Municipal Organisation and Administration* (Glasgow, 1896), p. 186.
- 48 *Ibid.*, p. 190.
- 49 A. S. Wohl, *Endangered Lives* (London, 1984), p. 140.

- 50 A. K. Chalmers, *Public Health in Glasgow* (Glasgow, 1930), p. 159.
- 51 *Public Health (Scotland) 1897*, CH.38 (1897), clause 66.
- 52 The Robroyston Hospital was originally built as a smallpox hospital but the use by the military of the hospital had extended its original 400 beds to nearly 600.
- 53 *Report on the Hospital and Nursing Services, Scotland* (London, 1918), Cmd. 699, p. 19.
- 54 *Ibid.*, col. 1039.
- 55 *Ibid.*, col. 1033.
- 56 *Ibid.*
- 57 *Medical Officer for Health, Annual Report 1918*, p. 8.
- 58 *Report on the Hospital and Nursing Services, Scotland*, p. 8.
- 59 *Ibid.*
- 60 *Ibid.*
- 61 O. M. Watt, *Stobhill Hospital, the First Seventy Years* (Glasgow, 1971), p. 30.
- 62 *Ninth Report of the Scottish Board of Health* (Edinburgh, 1928), p. 340.
- 63 *National Insurance Commission*, p. 19.
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- 65 Macgregor, *Public Health in Glasgow*, p. 136.
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- 68 *Seventh Report of the Scottish Board of Health* (Edinburgh, 1926), p. 265.
- 69 MacKenzie Committee. *Scottish Consultative Council, A Reformed Local Authority for Health and Public Administration* (Edinburgh, 1926).
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- 94 MOH Report 1937, p. 8.
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117 Seventh Report of the Scottish Board of Health, p. 264.

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120 Macgregor, Public Health in Glasgow, p. 73.

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123 'Report of the Western Regional Hospital Board 1954', quoted in Macgregor, Public Health in Glasgow, p. 32.