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The politics and ideology of local authority health care in Sheffield 1918-1948

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**The Politics and Ideology
of Local Authority Health Care in Sheffield
1918-1948**

Timothy James Willis

A thesis submitted in partial fulfilment of the requirements of
Sheffield Hallam University
for the degree of Doctor of Philosophy

September 2009

Abstract

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This thesis examines local authority health policy in Sheffield from 1918 to 1948. Sheffield was the first British city to elect a Labour Council in 1926. The Sheffield Labour Party pursued a policy of municipal socialism campaigning on a platform of service provision to include housing, health, education and transport. Health and hospital policies were closely related. In hospital policy the Council operated within a mixed economy of health care to provide a municipal general hospital service. Voluntary hospitals in Sheffield relied on a contributory hospital scheme after the First World War and sought and received the support of the Labour movement. Before the introduction of the NHS the health and hospital services of the city operated as a system that featured a mix of pragmatism and ideology.

The thesis argues that the role of politics and ideology has been overlooked in the history of British social policy. Government files relating to health policy and local government have been used as well as professional journals, local and national newspapers, Council Committee minutes, records of the Sheffield Labour Party and the records of the Sheffield Joint Hospitals Council. The work aims to offer a more detailed and more nuanced understanding of the development of local authority health policy in Sheffield before the NHS, than has previously been available.

The case study examines how local social, cultural and political factors influenced the provision of health care. The work contributes to debates on the role of the Medical Officer of Health in the interwar years. The Sheffield example also illustrates how local actors and groups sought to address problems of finance and access in health care using the available policy instruments at a time when health services were locally controlled.

The Politics and Ideology of Local Authority Health Care in Sheffield 1918-1948

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Portraits of Frederick Wynne, Medical Officer of Health Sheffield, 1921-1930 and William Asbury, Chairman of Sheffield County Borough Council Health Committee 1926-1942. Source; *The Royal Sanitary Institute, Fortieth Congress, Sheffield, 13-20 July 1929, Delegates Handbook.*

Ward boundary map of Sheffield, Source *Sheffield Daily Independent*, 30 January 1929.

Abbreviations used in the text

AEU	Amalgamated Engineering Union
BCG	Bacille Calmette-Guerin
BHA	British Hospitals Association
BMA	British Medical Association
DPH	Diploma in Public Health
EHS	Emergency Hospital Service
GP	General Practitioner
JHC	Sheffield and District Joint Hospitals Council
LGA	Local Government Act
LGB	Local Government Board
MB ChB	Bachelor of Medicine and Surgery
MCW	Maternity and Child Welfare
MH	Ministry of Health
MOH	Medical Officer of Health
MRC	Medical Research Council
MRCP	Membership of the Royal College of Physicians
NHS	National Health Service
NPHT	Nuffield Provincial Hospitals Trust
PAC	Public Assistance Committee
PEP	Political and Economic Planning
PHC	Public Health Committee
PRO	Public Record Office
S&DAHC	Sheffield and District Association of Hospital Contributors
SCA	Sheffield City Archives
SMO	School Medical Officer
SMS	Schools Medical Service
STLC	Sheffield Trades and Labour Council
SWWC	Sheffield Women's Welfare Clinic
TB	Tuberculosis
VD	Venereal Disease
WSI	Woman Sanitary Inspector

The Politics and Ideology of Local Authority Health Care in Sheffield 1918-1948

Introduction

Municipal medicine in the twentieth century is an under-researched area. This thesis examines local authority health policy in Sheffield from 1918-1948. The remit of local councils then was vastly wider than it is now. As Jerry White has stated 'whole spheres of public life were owned and managed locally that are now seen as entirely the province of national government or the private sector.'¹ The introduction of the NHS in 1948 effectively ended the operation of local democracy in health care provision. The need to defend local government as a vital aspect of the national democratic heritage began in the 1940s.² The early twentieth century saw a growth in borough power, with the 1930s in particular singled out as 'the zenith of local government'.³ Health services and hospitals were key aspects of this expanding remit. Two major policy initiatives, nationalisation and privatisation, have weakened the power of local government.

By international comparisons, local government in Britain is distinctive precisely because the central state holds the upper hand. The practice of the doctrine of *ultra vires* has meant that in Britain central government has had a very high degree of penetration into the machinery of local government. Central government has decided which services local government is allowed to provide and held the executive authority to alter the role of local government as it sees fit. Central control has increasingly dominated local decision making, a process that started in earnest from the middle of the twentieth century. The history of health policy in the twentieth century illustrates this key aspect of the British polity. The three decades before 1948 were an era when local politics and local decision making were significant factors in shaping health policy.

¹ J. White, 'From Herbert Morrison to command and control: the decline of local democracy', *History and Policy*, (2004), 1-12, historyandpolicy.org/papers/policy-paper-18.

² W.A. Robson, *The British System of Government* (British Council, Longman, London, 1940).

³ J.M. Mackintosh, *Trends of Opinion About the Public Health, 1901-1951* (Oxford University Press, London, 1953), 106.

The creation of the National Health Service in 1948 was a revolutionary step in social policy, marking the introduction of tax-funded health provision that was famously universal, comprehensive and free at the point of use. The road to 1948 was a long and a winding one. Alternative proposals for health service reform based on local government or social insurance principles were considered and rejected before the settlement of 1948. Ultimately a universal health service in Britain meant a nationalised health service where power was centralised in the hands of the Minister of Health and where the day to day running of the health service was overseen by regional health authorities, bodies that were deliberately devised to be independent of local government.

The Ministerial decision by Aneurin Bevan to nationalise the country's hospitals meant that power was drawn from local control on two fronts. Voluntary hospitals that had been traditionally run as charitable concerns under boards of governors were taken over by the state at the same time that local authorities lost many of their health care roles, including running municipal hospitals. In the years before the 1946 NHS Act, municipal health care expanded and a number of local authorities developed their former Poor Law hospitals into fully functioning municipal general hospitals under the Local Government Act of 1929.⁴ Charles Webster has remarked how local authorities controlled 72,500 general hospital beds in England and Wales by 1938 and how the health care work of local government 'had expanded to such a degree that this system was already occasionally called a national health service in policy discussions.'⁵

This study examines the manner in which one northern County Borough Council exercised the power it held over health policy in an era when local government played a far more significant role in the provision of health services. The work is an attempt to understand the ways in which locally specific social, cultural and political processes influenced the style and content of services delivered by elected representatives operating in conjunction with appointed officials. In theory, local government officers such as the Medical Officer of Health, the Medical Superintendent of the Municipal Hospitals and the Town Clerk were subordinate to the wishes of the Council and its

⁴ M.A. Powell, 'An Expanding Service: Municipal Acute Medicine in the 1930s', *Twentieth Century British History*, 8, 3, (1997), 360-379.

⁵ C. Webster, *The Health Service Since the War, Volume 1: Problems of Health Care: The National Health Service Before 1957* (H.M.S.O. London, 1988), 6, 8.

committees, yet long standing officials could wield considerable power. The complex relationship in local authority health policy between elected representatives and appointed officials was summarised by the Medical Officer of Health for Bradford, John Buchan in 1929:

Public Health is a branch of medicine, and its practice is to be carried out under the advice of a special kind of medical practitioner, but the control of all its activities lies in the hands of the elected representatives of the people, who are almost without exception at the beginning of their period of representation, ignorant of the health functions of the body to which they have been elected. Vicissitudes in Party fortune change the personnel of these bodies rapidly, and it is no easy task without something more than needed knowledge to maintain continuity of effort in a service so recently developed as that of public health.⁶

As the first English city to elect a Labour Council, Sheffield was under scrutiny from commentators and the national press, particularly as the first Labour Council was elected in 1926, the same year as the General Strike. Sheffield was a highly industrialised city, with a peculiar class structure for a city of its size - half a million people. A strong network of well supported working class organisations operated in Sheffield while civic middle class associational life was a much less significant factor than it was in other towns and cities.⁷ The thesis therefore examines how a Labour administration attempted to implement a municipal socialist policy through health and housing reform for a working class city, a policy which could lead to conflict with medical officials and with the central state. The notion of 'municipal socialism' has been a key element of the political history of Sheffield. In the telling and re-telling of the city's history, the Labour movement has been keen to represent the city as a bastion of municipal socialism.⁸ The term 'municipal socialism' is a problematic one standing as it does for the general expansion of civic responsibilities and services that took place from

⁶ John Buchan, the Medical Officer of Health for Bradford, 'Presidential address to the Society of Medical Officers', *Medical Officer*, 7 September, (1929), 103.

⁷ For middle class associational life in Norwich see B. Doyle, 'The Structure of Elite Power in the Early Twentieth Century City: Norwich 1900-1935,' *Urban History*, 24, (1997), 179-199.

⁸ See Sheffield Labour Party, *Six Years of Labour Rule* (Sheffield, 1932), Sheffield Labour Party, *Forty Years of Labour Rule* (Sheffield (1966), J. Mendelson, (et al), *The Sheffield Trades and Labour Council, 1858-1958* (Sheffield, 1958). D. Blunkett, and K. Jackson, *Democracy in Crisis the Town Halls Respond*

around 1900, as well as marking a left wing political agenda. The term was consciously and proudly used by the Sheffield Labour movement in the 1920s and 1930s and stood as a guiding ideology in policy formation and implementation. The popular appeal of 'municipal socialism' in Sheffield was such that for a time the term was appropriated as a positive description of Borough activity in election campaigns by Liberal and Conservative candidates in the early 1920s.

In the period of British history that followed the First World War, the potential strength of working class organisations became increasingly apparent and the need for more active management in the processes of societal change became a key concern of policy makers. Rodney Lowe has characterised the inter-war years in Britain as a period when central government developed social policy through a process of 'adjusting to democracy'.⁹ Referring to the work of T.H. Marshall, Asa Briggs notes that changes took place in the period such that 'within an inegalitarian money economy, there was being established an increasingly egalitarian system of "citizenship", carrying with it full and equal "membership" in the modern community'.¹⁰ The extension of the franchise in 1918, and again in 1928 can be seen as signalling a sea change in British history. New and more democratic notions of citizenship were developing that were accompanied by a complex set of changes that were particularly relevant to social policy. The expansion of local authority health services in these years can be seen as part of this inclusive process of 'adjusting to democracy.' A prime example of this adjustment can be seen in the way in which some towns removed hospitals from the Poor Law and the treatment of only the sick poor and instigated municipal general hospitals for the treatment of all citizens.¹¹ It was not only local authority hospitals that underwent change in the period. The voluntary hospital sector underwent profound structural changes in the inter-war years.¹²

(Hogarth Press, 1987).

⁹ R. Lowe, *Adjusting to Democracy: The Role of the Ministry of Labour in British Politics, 1916-1939* (Oxford, 1986).

¹⁰ A. Briggs, 'The History of Changing Approaches to Social Welfare', in *Comparative Development in Social Welfare* (London, 1972), 20.

¹¹ A. Levene, M. Powell and J. Stewart, 'The Development of Municipal General Hospitals in English County Boroughs in the 1930s', *Medical History*, 50, (2006), 3-28. A. Levene, 'Between Less Eligibility and the NHS: The Changing Place of Poor Law Hospitals in England and Wales, 1929-39', *Twentieth Century British History*, 20, (2009), 285-321.

¹² S. Cherry. 'Beyond National Health Insurance: The Voluntary Hospitals and Hospital Contributory Schemes: A Regional Study', *Social History of Medicine*, 5, 3, (1992), 455-482. S. Cherry. *Medical Services and Hospitals in Britain 1860-1939* (Cambridge University Press, 1996).

Sheffield was one of the places where traditional methods of voluntary hospital finance and governance were transformed in the inter-war years.¹³ Earlier reliance on charitable collections and donations was overtaken in Sheffield by the creation of the Penny in the Pound Scheme, a workers' hospital contributory scheme which operated from 1921 under the direction of the Sheffield Joint Hospitals Council. Contributory hospital schemes collected funds for voluntary hospitals and were generally organised by individual voluntary hospital administrations. The Sheffield Joint Hospitals Council had a very broad social base and included representatives of the Sheffield Trades and Labour Council, the University of Sheffield, local employers, the City Council, the churches, the press and representatives of the contributors. The inclusive nature of the Joint Hospitals Council was central to the success of the contributory scheme. The operation of the scheme increased ideas of entitlement to treatment and allowed arrangements to be made with the municipal sector through the practice of joint working. Co-operation was a characteristic of pre-NHS health services in Sheffield. The four individual voluntary hospitals in the city with their own identities, supporters and trustees were able to work together as a joint operation. At the same time both sides of the hospital divide, the voluntary and the municipal hospital sectors, worked in partnership to deliver medical services for the city.

As the former Chief Medical Officer George Godber pointed out in 1958, contrary to popular belief a wide range of health services were available to the population before July 1948:

It is sometimes suggested that the nature of the medical care available to our population changed abruptly in July 1948. This is quite untrue, since a complete range of medical and allied services was available before the National Health Service was introduced. What the service did was to change the ways in which people would obtain and pay for the care that they needed.¹⁴

This introductory chapter places the analysis of health services in Sheffield from 1918-1948 in context by outlining the existing trends in the history of health policy. It

¹³ M. Gorsky & J. Mohan with T. Willis, *Mutualism and Health Care: British Hospital Contributory Schemes in the Twentieth Century* (Manchester University Press, 2006).

highlights the research gap that has inspired the work and provides a rationale for the case study approach taken. Some existing perceptions of health care in Sheffield before the NHS are examined. And the chapter discusses the elements of political and social policy theory that have informed the research, in particular methods of examining the relationship between ideology and public policy. The chapter goes on to discuss the governance of health care in Sheffield between the wars as an example of the 'mixed economy of health care' and concludes with an outline of the structure of the remaining chapters of the thesis.

The importance of locality in the history of health policy

Until recently the history of local authority health care in the early to mid-twentieth century was very much a neglected topic of inquiry. Historians of medicine tended to overlook the services of local authorities and instead focus on national developments or on the origins and development of voluntary hospitals in the eighteenth and nineteenth centuries.¹⁵ Local authority health care was for a long time equated with a narrow interpretation of the 'Public Health', which was thought of in terms of strictly environmental concerns such as the improvements in sanitation that were made initially under the nineteenth century Public Health Acts. When they were mentioned, local authorities tended to be regarded as the passive recipients of central legislation, as little more than the agency on the ground responsible for the implementation of statutory sanitary measures and as the body responsible for implementing improvements to social housing. Recent work in the history of local authority health care has begun to challenge this perception of passivity.¹⁶ A long overlooked aspect of local government history has been that as well as being responsible for environmental public health measures local authorities in the first half of the twentieth century were increasingly important as the

¹⁴ G.E. Godber, 'Health Services Past, Present and Future,' *Lancet*, 5 July 1958.

¹⁵ E.g. B. Abel-Smith, *The Hospitals 1800-1948: A Study in Social Administration*, (Heinemann, London, 1964); J. Woodward, *To Do The Sick No Harm. A study of the British Voluntary Hospital System to 1875*, (Routledge and Kegan Paul, London, 1974). H. Marland, *Medicine and Society in Wakefield and Huddersfield, 1780-1870*, (Cambridge University Press, 1987).

¹⁶ M. Powell. 'An Expanding Service: Municipal Acute Medicine in the 1930s', *Twentieth Century British History*, 8, (3), (1997), 334-357. A. Levene. 'Between Less Eligibility and the NHS: The Changing Place of Poor Law Hospitals in England and Wales, 1929-39', *Twentieth Century British History*, 20, (2009), 285-321.

providers of acute medical care and therefore significant employers of medical professionals. The dynamics of policy formation in the localities has been under-researched. In the 1980s local variations in health indicators were highlighted in the 'healthy or hungry thirties?' debate. Here historians used national statistics to examine local variations in health trends to make an assessment of the standards of health for the inter-war years.¹⁷ The policy detail of specific places and therefore local authority health services between the wars remained under-researched.

A top-down approach to health policy formulation has dominated, with the focus on events at the national level of politics and policy. Accounts of Ministerial decision making in the memoirs of senior Ministry of Health civil servants covered discussions with elite groups such as the British Medical Association and the Royal Colleges.¹⁸ The result was a historiography of the development of health care in Britain that neglected the importance of grassroots ideas and local policies. The official history of the National Health Service was produced using the records of the Ministry of Health and health care reform was examined from the perspective of senior medical practitioners, the civil service and national politicians. A key debate centred over whether the NHS was the result of a consensus in health reform. The debate drew on national sources which further served to obscure a role for local factors in shaping health policy in the twentieth century.¹⁹ The production of biographies of key players in the creation of the welfare state and the NHS, especially Bevan and Beveridge, added to the top down perception of the history of health policy.²⁰

¹⁷ For a pessimistic view of the health of the nation in the inter war years see L. Bryder, 'The First World War Healthy or Hungry?', *History Workshop Journal*, 24, (1987), 141-157 and C. Webster, 'Healthy or Hungry Thirties?', *History Workshop Journal*, 13, (1982), 110-129. For an optimistic view see J.M. Winter, 'Unemployment, nutrition and infant mortality in Britain 1920-1950', in J.M. Winter (ed.), *The Working Class in Modern British History: Essays in Honour of Henry Pelling* (Cambridge, 1983).

¹⁸ J.E. Pater, *The Making of the National Health Service* (King Edwards Hospital Fund for London, London, 1981).

¹⁹ C. Webster, *The Health Services Since the War, Volume 1: Problems of Health Care: The National Health Service Before 1957* (HMSO, 1988). C. Webster, *The Health Services Since the War, Volume 2: Government and Health Care* (HMSO, 1996). D.M. Fox, *Health Policies and Health Politics: The British and American Experience, 1911-1965* (Princeton, NJ, 1986). H. Eckstein, *The English Health Service its Origins, Structure and Achievements* (Cambridge, Mass. 1958). F. Honigsbaum, *Health, Happiness and Security: The Creation of the National Health Service*, (Routledge, London, 1989). R. Klein, *The New Politics of the NHS* (Longman, Harlow, 1995). C. Ham, *Health Policy in Britain* (Macmillan, London, 1992). C. Thunhurst, *It Makes You Sick: Health Policy in Britain* (Pluto, London, 1982). L. Doyal, *The Political Economy of Health* (Pluto, London, 1979).

²⁰ M. Foot, *Aneurin Bevan: A Biography, Volume 1 1897-1945* (Macgibbon and Kee, London, 1962). M. Foot, *Aneurin Bevan: A Biography, Volume 2 1945-1960* (Davis-Poynter, London, 1973). J. Campbell,

The focus on the Ministry of Health is understandable, it held administrative, regulatory and fiscal control over local government with the power to sanction 'grants in aid' for the development of local authority health services such as tuberculosis, venereal disease and maternity and child welfare services. The Ministry introduced legislation to extend the health care remit of local authorities including the VD Act (1917), The Maternity and Child Welfare Act (1918), the Tuberculosis Act (1921), the Local Government Act (1929) and the Cancer Act (1939). Central government steered local government activity through permissive and mandatory legislation and by the issuing directive Ministerial 'circulars'. The Ministry had a regulatory watchdog role through the monitoring and assessment of local government services. But, the first half of the twentieth century was a period when local forms of democracy and decision-making were at their peak.²¹ The Ministry was established in 1919 in an effort to streamline disparate bodies responsible for the provision of statutory health services. The Ministry's first Chief Medical Officer, George Newman, had a vision for a holistic approach that combined traditional regulatory elements such as environmental health responsibilities coupled with a modern emphasis on the promotion of personal health services and better hygiene.²² In practice this idea of an holistic approach to health policy proved difficult to implement. The Ministry suffered from cuts in public spending, it also lacked genuine executive authority over all the health services of the nation. The operating procedure was for the Ministry to suggest courses of action to local authorities acting in an advisory and expert function.

Any encroachment by the Ministry into the territory of local autonomy was vigorously defended by Councillors and local authorities.²³ In a similar fashion local decision making was a key part of the operation of the voluntary hospitals. The lack of real central authority, the high degree of local discretion and government through

Nye Bevan: A Biography, (Hodder & Stoughton, London, 1987). J. Harris, *William Beveridge: A Biography* (Oxford University Press, 1997). M.A. Powell, *Evaluating the National Health Service* (Open University Press, Buckingham, 1997).

²¹ M. Loughlin, M.D. Geldfand and K. Young, *Half a Century of Municipal Decline 1935-1985* (Allen and Unwin, London, 1985).

²² S. Sturdy, 'Hippocrates and State Medicine: George Newman Outlines the Founding Policy of the Ministry of Health', in C. Lawrence and G. Wiesz, (eds.), *Greater Than the Parts Holism in Biomedicine, 1920-1950*, (Oxford University Press, 1988), 112-34.

²³ For the case study of Wolverhampton Jones has shown that individual Councillors once elected could run Committees as petty empires. G.W. Jones, *Borough Politics: A Study of Wolverhampton Town Council, 1888-1964* (London, 1969).

permissive legislation inevitably meant that wide variations existed in health service provision in different locations. The inter-war years witnessed the zenith of local government powers, but the high point for local autonomy resulted in what has been described as an 'uneven zenith'.²⁴ The NHS was an attempt to address the problem of regional variation in health service provision and bring uniformity and order to what was essentially a patch-work of provision.

Setting the context for a local study

In the 1980s John Pickstone suggested that the key to understanding the differential degree of the development of health and hospital services throughout the country was to place their development within a wider understanding of the local social and political context in which these processes operated – the local political economy.²⁵ Pickstone extolled the virtue of the case study approach suggesting that only by focusing on a particular geographical area, such as a single city, can an examination of the development of health policy be conducted which fully appreciates the influence of a wide range of locally formulated social dynamics.²⁶ As Pickstone stated, 'the challenge is not just to contextualise medical phenomena or institutions, it is to learn how medicine was related to the central structures and the key occupations of local communities as these changed over time.'²⁷ In the Sheffield case, specific industrial, political and social characteristics provide fertile ground for analysis. In the instances where local authority services have been the central focus of historical work, research has tended to focus on one branch of health care, typically the development of maternity and child welfare services.²⁸ The history of other important elements of local authority

²⁴ R. Lee, 'Uneven Zenith: Towards a Geography of the High Period of Municipal Medicine in England and Wales,' *Journal of Historical Geography*, 14, 3, (1988), 260-280.

²⁵ J.V. Pickstone, *Medicine in Industrial Society* (Manchester University Press, Manchester, 1985).

²⁶ J.V. Pickstone, 'Medicine in Industrial Britain: the Uses of Local Studies', *Social History of Medicine*, 2, 2 (1989), 197-203.

²⁷ J.V. Pickstone, 'Medicine in Industrial Britain: the Uses of Local Studies', *Social History of Medicine*, 2, 2 (1989), 203.

²⁸ L. Marks, *Metropolitan Maternity: Maternal and Infant Welfare Services in Early Twentieth Century London* (Rodopi, Amsterdam, 1996); E.P. Peretz, 'Local Authority Maternal and Child Welfare Services in England and Wales, 1919-1939: A Comparative Study' (unpublished University of Middlesex Ph.D. thesis, 1992). T. McIntosh, 'A Price Must Be Paid For Motherhood: The Experience of Maternity In Sheffield, 1879-1939' (unpublished University of Sheffield Ph.D. thesis, 1997). J. Welshman, 'The School Medical Service in England and Wales, 1907-1939' (unpublished University of Oxford D.Phil

health care in the period such as the development of municipal general hospitals as well as the attitudes and ideas of key players in health and politics towards the most appropriate policy instruments to tackle disease and instigate public service provision, have remained under researched.

John Welshman's analysis of the history of public health in twentieth century Leicester marks a welcome development. Welshman notes that social historians of medicine have long made overtures on the value of local studies, yet Welshman's work is the first published full length investigation of health policy in one locality in Britain in the twentieth century.²⁹ Welshman examined the history of public health services in a progressive East Midlands city, where the Borough Council had a positive attitude to the provision of services, where national developments were often anticipated and where well connected influential public officials advised the Council. Welshman's work on Leicester addresses the question of the usefulness of local studies, noting that in many ways Leicester was considered a model authority by the Ministry of Health, it attracted Medical Officers of Health of higher than average calibre and was a comparatively prosperous town, for these reasons Welshman points out that his findings may be atypical. The nature of case studies of particular places means that although locally specific, and atypical of the country in general, the approach can be seen as an important contribution towards improving our wider understanding of the development of British health policy as it was formed and practiced at the local level. Welshman proposes that only through archival work in the localities using a wide range of sources can the development of local authority health care in twentieth century Britain be more fully understood.³⁰

The relevance of the case study of single places has been questioned by some. Martin Powell has argued that 'while ... case studies are valuable, they can say little about the system as a whole. In short, there is the problem of typicality of such areas.

thesis, 1988). B. Harris, *The Health of the School Child: A History of the School Medical Service, in England and Wales* (Buckingham, Open University Press, 1995).

²⁹ J. Welshman, *Municipal Medicine: Public Health in Twentieth Century Britain* (Peter Lang, Oxford, 2000), 37.

³⁰ J. Welshman, *Municipal Medicine: Public Health in Twentieth Century Britain* (Peter Lang, Oxford,

Indeed, some areas may be selected for study precisely because they are distinctive.³¹ Powell suggests that a 'middle range' approach should be adopted, which attempts to link the national level with the local in order to contextualise previous local studies. Powell's work has made use of certain variables such as the political complexion of Borough Councils and population size to assess whether these had a bearing on health care expenditure. Powell has stated that 'both Labour Party strength on the council and population size were positively associated with [health] expenditure.'³²

Knowledge of local circumstances and processes remains important and political complexion and population size should not necessarily be read across as leading to the development of health policies. Both Birmingham and Liverpool had well developed municipal hospital services between the wars, at a time when both cities were Conservative strongholds and did not see Labour majorities on their respective City Councils until after the Second World War.³³ In the case of Sheffield, analysis shows that the Labour local authority maintained its commitment to a health service provided by local government, however the Council in the 1930s operated in a mix of ideology and pragmatism entering into partnership agreements with the voluntary sector. Unpacking the specific local processes that shaped health service provision is necessary. Labour historians have tended to hold Sheffield Council up without question as an exemplar of municipal socialism and progressive welfare policy. Detailed analysis of the local statutory and non-statutory actors and groups involved illustrates that local authority provision operated within a complex policy landscape.

2000), 299.

³¹ M. Powell, 'Did Politics Matter? Municipal health Expenditure in the 1930s', *Urban History*, 22, 3, (December, 1995), 360-379, 362.

³² M. Powell, 'Did Politics Matter? Municipal health Expenditure in the 1930s', *Urban History*, 22, 3, (December, 1995), 360-379, 378.

³³ Labour took control of Birmingham City Council in 1945 and Liverpool City Council in 1955. Both Birmingham and Liverpool were regarded as progressive cities in the development of their municipal hospitals in the 1920s and 1930s. PRO MH 66/442 Ministry of Health Survey of the Public Health Services of the County Borough of Birmingham. PRO MH 66/721 Ministry of Health Survey of the Public Health Services of the County Borough of Liverpool.

Existing views of local authority health care in Sheffield

Ray Earwicker's 1982 thesis, examined the Labour Party and the creation of the NHS, citing local perspectives from places such as Bradford, Willesden and Sheffield, to suggest that the establishment of municipal health services influenced the development of the Labour Party's national health service policy.³⁴ Earwicker stated that 'in Sheffield, the fifth largest municipality in England, the Labour local authority ... spent many years building a first class health service'.³⁵ Earwicker was not alone in delivering a glowing assessment of the health services of Sheffield City Council. John Rowett in his 1979 thesis on the history of the Labour Party and local government, stated that;

... Viennese experiments in municipal Socialism had their British counterpart. A similar concern for the provision of social welfare and cultural facilities characterised Labour administration in the only British city under the party's control until 1933. There too municipal socialism meant using the great municipal machine for the improvement of the city and to bring the greatest health, educational and cultural benefits to the people.³⁶

Similar acclaim for the health and welfare services provided by Sheffield City Council have, not surprisingly, been provided by the Sheffield Labour Party itself. Writing in 1966, at the peak of Wilsonian Corporatism the Labour Council celebrated four decades of almost continuous control of the Council Chamber with a celebratory publication *Forty Years of Labour Rule*, and claimed that;

³⁴ R. Earwicker, 'The Labour Movement and the Creation of the National Health Service, 1911-1948' (unpublished University of Birmingham Ph.D. thesis, 1982).

³⁵ R. Earwicker, 'The Labour Movement and the Creation of the National Health Service, 1911-1948' (unpublished University of Birmingham Ph.D. thesis, 1982), 288.

³⁶ J. Rowett, 'The Labour Party and Local Government: Theory and Practice in the Inter-War Years' (unpublished University of Oxford D.Phil. thesis 1979), 342.

The Sheffield Labour Party can be said to have anticipated the Welfare State as we know it today by taking advantage of all the permissive legislation available, some of which only became compulsory later. Labour's record over the years in treatment of the blind, deaf, dumb, and mentally sick, the aged, in fact all the under privileged and handicapped people of any age or in any respect, will stand comparison with any authority in the country.³⁷

Through the use of sources that were previously unavailable and sources that have been previously under-exploited by historians, this thesis aims to present a more detailed and nuanced assessment of local authority health care in Sheffield from 1918-1948. The official assessment of inter-war health services in Sheffield was more critical than that of labour historians and the Sheffield Labour Party. A series of detailed Ministry of Health surveys were undertaken in the 1930s to assess the health services provided by local authorities; these sources have been particularly useful. The surveys (held at PRO MH 66 at the National Archives) were conducted in order to assess the progress that had been made in health service provision by local authorities, following the reforms that were introduced under the Local Government Act of 1929.³⁸ The 1934 survey for Sheffield showed that the Ministry's opinion of municipal health care in the city was something of a curate's egg; good in parts, and bad in others.³⁹

To reach a more detailed and more nuanced understanding of local authority health policy in Sheffield, Ministry of Health records have been analysed in conjunction with a close reading of local archival material, including Council minutes for the Health, Hospitals and Estates Committees, Medical Officer of Health Annual Reports, University of Sheffield records as well as local newspapers, political party literature, contemporary journals, minutes of Sheffield Trades and Labour Council and the records of the Sheffield Joint Hospitals Council and its workers hospital contributory scheme.

³⁷ Sheffield City Council Labour Group, *Forty Years of Labour Rule*, (Sheffield, 1966).

³⁸ There are 1084 surviving files and volumes held at the National Archives at PRO MH 66 relating to the Public Health Surveys undertaken in the 1930s to assess how far County Borough Councils and County Councils had complied with the health provisions of the 1929 Local Government Act.

³⁹ PRO MH 66/1079 Ministry of Health Survey of Public Health Services in the County Borough of Sheffield, 1934.

Recent work by historians on the development of local authority health services in the inter-war years has not focussed on Sheffield. Aggregate analysis has taken place and the history of municipal health care in London has been examined.⁴⁰ Steve Sturdy's work on the development of medical teaching at the University of Sheffield has been a useful starting point when framing this study of local authority health care.⁴¹ Sturdy analysed the way in which the academic medical elite of the city between 1890 and 1922 made a conscious effort to ensure that the University was linked to the local authority and the network of civic bodies associated with the city's metal trades. The laboratory work of the Public Health Department was carried out under contract to the University and Medical Officers of Health were made honorary Professors of Public Health at the University from 1897-1847.⁴² The syllabus of medical training and departmental research specialisms was re-designed to reflect the needs of a metal town.⁴³ Members of the University medical school at the turn of the century and in particular Professor Arthur Hall, promoted the development of clinical science, and ensured that close involvement in the city's voluntary (teaching) hospitals took place. The Vice Chancellor of the University of Sheffield, Sir Henry Hadow, was the Chairman of the Joint Hospitals Council from its inception in 1919 until 1930.⁴⁴ Sturdy argues that the high degree of involvement in civic affairs by the University of Sheffield was due to the fears of academics and medical practitioners, that the increasing Labour representation on the City Council in the 1920s would lead to political interference in health policy and could be a threat to their livelihoods. University records also show that the local authority Tuberculosis Officer was appointed Lecturer in Medicine to the University Medical School in 1919 with a remit to give instruction in tuberculosis to fifth year students and to carry out practical demonstrations of tuberculosis work at the City Dispensary and Sanatoria.⁴⁵

⁴⁰ A. Levene, M. Powell and J. Stewart, 'The Development of Municipal General Hospitals in English County Boroughs in the 1930s', *Medical History*, 50, (2006), 3-28. J. Stewart. 'The Finest Municipal Hospital Service in the World? Contemporary Perceptions of the London County Council's Hospital Provision, 1929-39', *Urban History*, 32, 2, (2005), 327-344.

⁴¹ S. Sturdy, 'The Political Economy of Scientific Medicine: Science Education and the Transformation of Medical Practice in Sheffield, 1890-1922', *Medical History*, 36, (1992), 125-159.

⁴² S. Sturdy, 'The Political Economy of Scientific Medicine: Science Education and the Transformation of Medical Practice in Sheffield, 1890-1922', *Medical History*, 36, (1992), 125-159.

⁴³ S. Sturdy, 'The Political Economy of Scientific Medicine: Science Education and the Transformation of Medical Practice in Sheffield, 1890-1922', *Medical History*, 36, (1992), 125-159.

⁴⁴ Sheffield Joint Hospitals Council Minutes, 1919-1930, held at Westfield Health Scheme Sheffield.

⁴⁵ University of Sheffield Faculty of Medicine Minutes, 1 December 1919, Sheffield University Archives 8/6/6.

The technical side of Public Health in Sheffield, involving laboratory testing and the analysis of samples required by the City Council's Health Department was contracted out to the University under an arrangement made by the Medical Officer of Health, in 1897, John Robertson.⁴⁶ The university continued to do all the testing and analysis work for the Council until a purpose built public health laboratory was opened by the local authority at the municipal City General Hospital in 1947.⁴⁷ Personal contact between local authority officers and the University medical practitioners was important throughout the inter-war years and joint research projects were undertaken. The Sheffield MOH in the 1920s, Frederick Wynne, collaborated with Professor Arthur Hall on a study funded by the Medical Research Council into an outbreak of epidemic encephalitis or 'sleepy sickness' in the city in 1924.⁴⁸ Professor Hall was instrumental in the design of a plan for the operation of the Sheffield's municipal and voluntary hospitals into a system in the 1930s, a plan co-authored with James Clark the local authority Deputy Medical Officer of Health.⁴⁹ If the Sheffield example illustrates harmonious working relations and productive joint working, how can we understand the role played by politics and ideology?

Ideology and Social Policy

Charles Webster has argued the case for the consideration of politics and ideology in the development of welfare policy in Britain. Noting that 'the extent of the Labour contribution is not easy to assess because its involvement took many forms ... but this provides no excuse for its neglect.'⁵⁰ In her examination of maternal health care in Sheffield in the late nineteenth and early twentieth century, Tanya McIntosh has

⁴⁶ Robertson established the bacteriology laboratory of the University Medical Department in 1897, he was simultaneously Professor of Bacteriology at the University of Sheffield and Medical Officer of Health. Arthur Hall to David Naborrow 13 June 1946. Arthur Hall stated that 'Robertson was one of the first to realise the extreme importance of the subject to that of Public Health', Papers of Arthur Hall, Some Notes on the History of Sheffield Medical School, 1943, Sheffield University Archives, Accession 82, Box 9 Medical School Papers.

⁴⁷ MOH Annual Report for Sheffield, 1947.

⁴⁸ Medical Research Council, *The Sheffield Outbreak of Epidemic Encephalitis in 1924: The Report of a Sub-Committee Appointed by the Medical Advisory Committee of the Local Division of the British Medical Association* (H.M.S.O., London), 1926).

⁴⁹ See Chapter 4.

⁵⁰ C. Webster, 'Conflict and Consensus: Explaining the British Health Service', *Twentieth Century British History*, 1, (2), (1990), 148-149.

specifically downplayed the significance of ideology in shaping health care in the city. McIntosh argued that 'both the council and voluntary groups pursued policies that were not based on ideology but depended upon pragmatism and consensus ... the tone of all groups was pragmatic rather than ideological'.⁵¹ The McIntosh thesis goes on to state that for Sheffield 'the inter-war years in particular demonstrated conspicuous general levels of consensus over welfare developments and a lack of ideological debate'.⁵² Where McIntosh has argued that ideology was not a factor in the development of health care in Sheffield, this work takes its cue from the interpretation of Webster, Pickstone and Sturdy that politics and specific ways of thinking were important to the direction of policy.

Both Charles Webster and Michael Freeden have (separately) argued the case for an ideological and political interpretation of events in the history of welfare policy in twentieth century Britain.⁵³ For Webster, politics and politicians in general (and especially Labour politicians) have largely been rendered otiose by historians who have examined the events leading up to the creation of the NHS.⁵⁴ By focussing on certain elite groups and in assuming that a technocratic consensus was the motor of health reform before the NHS, political ideas and the importance of conflicting opinions over the form that health care reform might take, were written out of the existing historiography.

The contribution of the Left to the development of health policy in the early twentieth century was written out of the story in the first histories of the health service that were produced in the 1950s. Eckstein's analysis explicitly denied a role for Labour until the point at which the Left could not be ignored as they themselves became part of the technocratic elite when the Labour Party formed the Government after the 1945

⁵¹ T. McIntosh, 'A Price Must Be Paid for Motherhood: The Experience of Maternity in Sheffield, 1879-1939' (unpublished University of Sheffield Ph.D. thesis, 1997), 220.

⁵² T. McIntosh, 'A Price Must Be Paid for Motherhood: The Experience of Maternity in Sheffield, 1879-1939' (unpublished University of Sheffield Ph.D. thesis, 1997), 45.

⁵³ C. Webster, 'Conflict and Consensus: Explaining the British Health Service', *Twentieth Century British History*, 1, 2, (1990), 115-51. M. Freeden, 'The Stranger at the Feast: Ideology and Public Policy in Twentieth Century Britain', *Twentieth Century British History*, 1, 1, (1990), 9-34.

⁵⁴ C. Webster, 'Conflict and Consensus: Explaining the British Health Service', *Twentieth Century British History*, 1, 2, (1990), 119.

general election.⁵⁵ Eckstein's somewhat narrow description of the socialist conception of health care, ruled out the possibility of the left being at the forefront of health reform in the decades prior to 1948;

Of all the people and organizations articulately concerned with medical reform before the war the socialists were the last and, in some ways the most half-hearted in the field. The services provided by the National Health Service are very far removed from British socialism's classic image of an ideal medical system. The essence of that ideal was a society so just and so efficiently organised that a need for medical services simply would not arise. Illness, thought the socialists, was a product of social conditions, like unemployment or any other grave social evil. It was the result of bad housing, bad nutritional standards, excessive drinking, overwork and lack of adequate sanitation. The function of a socialist society would not be to cater to disease but to abolish it.⁵⁶

There is some truth in Eckstein's caricature of the socialist attitude to health care that can be illustrated in an analysis of local authority health care in Sheffield. The Chairman of the Health Committee, from 1926-1942 William Asbury a staunch anti-vaccinator, proposed that better housing rather than medical intervention was the route to better health. The fact that debates over vaccination were taking place in Sheffield in the 1920s was unusual. These issues had been settled much earlier in places like Leicester and Keighley.⁵⁷ Yet, in many other respects, the view of Eckstein that the left were not interested in health policy does not stand up. The Labour Council in Sheffield developed the city's health policy and were responsible for the two former Poor Law hospitals being developed as part of a fully functioning general hospitals system. In 1937 The Council also attempted to bring the control of South Yorkshire Mental Hospital under the remit of the Health Committee in an effort to expand the scope of the local authority health service and take control of the mental hospital away from the West Riding County Council.⁵⁸ Rather than dismiss the Left, outright, as irrelevant to the development of

⁵⁵ H. Eckstein, *The English Health Service: Its Origins, Structure and Achievements* (Cambridge, Mass., 1958).

⁵⁶ H. Eckstein, *The English Health Service: Its Origins, Structure and Achievements* (Cambridge, Mass., 1958), 102.

⁵⁷ S.M.F. Fraser, 'Leicester and Smallpox: The Leicester Method', *Medical History*, 24, (1980), 315-332.

⁵⁸ Prior to the Second World War the Labour Council prepared a plan for the local authority to take over control of the South Yorkshire Mental Hospital, which though located at Middlewood, within the

health policy, it is perhaps more useful to analyse socialist and Labourist ideology and health care through the words and deeds of key actors and organisations in places like Sheffield. Analysis of the Sheffield example shows that health policy was important to the Labour Party, and along with housing and education formed the basis of a municipal socialist agenda.

The claim by Eckstein that in health reform 'the Labour party was certainly not in the vanguard of the agitation. It joined the team, at best in the middle of the game,'⁵⁹ has been previously challenged by Arthur Marwick, Ray Earwicker and Charles Webster.⁶⁰ Marwick attempted to put Labour back into the picture as protagonists in health reform at the level of national policy, while Webster has recognised the role of embryonic local Labour parties in the opening years of the twentieth century, applying political pressure and agitating for health reform such as the establishment of schemes of infectious disease notification. For Webster, 'Labour groups in the London boroughs, Bradford and Sheffield were pioneers in the field of public health even before the First World War'.⁶¹ The 1920s in particular saw a lack of direction from the national leadership of the Labour Party over health policy, where instead it focussed primarily on housing in election manifestos. With the formation of the Socialist Medical Association in 1930 there was a shift in emphasis onto health care and hospitals.⁶² Webster, has argued that the reason that politics has been left out of the history of health care is largely due to the assumption among historians and the public in general that the NHS was founded in 1948 on a broad consensus. Webster argues that health reform was driven by political conflict and ideology and that initiatives at the grassroots as well as the reactions of the

Sheffield city boundary, was administered by the West Riding County Council. As Chairman of Sheffield City Council Health Committee Asbury complained that travelling by train to attend Governors meetings in Wakefield was too time consuming when most of his work was based in the city. Sheffield City Archives SCA 582 2/1, Proofs of Evidence to the House of Commons Committee, Sheffield Corporation Bill, 1937. For the history of Middlewood Hospital see F.T. Thorpe, *A History of Middlewood Psychiatric Hospital: 1872-1972* (Middlewood Hospital, Sheffield, 1972).

⁵⁹ H. Eckstein, *The English Health Service: Its Origins, Structure and Achievements* (Cambridge, Mass., 1958), 108.

⁶⁰ A. Marwick, 'The Labour Party and the Welfare State in Britain, 1900-1948', *American Historical Review*, 73, (1967), 380-403. R. Earwicker, 'The Labour Movement and the Creation of the National Health Service, 1911-1948' (unpublished University of Birmingham Ph.D. thesis, 1982). C. Webster, 'Labour and the Origins of the National Health Service', in N.A. Rupke, *Science, Politics and the Public Good* (Macmillan, London, 1988).

⁶¹ C. Webster, 'Labour and the Origins of the National Health Service', in Rupke, N. A. (ed.), *Science, Politics and the Public Good* (MacMillan, Basingstoke, 1988), 186.

⁶² C. Webster, 'Labour and the Origins of the National Health Service', in Rupke, N. A. (ed.), *Science,*

Government to Labour Party policy documents should be considered as an important aspect of the story. Early reform plans for health services assumed that a major reorganisation of health care in Britain would be on a regional or local basis. The *Interim Report of the Ministry of Health Consultative Council on Medical and Allied Services*, i.e. the Dawson Report of 1920, saw GPs at the bottom of the hierarchy dealing with routine medical problems; difficult cases would be referred up the chain to medical centres staffed by groups of GPs where specialised knowledge and skills would be pooled.⁶³ The cases that were more complicated would be referred to the next authority, the consultants in the voluntary hospitals, and the apex of the hierarchy was to be the university medical schools situated at the geographical centre of this reformulated division of labour.

Webster claims a role for the Labour Party here in providing the inspiration for the Report in the first place, where the Dawson Report was ‘a counterblast to Labour proposals, written from the perspective of a medical elite desperately searching for a means to salvage the general practitioner from impending redundancy’.⁶⁴ Webster downplays the importance of the Dawson Report as a blueprint for health reform in the inter-war years, seeing its main significance as setting the tone and language for health thinking in the inter-war years, especially introducing notions of ‘primary’ and ‘secondary’ care.⁶⁵ The Dawson Report was after all an interim paper, with no published final report. As a plan for action it was ignored for most of the period in question until the national emergency of the Second World War.

By way of contrast Daniel Fox has contended that the NHS was indeed the product of a consensus, one that began with the Dawson Report. Fox constructed the notion of ‘hierarchical regionalism’ as the major driving force in health policy in the

Politics and the Public Good (MacMillan, Basingstoke, 1988), 187.

⁶³ Consultative Council on Allied and Medical Services, *Interim Report on the Future Provision of Medical and Allied Services*, Cmnd 693, London, (1920).

⁶⁴ C. Webster, ‘Labour and the Origins of the National Health Service’, in Rupke, N. A. (ed.), *Science, Politics and the Public Good* (MacMillan, Basingstoke, 1988), 186.

⁶⁵ C. Webster, ‘Conflict and Consensus: Explaining the British Health Service’, *Twentieth Century British History*, 1, 2, (1990), 121.

middle years of the twentieth century.⁶⁶ This theory argues that advances in medical science in the laboratories of teaching hospitals and medical schools:

... were translated into procedures which were tested in teaching hospitals and then transmitted down a hierarchy of institutions and practitioners. The task of officials of public and philanthropic organisations ... was to create and systematise these hierarchies and make their benefits more accessible to citizens of all social classes.⁶⁷

Rather than regarding the NHS as a product of the experience of the Second World War and the work of Bevan and the Labour Government, Fox sees the NHS emerge from a widespread consensus over the benefits of hierarchical regionalism embraced by a very diverse group of stakeholders and interested parties including the BMA, the Ministry of Health, the voluntary hospitals, the TUC, The Socialist Medical Association and the local government bodies. One problem with the concept of 'hierarchical regionalism' is its over emphasis of the idea that health reform was the result of a struggle for both territory and professionalisation. Both aspects are relevant to the story, but they were not the only factors driving health reform. Webster has criticised Fox for his lax definition of the term 'region,' which appears to relate only to the pre-existing local authority boundaries, rather than to the defined geographical health regions. The claim that a regionalist agenda was an accepted facet of health reform can also be questioned. Webster points out how 'the advocates of regionalism tended to meet a blank wall of opposition from the local authorities, who saw most proposals for co-ordination as threatening a derogation of their powers.'⁶⁸

There is some evidence that regionalism was higher up the agenda towards the end of the inter-war period, but plans such as those by The Sankey Commission appointed by the British Hospitals Association in 1937 were not well defined.⁶⁹ It was as late as 1939 that a significant body with the specific aim of promoting the idea of

⁶⁶ Webster, 'Conflict and Consensus', 125. Fox, *Health Policies*, 21-36.

⁶⁷ D. Fox, 'The National Health Service and the Second World War: The Elaboration of Consensus.', in H.L. Smith, (ed.), *War and Social Change: British Society in the Second World War* (Manchester University Press, 1986), 32-57. 33-34.

⁶⁸ C. Webster, 'Conflict and Consensus: Explaining the British Health Service', *Twentieth Century British History*, 1, 2, (1990), 125.

⁶⁹ British Hospitals Association, *Report of the Voluntary Hospitals Commission*, [Sankey Commission]

regionalism in hospital administration was formed, the Nuffield Provincial Hospitals Trust (NPHT).⁷⁰ Ernest Rowlinson, the Labour Leader of Sheffield City Council from 1926 to 1941, was one of the twelve Trustees of the NPHT. Rowlinson's involvement could be read as support for the acceptance of regional administrative structures in health reform, or it could be read as an example of involvement in order to defend the local authority cause. In either case Rowlinson's role in the NPHT was brief, as he died in 1941.⁷¹ Rowlinson's deputy and successor as Council Leader, William Asbury saw that the tide was turning towards regionalism at the end of the 1930s, however in Asbury's conception of health reform and hospital co-ordination, there would always be a key role for local government. Speaking in 1939 Asbury stated:

... it is more than likely that the hospital system of the country will eventually be reorganised on a regional basis ... the only satisfactory approach to the problem is for all hospitals intended for the acute sick to pass into the control of local authorities.⁷²

Despite this pre-War defence of the role of local government in any future health reform, there is scant evidence that the Labour Party in Sheffield put up any opposition to the introduction of a centrally controlled, nationalised and regionally managed NHS in 1948. This silence is puzzling. However, with Rowlinson dead and Asbury enlisted by 1942, the Labour leadership that had been responsible for the development of local authority health care in the period was not present in Sheffield to make the case for local control at the time of the introduction of the NHS. The silence of the Left in Sheffield could also be read as deference to the nationalisation policy of Bevan and the Labour government.

The loss of local democratic control in health care was raised by elements of the Labour movement in the 1950s. Some Labour figures believed that proper regional

(London, 1937).

⁷⁰ The Nuffield Provincial Hospitals Trust was set up in 1939 with a million Morris Motor shares, as an advisory body to promote the working of provincial hospitals in a co-ordinated or regional basis. In 1941 there were four regional and eleven NPHT divisional councils in England and Wales. Abel-Smith, *Hospitals*, 444.

⁷¹ H. Mathers, 'Ernest Rowlinson' in J. Bellamy and J. Saville, (eds.) *The Dictionary of Labour Biography*, vol. VI (MacMillan, London, 1982), 235-236.

⁷² *Public Assistance Journal and Health and Hospital Review incorporating the Poor Law Officers Journal*, 17 March 1939, 297.

government was the logical next step for Labour's legislative reform programme and believed that powers rescinded in 1948, including the power to administer hospitals would be devolved back down to the local authorities under a new regional structure for the UK. This view was put forward by Aneurin Bevan himself in 1954. Bevan argued for the popular election (rather than selection by the Minister) of health authority members and stated that 'a radical reorganisation of the structure of local government' was necessary, in order 'to allow the administration of the hospitals to be entrusted to the revised units of local government'. After six years of the operation of a nationalised and centralised health system with independent GPs and hospitals removed from local control, Bevan declared himself to be 'by experience and conviction a local government man' and that 'local government management of the hospitals is best.'⁷³ Bevan's rediscovery in the 1950s of the democratic case for local government control of hospitals was however being made from the back-benches and not as Minister of Health.

The 1946 NHS Act abandoned the idea of a significant role for local authorities in a national health service as the fierce opposition from doctor's leaders made the long standing Labour policy untenable. In Cabinet, Herbert Morrison's belief that local government should form the basis of the NHS led to rows with Bevan.⁷⁴ And as Bernard Crick stated 'pluralism fundamentally lost out when Aneurin Bevan defeated Herbert Morrison's wise argument for the new health service to be run by local government'.⁷⁵ The solution arrived at by Bevan has long been hailed as a decisive piece of political diplomacy, making the NHS possible through the appeasement of the right people and being prepared to upset others in a hostile situation with numerous stakeholders and interested parties.⁷⁶ Bevan's actions were perhaps the prime example of politics being the art of the possible in the history of British social policy.

Some studies that have attempted to place ideology at the centre of health policy analysis in the 1970s have been criticised for lacking empirical research detail and for being too abstract and theoretical. These studies employed wider notions of 'welfare'

⁷³ A. Bevan, 'Local Government Management of Hospitals is Best', *Municipal Journal*, (12 March 1954), 544 -555.

⁷⁴ N. Timmins, *The Five Giants: The Biography of the Welfare State* (Harper-Collins, London, 1995), 117.

⁷⁵ B. Crick, *Independent on Sunday*, July, 1997.

rather than make an attempt to analyse the detailed specifics of the development of health and hospital services. Analysts working within a Marxist framework, such as Ian Gough and Vincent Navarro, were criticised for an over reliance on assertion and circular functionalism in their attempts to explain the dynamic relationships between political change and historical developments in health policy.⁷⁷ For Charles Webster:

... the majority of Marxist writings are aloof from empirical detail because it is assumed that the capitalist state reacts spontaneously to generate appropriate increments in welfare services in order to secure the efficient reproduction of labour power and maintain levels of capital accumulation regardless of labour mobilization.⁷⁸

The approach taken by Webster has been to acknowledge the importance of ideology and politics to health reform by suggesting that this can be traced through the development of Labour movement thinking on the health services, initially through the reformism of the Fabians and the Webbs to the more radical approach of the Socialist Medical Association, and eventually to a position where key elements of the civil service and the Labour movement connected at the top of policy-making in a 'Labour-bureaucrat' coalition. For a local examination of the role of politics and ideology in the development of social policy an appropriate methodology is required.

⁷⁶ J. Campbell, *Nye Bevan: A Biography* (Hodder and Stoughton, London, 1987), 177-178.

⁷⁷ I. Gough, *The Political Economy of the Welfare State* (MacMillan, London, 1979). V. Navarro, *Class, Struggle, the State and Medicine; An Historical and Contemporary Analysis of the Medical Sector in Great Britain* (Martin Robertson, London, 1978).

⁷⁸ C. Webster, 'Conflict and Consensus: Explaining the British Health Service', *Twentieth Century British History*, 1, 2, (1990), 135.

Ideology : 'the stranger at the feast'

Michael Freeden offers an attractive rubric for historians attempting to test the notion that ideas have been important to the development of social welfare policy from 1900.⁷⁹ Freeden notes that historians of the twentieth century have shied away from an examination of the ideological basis of developments in British politics. He suggests that where the role of ideas have been recognised, for instance in the evolution of the welfare state, there has been a certain artlessness in the interpretation, which cannot transcend the boundaries of the famous ideological 'isms,' so that the questions asked about the development of social policy tend to be based around notions of whether the welfare state was the outcome of either a 'liberal' or 'socialist' ideology. Freeden states in order 'to understand British social welfare policy, we need to understand that liberalism and socialism have interwoven far more than political parties concede.'⁸⁰ Freeden argues that there has been a tendency among historians towards the use of certain sources such as previously unseen private papers which;

prompts researchers to over stress unpublished 'primary sources' at the expense of far more promising material. When it comes to political ideas, British intellectuals are not over revealing in committing their speculations to the note paper of private correspondence, but what they have written in the form of pamphlets and journalistic newsprint is very edifying. Newspaper articles and leaders, book reviews and specialist journals are rich and only sporadically explored compendia of political ideologies and deserve the tag 'primary source' every bit as much as the often uninformative letter or ministerial memo. In sum, twentieth century sources offer a markedly underexploited abundance of information to the student of political ideologies and their manifestation in political action.⁸¹

This thesis has taken Freeden's rubric and applied it to the case study of health policy in Sheffield before the NHS. An active Labour press and local press existed in Sheffield in the period and the key protagonists in health policy formulation published

⁷⁹ M. Freeden, 'The Stranger at the Feast: Ideology and Public Policy in Twentieth Century Britain', *Twentieth Century British History*, 1, 1, (1990), 9-34.

⁸⁰ Freeden, 'Stranger', 12.

⁸¹ Freeden 'Stranger', 13

articles and book reviews here and presented ideas and debates in professional health and local government journals. Through the use of these sources as well as committee minutes and Ministry Reports the aim is to deepen our understanding of the ideological mindset of key protagonists. Freeden has highlighted a common tendency when welfare and ideology are considered, to adopt an 'on-off switch' approach. Here, British history in the twentieth century is seen as only periodically susceptible to the influence of ideologies.⁸² 'Thus we find leaps executed in the study of welfare policies from the Edwardian period to the aftermath of the Second World War, as if no thinking of significance had taken place in between'.⁸³ The implication for studies such as this one, which begin with the end of the First World War era and end with the post Second World War years, is to recognise that ideology was a constant rather than a visitor. As Freeden states 'There exist ... no non-ideological periods in modern British history: to suggest otherwise would be to imply that no one thought systematically about politics in such periods and that no discernible patterns of thinking are evident.'⁸⁴

An acceptance that ideology has been constantly relevant, should not lead to a situation where ideology is seen as everything and that all acts are to be explained as ideologically driven. David McLellan has warned that taking an omnipresent view of ideology can be misleading, as it has the danger of reducing all 'social phenomena to the status of mere propaganda'.⁸⁵ However, if we accept that politics and policy-making is about mediation and the negotiation between political ideas and what is actually practically possible in a given situation, then to assume that fundamental core beliefs and political concepts were important to decision makers is a viable stance. Freeden defines ideologies in a broad sense as the practical realisation of a world view, so that ideologies are:

those systems of political thinking, loose or rigid, deliberate or unintended, through which individuals and groups construct an understanding of the political world they, or those who preoccupy their thoughts, inhabit and then act on that understanding.⁸⁶

⁸² Freeden 'Stranger', 29.

⁸³ Ibid.

⁸⁴ Ibid.

⁸⁵ D. McLellan, *Ideology* (Buckingham, Open University Press, 1995), 75.

⁸⁶ M. Freeden, *Ideologies and Political Theory* (Oxford, 1996), 3.

This thesis therefore makes an attempt to recognise that politics and ideology were important in the shaping of political decisions and policy choices in health care within the particular historical period and place, Sheffield between 1918 and 1948.

The mixed economy of welfare

The history of the welfare state in Britain has tended to be traced along an ever more progressive story where the evils of the nineteenth century were gradually replaced by a benevolent collectivism brought about through the state as it encroached more and more on the territory of the voluntary sector, absorbing within the state apparatus certain elements of charity and voluntarism that had previously provided services. Culminating ultimately with the post-Second World War welfare state.⁸⁷ Historians have moved away from this Whiggish view of welfare history and acknowledge that welfare provision was, and has remained a mixed economy of mutual, private, state, charitable, familial and commercial activity. Developments particularly in the field of the social history of medicine have encouraged a more pluralistic approach to the study of welfare history. There has been a recognition that something of a 'moving frontier' existed between the state and the voluntary sector and that understanding the changes in this balance of power over time can help to explain the changing nature of British society.⁸⁸ Jane Lewis in particular has been associated with the description of twentieth century health services as belonging to a 'mixed economy of welfare' calling for a recognition of the different roles of statutory and non statutory providers that could work in partnership as much as conflict.⁸⁹

The Governance of Health Care

Similar developments can be seen in political science where an increased use of the term 'governance' rather than 'government' has developed in order to capture

⁸⁷ The classic evolutionary account of the welfare state is D. Fraser, *The Evolution of the British Welfare State* (Macmillan, 1973).

⁸⁸ G. Finlayson, 'A Moving Frontier: Voluntarism and the State in British Social Welfare, 1911-1949', *Twentieth Century British History*, 1.1, (1990), 183-206.

notions of a mixed economy in policy delivery and to help to explain the multi-agency approach adopted in the post 1979 era in policy formation and service delivery.⁹⁰ The usage of the term can be related to late twentieth century political and administrative developments such as devolution and decentralisation as well the greater use of public-private-partnerships in service provision. The work of R.A.W. Rhodes has been associated with this linguistic and analytical development. Rhodes has described governance as 'a change in the meaning of government, referring to a *new* process of governing; or a *changed* condition of ordered rule; or a *new* method by which society is governed. (Emphasis in original). Rhodes has used the term 'governance' to refer to '*self-organising, inter-organisational networks.*'⁹¹

In recognising the longevity of the mixed economy of welfare the *newness* or 'novelty' of 'governance' can be questioned. In the decades before the NHS an effective municipal health service depended not only on the commitment of the Council to the provision of its own services, but also on the ability of local authority politicians and officers to work in partnership with other agencies. Governance is a useful concept if it serves to broaden our perceptions of power and policy-making into areas of civil society that goes beyond the confines of Whitehall and the Town Hall. In examining the arrangements for health facilities that existed in Sheffield in the decades before the NHS it is clear that 'joint working', 'governance', 'pluralism' or the 'mixed economy of welfare' were integral to policy-making and service delivery. These ideas and practices, whatever the linguistic term used are relevant to the analysis of the pre-NHS period and should not be seen solely as a new feature of the political and administrative framework post 1979.

⁸⁹ J. Lewis, 'Gender, the Family and Women's Agency in the Building of 'Welfare States': The British Case', *Social History*, XIX, (1994), 37-55.

⁹⁰ For use of the term governance see M. Adshead and B. Quinn, 'The Move From Government to Governance: Irish Development Policy's Paradigm Shift', *Policy and Politics*, 26, 2, (1998), 209-225. and R. Rhodes, 'The New Governance: Governing Without Government', *Political Studies*, 44,4, (1996), 652-665.

⁹¹ R.A.W. Rhodes, 'Diplomacy in Governance', *Politics Review*, 7, (1998), 24.

The Ideology of Municipal Socialism

Language is important to the communication of political ideologies and the operation of political programmes. The original usage of the term 'municipal socialism' was very similar to the first use of the term 'welfare state', in that both phrases were coined in a pejorative sense, by those who opposed increased state involvement (one local, one national) in the provision of services that would otherwise be provided by commerce or the voluntary sector. Both terms have gone on to assume political and historical significance. Both terms have been appropriated in particular eras and given positive connotations by those who advocate the collective provision of services. The 'welfare state' was originally a term of abuse used by Conservative MPs for the programme of social reforms proposed by the Labour Party in the 1940s.⁹² In the 1950s, William Beveridge was at great pains to distance himself from use of the term 'welfare state'.⁹³ The term 'municipal socialism' was first used by supporters of the free market when making complaints against the rise of publicly organised and financed interventions in the collective provision of public utilities and welfare services at the turn of the twentieth century.

A series of articles appeared in *The Times*, in 1902 and 1903, which expressed abject horror at the municipalising developments in local government, and typified fears over the growth of state involvement in the administration of the public sphere.⁹⁴ The cities of Glasgow, Birmingham and Sheffield were singled out by *The Times* as centres of municipal socialism. Despite the fact that these towns at the turn of the century were

⁹² Oakley notes that the term 'welfare state' was invented in 1934 by Alfred Zimmern, Professor of International Relations at Oxford University. It was used three years later by the economist George Schuster. The term was popularised by the Archbishop of Canterbury in his book, *Citizen and Churchman* published in 1941. A. Oakley, 'An Introduction to the Politics of the Welfare State', in A. Oakley and S. Williams, *The Politics of the Welfare State* (London, 1994), 2. On the pejorative use of the term 'welfare state' see, R. Lowe, 'The Second World War, Consensus and the Foundation of the Welfare State', *Twentieth Century British History*, vol. 1, 2, (1990), 152-182.

⁹³ In a speech to the British Hospital Contributory Schemes Association in 1954, Beveridge expressed doubts over the use of the term 'Welfare State, because it gives to some people the idea that all they need for welfare should be provided by the State and that all they have to do is to use their votes to get it from the State ... much more has to be done by private citizens for themselves and in helping their neighbours.' Sir W. Beveridge, 'The Role of the Individual in Health Service', paper delivered at BHCSA Annual Conference, 1954, (BHCSA, Bristol, 1954), 5-15. Held at Westfield Health Care Sheffield.

⁹⁴ See series of articles in *The Times*, September and October 1902, and 23 August 1903.

under Liberal and Tory control, with very few socialist Councillors. In 1902, *The Times* claimed that with Labour Councillors on the Sheffield Health Committee ‘this spending Committee, which employs 720 men, is now the personification of the Sheffield Trades Union Council.’⁹⁵ This sensationalist red scare and nationally publicised attempt to raise public horror at the activities of local government, was allied to concerns over the emerging Labour Party and its potential challenge to the status quo. *The Times* articles feared that British town halls were in danger of coming under the influence of ‘poorly paid secretaries of local trades unions’ and ‘labour representatives who have probably never earned more than 30 shillings a week, and may not possess practical knowledge of finance and industrial management.’⁹⁶

Municipal socialism has generally been used to refer to two distinct periods of British history. The first being the late nineteenth and very early twentieth century when for example Unionist politicians in Birmingham introduced large scale redevelopment schemes and the municipalisation of services such as gas, water and the tramways. Fabian political thinkers, such as the Webbs, drew their enthusiasm for municipal socialism at the time from these examples of civic collective action. Each new Fabian Tract that appeared at the turn of the twentieth century, proposed more and more areas of life that should be brought under municipal control, including the hospitals.⁹⁷ The other period of British history notable for the use of the term ‘municipal socialism’ was in the 1970s and 1980s with Labour Councils polarised against a Conservative Government. The period examined by this thesis is concerned with a different and previously under explored era of municipal socialism in Britain: the 1920s and 1930s.

The term ‘municipal socialism’ is problematic and can be somewhat ambiguous, incorporating as it does both a political ideology of collectivism and the more neutral

⁹⁵ *The Times*, 10 September 1902.

⁹⁶ *The Times*, 8 September 1902.

⁹⁷ The Fabian Society produced a series of Fabian Tracts on municipalization at the end of the nineteenth century and at the start of the twentieth century. In 1891, four such tracts appeared; No 32 *The Municipalization of the Gas Supply*, No 33 *The Municipalization of the Water Supply*, No 35 *The London Docks*, No 37 *A Labour Policy for Public Authorities*, all made the case for the municipal ownership of utilities in order that fair wages and working conditions could be secured for municipal workers. In 1899 Fabian Tract No 90 argued for the municipalisation of *Milk*, No 91 for *Pawnshops* and No 92 for *Slaughterhouses*. No 95 published in 1900 proposed that local authorities should take over Poor Law Infirmaries and develop *Municipal Hospitals* with resident and visiting medical staff and facilities for the training of nurses.

notion of city government. To avoid confusion a distinction should be made between 'municipal trading', and 'municipal socialism'. Municipal trading is a term that can be used to describe the control and ownership of public utilities, such as water, electricity and transport, by the local authority of any political persuasion with the intention of using the profits from running these concerns to reduce the burden of local taxation. Municipal socialism – in the context of Sheffield - should be seen as the practical implementation of an ideology of the Left in spending locally generated resources in the pursuit of the collective ownership of utilities and the provision of welfare services, i.e. the investment of rate revenue in public services. The election of a Labour Council in Sheffield in 1926 meant a marked shift in ideas relating to the appropriate use of revenue raised from municipal enterprises. The Labour case in the 1920s was for profits generated from services such as transport being directed to the provision of social services rather than the policy of the Liberal/Conservative alliance for rate reduction. The Labour Leader Ernest Rowlinson stated in 1923 that 'to apply profits to a reduction of the rates is a doctrine that tickles the mental palate. Anyone, except those anxious to aid their friends in big business, could imagine that there were profits when money is owing in the case of Sheffield of £819,000.'⁹⁸ Sheffield from 1926 offers a practical example of municipal socialism in action, where a programme of municipal management was put into place at a time when the ideas of the metropolitan Left, the Fabians and Webbs had abandoned notions of the benefits of local action in their embrace of central planning.⁹⁹

Early twentieth century debates for an increased role for the state, particularly the local state, in the delivery of services including health care took place at a time in British history when certain urban areas were increasingly identified with the Labour Party, and a burgeoning working class politics saw working class representatives participate in government and administration.¹⁰⁰ Morris has suggested that 'the British towns of the industrial revolution were substantially the creation of the middle class and in turn

⁹⁸ *Sheffield Mail*, 23 October 1923.

⁹⁹ For the ideology of the Webbs see, J. Stapleton, 'Localism Versus Centralism in the Webbs' Political Thought', *History of Political Thought*, 12, (1991), 147-165.

¹⁰⁰ By the end of the 1930s Labour controlled over half of the London Metropolitan Boroughs, ¼ of all the County Boroughs and one fifth of Urban District Councils. J. Rowett, 'The Labour Party and Local Government: Theory and Practice in the Inter-War Years' (unpublished University of Oxford D.Phil. thesis 1979), 251-252.

provided the theatre within which that middle class sought, extended, expressed and defended its power'.¹⁰¹ Extending this notion of the nineteenth century city as an avowedly middle class locale, Savage has noted how the progressive municipal vision provided by various local Labour Parties in the localities during the early twentieth century enabled the formation of cities in the twentieth century as working class locales, hence:

the Labour movement became, in many cities, a party of collective welfare provision, which was concerned to run cities efficiently, and therefore that working class politics, whilst continuing to be based in neighbourhood activity, transcended this level and played an increasingly important role in defining urban culture and city life. And, as Labour gained control of municipal authorities and so had greater ability to make the city in the image of the working class, so they could also facilitate working class formation.¹⁰²

The critical decade in which the working class was able to establish bases of power, was the 1920s. The decade saw an increased suburbanization and ruralization of the middle classes that allowed the working class to 'constitute themselves at spatial scales above those of neighbourhood alone, and gain a greater presence in the urban realm'.¹⁰³

The political and social history of Sheffield after the First World War illustrates this process: one where popular appeals to social justice and a sensibility that the community was entitled to some reward following the sacrifices of the war were prominent. Where local democratic action was a viable and practical means to achieve social reform. A greater sense of collectivism was evident in changes to party politics and in urban associational life. Labour fought every municipal seat for the first time in Sheffield in 1919, before taking control of the Council in 1926. The Labour Party remained in control of the Council in Sheffield for 71 of the remaining 74 years of the twentieth century.¹⁰⁴ In the eight years from 1918 to 1926 the city was governed by an

¹⁰¹ R.J. Morris, 'The Middle Class and British Towns and Cities of the Industrial Revolution, 1780-1870', in D. Fraser and A. Sutcliffe, (eds.) *The Pursuit of Urban History* (Edward Arnold, London, 1983), 286.

¹⁰² M. Savage, 'Urban History and Social Class: Two Paradigms', *Urban History*, 20, 1, (April, 1993), 76.

¹⁰³ Savage, 'Urban History and Class', 76.

¹⁰⁴ Following the 1926 ballot Labour failed to hold control of Sheffield County Borough/City Council for three one year periods in the twentieth century in 1932, 1969 and 1999. *Sheffield Year Book*, 1933, 1969.

alliance of Liberal and Conservative councillors who operated under the label of The 'Citizens' Alliance', by 1930 this group had rebranded as 'The Municipal Progressive Party'.¹⁰⁵ In 1920 the two Sheffield Trades Councils - the Sheffield Federated Trades Council, a Lib-Lab body mainly concerned with the interests of workers in the 'light' trades of cutlery and tool manufacture, merged with the Sheffield Trades and Labour Council, a more left wing organisation, concerned with workers in the 'heavy trades' of steel manufacture and heavy engineering, associated with the industrial East End of the city, the steel corridor of the Don Valley.¹⁰⁶ Consolidation and collective action was also a feature of the voluntary sector. In 1919 the Sheffield Joint Hospitals Council was created, in order for the four independent voluntary hospitals to join together in order to come up with a solution to address the serious financial problems facing voluntary hospitals after the First World War.¹⁰⁷ The organisational structure of the Poor Law in the city was also transformed in the 1920s. Until 1925 the two sides of the city had had separate poor law unions, the Sheffield Union in the east, north and centre and the Ecclesall Union in the south and west. The two Unions had different levels of poor rate as well as different levels of poor relief.¹⁰⁸ In the mid-1920s these two bodies merged into a single city wide body further enhancing the development of the city of Sheffield into a more unitary place and over-riding the long held idea of Sheffield as a city that was made up from a series of connected townships or villages.

This growing sense of Sheffield as a unitary civic entity, was fertile ground for the policy of municipalisation. In the late Victorian era, Liberal and Tory Councils in Sheffield brought in the municipalisation of the water supply, the tramways and the provision of electricity, however by the early 1920s the policy of municipalisation was curtailed and can be characterised as 'thus far and no further'.¹⁰⁹ The belief in minimal local government persisted on the Right in Sheffield into the twentieth century. The

¹⁰⁵ A. Thorpe, 'The Consolidation of A Labour Stronghold, 1926-1951', in C. Binfield, (ed.) *The History of the City of Sheffield* (Sheffield Academic Press, Sheffield, 1993), 85.

¹⁰⁶ S. Pollard, *A History of Labour in Sheffield* (Liverpool University Press, Liverpool, 1959), 265.

¹⁰⁷ Sheffield and District Association of Hospital Contributors, *Record of the Penny in the Pound Scheme, 1919-1948* (Sheffield, 1948).

¹⁰⁸ B.J. Elliot, 'The Last Five Years of the Sheffield Guardians'. *Transactions of the Hunter Archaeological Society*, (1973), 132-137.

¹⁰⁹ The lack of enthusiasm for municipal projects was noticeable on the right before the First World War. Hawson notes of the leader of the Liberal then Citizen Group, William Clegg, 'although he was a municipaliser he thought that they had gone as far as they should'. H.K. Hawson, *Sheffield The Growth of a City, 1893-1926* (Northend, Sheffield, 1968), 258.

guiding philosophy of the Citizens Alliance was expressed as 'Economy' in all aspects of public life. 'Economy' stood for economic retrenchment, with the goal of reducing the rates rather than use revenue to expand the public service provision. The Left, on the other hand, campaigned on a ticket of public services expressed in Labour's 1926 statement *A Progressive Charter For Sheffield Ratepayers*, where Labour called for widespread municipalisation schemes. These included better provision for the mentally handicapped and the blind, increased municipal involvement in health care and education facilities, as well as the introduction of a direct labour department and a reduction in tram fares.¹¹⁰ This municipal socialism through welfare theme illustrates that the Labour Party in Sheffield was not just concerned with trade union issues and labour representation, but was savvy enough to offer an electoral programme based on using the municipal machine to provide welfare services.¹¹¹

In 1932 a celebratory document *Six Years of Labour Rule*, was published containing a chapter headed '*Municipal Socialism*' that described the reforms that had been carried out by a 'Socialist Health Committee'.¹¹² This was an unequivocal sign that the term 'municipal socialism', previously used in a pejorative sense was appropriated by Labour politicians in Sheffield in the 1920s. The Labour Party identified itself as the engine of municipal socialism. *Six Years of Labour Rule* stated:

The Health side has still further been safeguarded by a large increase in the medical service both in the clinics and in the schools. The dental staff has doubled, and others have increased leading to tuberculosis, anaemia, malnutrition being wiped out in hundreds of cases. In no other area in the country could a Socialist Health Committee have had greater scope for its activities and during the last six years under review we have raised our health services to a standard not surpassed by any other comparable authority in Great Britain.¹¹³

The era of local control was short-lived. For one commentator the core beliefs of

¹¹⁰ *Sheffield Co-operator*, November 1926.

¹¹¹ Thorpe argues that Labour in Sheffield deliberately courted the electorate with its policies by developing a 'clientage' of voters, in particular through building a reputation as a good landlord and good employer. A. Thorpe. 'The Consolidation of A Labour Stronghold, 1926-1951', in C. Binfield, (ed.) *The History of the City of Sheffield* (Sheffield Academic Press, 1993), 118.

¹¹² Sheffield Labour Party, *Six Years of Labour Rule* (Sheffield, 1932).

the national Labour Party were discarded in the 1940s and 1950s to the point where even 'the belief in local democracy ... has faded completely, in its place we find a relentless drive towards centralization and bureaucracy.'¹¹⁴ Robson recognised that the Labour Party's core belief in equality was contrary to the inevitable differences arising from localism. That equity in welfare provision would demand an evenness of provision signalling the centralisation of the British state where nationalisation and central planning would witness the effective end of real powers for local democracy. The post-War Labour Government's decision to nationalise the NHS, rather than municipalize the health services, and in particular the hospital services, has been cited by a former Home Secretary and Labour Leader of Sheffield City Council as 'Labour's great mistake'.¹¹⁵

Any case study is limited by its geographical boundaries and by its lack of wider application. Laybourn has warned against the extrapolation of findings from case studies and the dangers of inferring that things were the same - or could have been the same - elsewhere.¹¹⁶ By building on the above discussion the case is made that a local study is relevant in order to gain a depth of understanding through detailed archival work to test the notions put forward by Webster and Freedman that analysis of politics and ideology can help us to better understand the development of health and social policy formation in Britain. The thesis aims to make a contribution to knowledge by examining the choices and decisions faced by individuals and groups involved in health policy in Sheffield before the NHS to better understand the political world that they lived in and to help explain how and why they thought and acted as they did.

¹¹³ *ibid.*

¹¹⁴ W.A Robson, 'Labour and Local Government', *Political Quarterly*, 24, (1), (1953), 39-55, 40.

¹¹⁵ D. Blunkett and P. Jackson, *Democracy in Crisis* (Hogarth, London, 1985).

¹¹⁶ K. Laybourn, 'The Rise of Labour and the Decline of Liberalism: The State of the Debate', *History*, 80, 259, (June 1995).

Structure of the Thesis

This introductory chapter has described the relevant historiography that the study belongs to in terms of the history of health policy and local government. The aims and the limitations of the thesis have been discussed. Some existing perceptions of health care in Sheffield before the NHS have been noted and the suggestion made that a more detailed and nuanced analysis is required. Issues of methodology have been raised, particularly Freedden's 'stranger at the feast' contention that there is more to say on the role of ideology in the history of social welfare in Britain than the focus on Edwardian Liberalism and the post Second World War welfare state. It has also noted Freedden's argument that ideas and competing notions of structured thinking are important to all eras. Previously neglected source material such as Ministry of Health Surveys, contemporary newspaper articles, specialist periodicals and the minutes of committees have been cited as key source material.

Chapter 1 provides historical and geographical context for the work through an examination of aspects of the history of Sheffield. The chapter examines factors such as landscape and geography. Social, economic and political change in the late nineteenth century and Edwardian era had important implications for policy makers charged with the governance of the city in 1918-48. Industry was particularly important to the social and political structure of Sheffield. Housing policy before 1914 is briefly assessed. The chapter concludes with an examination of the Sheffield political parties.

Chapter 2 examines Public Health policy in Sheffield in the 1920s, a period under Frederick Wynne as Medical Officer of Health. The issue of open air schools is explored as well as the leadership shown by the MOH in his willingness to take on vested interests over the condition of the milk supply. Differing views between the MOH and the Labour Chairman of the Health Committee, William Asbury are examined in relation to an outbreak of smallpox in Sheffield in the winter of 1926/27, a difference of opinion that brought ideological concerns to the fore.

Chapter 3 provides an analysis of Public Health in Sheffield during the 1930s. The views of the Ministry of Health are utilised through an examination of the 1934 Public Health Survey for Sheffield. The significance of the Local Government Act, 1929 is discussed as well as the distinctive features of the Tuberculosis Service in Sheffield, seen as unusual by the Ministry, with high referral rates in a city with low TB death rates. The thinking behind a TB re-housing scheme introduced in association with the Council's municipal housing agenda is examined. The Maternity and Child Welfare Service and the Venereal Disease Service of the Council were criticised by the Ministry. The assessment of the Ministry of Health is critically discussed.

Chapter 4 provides an analysis of events in hospital history in Sheffield after the First World War and before the introduction of the NHS. The four voluntary hospitals in Sheffield came together under an advisory Joint Hospitals Council and developed a workers hospital contributory scheme that was pro rata, supported by Labour and where employers made significant financial contribution. Labour's relationship to the scheme is explored and the importance of securing the support of Labour is examined. The development of a municipal general hospital service is featured as well as an examination of the drivers behind the design and operation of a joined up municipal and voluntary hospital system for Sheffield in the 1930s.

Chapter 5 offers a brief examination of the issue of local authority housing in Sheffield between the wars. To the Labour Council health and housing policy were two sides of the same coin. Housing policy was split along party lines with Labour defending its policy of building high quality, garden city style houses on suburban estates by direct labour and the Liberal/Conservative alliance favouring inner city flats built by private contractors. The findings of a social survey into housing in Sheffield are used. The thesis concludes by revisiting the aims and objectives presented here. It provides an assessment of how far the original aims have been met in light of the empirical research conducted and presented as evidence.

CHAPTER 1

Sheffield: The making of a working class city

This chapter examines aspects of the history of Sheffield in order to contextualise the later analysis of local authority health policy in the city. The unusual geography of Sheffield - in terms of landscape and location - is seen as integral to the development of particular industries, which in turn shaped the city's economic, social and political history. These elements are examined in relation to their influence on the formation of Sheffield as a civic entity. Rapid urbanisation in the late nineteenth and early twentieth century left a legacy of poor housing in Sheffield. The extent to which the local state should be involved in the provision of housing and other services became key electoral issues before the First World War. Claiming to offer 'real municipal socialism' was a common feature in the campaigning rhetoric of local politicians of all parties – with varying degrees of commitment to the provision of services via the rates. The chapter concludes with an analysis of the state of the political parties in the city in the early years of the twentieth century. It examines how the Liberal and Conservative Parties abandoned their separate party identities and joined forces to oppose the Labour Party. A distinctive feature of Labour politics in Sheffield was the way that the Party consolidated its electoral success.

Sheffield sits at the foot of the Pennines, it is hilly and in the extreme south of the West Riding on the fringe of the tourist resort of the Peak District. It is a vast industrialised area in the midst of fine countryside, like a gigantic inkblot in the midst of a virgin sheet of paper, this has given rise to a contrast which has caused it to be described as "Hell in the midst of Heaven".¹

Ah Sheffield! Long thou's been maligned
By those who passed thy beauties by;

We've known thou hast a noble frame
And wished the City were the same.
And now that wise men rule thy lot
And seek the good of human kind,

Thy streets shall match the golden gorse
Thy halls a dream of beauty find.²

These two views of Sheffield in the 1930s, the first from a Ministry of Health Inspector, the second from a Labour councillor capture the characteristics of an unusual city. A northern industrial city bordered by the Derbyshire and south Yorkshire countryside, Sheffield was formed and shaped by two distinctive factors, its landscape and its industry. History and geography are inescapably linked in the story of Sheffield. And as the geographer Doreen Massey states 'in trying to understand the identity of places we cannot - or perhaps should not- separate space from time or geography from history'.³ Massey has put forward the notion that the identity of a place is malleable and a dynamic phenomenon, observing that 'the identity of places is very much bound up with the *histories* which are told of them, *how* those histories are told, and which history turns out to be dominant.'⁴ (Original emphasis). Using this interpretation, the identity of a place is seen as a process, where the identity of a place is made and can be re-formed over time. As Massey notes 'it may be useful to think of places, not as areas on maps, but as constantly shifting articulations of social relations through time'.⁵

A particular kind of industry and a particular kind of politics have come to be associated with Sheffield. Sheffield has often been characterised as a Labour stronghold. Labour politics has been an important part of the city's identity, from the Chartist Town Councillors of the 1840s and 1850s, to the trade union 'Outrages' of the 1860s and beyond.⁶ The election of the Labour Party as the majority group on the City Council in 1926 furthered the cause of municipal socialism in the city, and saw the development of a certain kind of 'civic pride', one that was more concerned with the development of social policy and decent housing than with the usual trappings of civic life such as the construction of imposing public buildings. This somewhat unusual concept of civic pride will be a theme in this chapter.

¹ C. J. Donelan, Ministry of Health Inspector, City of Sheffield Survey of Health Services, (1934), 5, PRO MH 66/1076.

² An Alderman of the City, [Alf Barton], *In Praise of Sheffield, A Poem* (Sheffield, 1930). Barton was a Labour Councillor and Alderman. He was Chairman of the City Council Libraries and Museums Committees 1926-1933.

³ D. Massey, 'Places and Their Pasts', *History Workshop Journal*, 39, Spring (1995), 187.

⁴ D. Massey, 'Places', 186.

⁵ *ibid.* 187.

Factors that were important in the making of the identity of other British cities, have been notable by their absence in the history of Sheffield. In particular important cleavages based on ethnicity and religion which have been deeply rooted in shaping the tensions in places such as Liverpool and Glasgow are on the whole not part of the story of Sheffield. Thorpe has characterised ethnicity and religion as potential 'hostile dogs that did not bark' in Sheffield.⁷ Both historians and historical geographers have stressed the need to avoid the writing 'essentialist' histories of times or places.⁸ That is, a type of history which claims to discern the essence of a place or a historical era, as a single definitive, entity. Early commentaries on the development of Sheffield, though, found its key defining feature as essentially industry. Patrick Abercrombie, the leading architect and town planner was commissioned by the Council in the 1920s to produce *Sheffield: A Civic Survey and Plan*, Abercrombie summarised Sheffield as 'the largest purely manufacturing town in the country.'⁹ He noted that the city had a cathedral and a university, but that:

there is never any uncertainty that these are ancillary to its realisation as a complete community - there can be no doubt as to its main occupation as there is for example at Chester - a County Town, market centre, cathedral city, manufacturing borough, residential and recreational resort. All of which are important and therefore make it impossible to say which one is fundamental. Sheffield has no such complex structure. Its simple aim is to be a successful manufacturing community and everything must tend directly to that end. Even its university courses will be tinged with the study of primary needs and its more remarkable medical specialisations will reflect the disorders incident to its technical trades.¹⁰

Recognising the central role of industry is key to understanding the nature of Sheffield. Physically, industry inspired the urbanisation of Sheffield bringing in people

⁶ S. Pollard, *The Sheffield Outrages* (Adams and Dart, Bath, 1971).

⁷ A. Thorpe, 'The Consolidation of A Labour Stronghold, 1926-1951'. in C. Binfield, (ed.) *The History of the City of Sheffield* (Sheffield Academic Press, Sheffield, 1993), 87.

⁸ D. Massey, 'Places and Their Pasts', *History Workshop Journal*, 39, Spring (1995), 182-192. J. Baxendale and C. Pawling, *Narrating the Thirties: A Decade in the Making, 1930 to the Present* (MacMillan, Basingstoke, 1996).

⁹ P. Abercrombie, *Sheffield A Civic Survey and Suggestions Towards a Development Plan* (Liverpool University Press, 1924), 6.

¹⁰ P. Abercrombie, *Sheffield a Civic Survey* (Liverpool, 1924), 7.

from surrounding counties. Industry shaped the social geography of the place in terms of a residential south and west and an industrial north and east. Industry was important to the organisation of politics and civil society.

Location, Landscape and Industry

The twin processes of urbanisation and industrialisation transformed British towns and cities in the nineteenth century. By the start of the twentieth century the population of Sheffield was larger than that of other British cities such as Bristol, Newcastle or Liverpool, yet in many ways Sheffield was the least ‘civic’ of all the major British cities. The pace of change was staggering. Where the population of Britain doubled from 1801-1851, in Sheffield it trebled.¹¹ The population then proceeded to treble again in the last fifty years of the century. The combined population of the six townships that made up Sheffield in 1801, was 45,755. In 1841, two years prior to incorporation the population was at 111,091. By 1861, the population was 185,172, and 239,946, by 1871. In 1891 it was 324,234 and with the extension of the city boundary to include Hillsborough, Ecclesfield and Norton Woodseats in 1901 it was 380,793. With the influx of workers to serve the armament factories during the First World War, the population in 1921 was 490,639 and remained around half a million for the rest of the twentieth century.¹²

For one of England’s largest cities, Sheffield is unusual in being neither a port, nor an administrative centre, nor a communications centre. Sheffield is an industrial city, in the sense that its development as a major population centre, is related to industry to a far higher degree than is the case for other places. Like a number of characteristic aspects of the place, such as its class structure, its politics, and its government, the physical location of the town is closely associated with industry. Even its foliage is linked to its function as an industrial centre, as Richard Burns states, ‘the lovely and characteristic silver birches that plate hillsides too steep for building, were planted

¹¹ S. Pollard, *A History of Labour in Sheffield* (Liverpool University Press, Liverpool, 1959), 6.

¹² A.D.H. Crook, ‘Population and Boundary Changes, 1801-1981,’ in C. Binfield, (ed.), *History of the City of Sheffield* (Sheffield, 1993), 482-483.

because birch twigs were part of the steel process.’¹³ Dennis Smith has described Sheffield as ‘a geographical and demographic accident.’¹⁴ The fast flowing waters of its five rivers, the Don, Rivelin, Sheaf, Loxley and Porter, together with the proximity to coal for power, the abundant woodland for charcoal used in smelting, the iron-ore deposits for raw material, the millstone grit for grinding wheels, and limestone used for flux in the steel process, configured to make Sheffield a centre of metal manufacturing. The water that powered the wheels of the early grinders, was provided by the steep hills and valleys of the town’s five rivers. Wickham described how the Loxley, Porter, Sheaf and Rivelin flow into the Don from the west such that the layout of the town, as dictated by the course of its rivers looks like an upturned right hand, providing ‘a rough map of the ancient parish, the fingers being the streams running into the Don.’¹⁵

The water powered forges encouraged early settlements to develop in the west of the city. Looking outwards, this early association with industrial production marked Sheffield out as an unusual Yorkshire town, and looking inwards, it was along the location of industry that Sheffield itself was divided into different social, economic and political spheres. Small scale metal working for cutlery, edge-tool manufacturing, silver and silver-plate works were based in the centre of the town in hundreds of small workshops. The small scale capital investment required for the start-up and operation of these workplaces meant that there were very few large scale employers during the Industrial Revolution in comparison with the cotton or textiles industries of other places. As a consequence the industrial structure of Sheffield developed around a large number of small scale entrepreneurs or ‘little mesters’. A common theme among historians is that there was less distance in Sheffield between employer and employee making for a shared lifestyle and outlook. Childs has noted how:

unlike the merchants of Liverpool or the cotton kings of Manchester, the masters of Sheffield’s industry had at some time been apprentices and journeymen. Many of the employers of the town therefore had a greater

¹³ R. Burns, ‘The City as Not London’, in M. Fisher and U. Owen, *Whose Cities?* (Penguin, London, 1991), 62-69.

¹⁴ D. Smith, *Conflict and Compromise: Class Formation in English Society, 1830-1914* (London, 1982), 7.

¹⁵ E. R. Wickham, *Church and People in an Industrial City* (Lutterworth Press, London, 1969), 17.

affinity with the employed. This in turn could mean that social values and political thought had a greater homogeneity than elsewhere.¹⁶

As well as the importance of metal industries, another striking feature of the city is its marked west/east residential segregation on class lines. The south-west of the city, towards Derbyshire, having the benefit of prevailing wind from the Pennines, became the 'residential' sector and was where Sheffield's small middle class was located. The image of Sheffield to the outside world, from the middle of the nineteenth century to the middle of the twentieth century, was mainly one of grime and smog, but a city surrounded by attractive suburbs and open countryside. Typical of these descriptions is one from 1851 which noted the contrast between the 'dingy mean appearance' of the town as a whole, and the 'extreme beauty of the surrounding country, embellished as it is, in every direction, by the numerous villas of the opulent bankers, merchants and manufacturers of Sheffield'.¹⁷ These contrasting features are a comment on topography, but also an expression of the language of class, and an appreciation of the residential segregation that developed in British cities by the mid-nineteenth century.¹⁸

Towards the end of the nineteenth century and the development of large scale steel production the hilly topography of Sheffield meant that finding viable industrial space was a major concern. There developed a concentration of steel works in the east end of the city, in the only available flat space situated along the Don Valley. This industrial land use further polarised Sheffield with its middle class residential suburbs in the west, as the east became a place of work and housing for workers. The east-end districts of Attercliffe, Brightside and Darnall, along the Don Valley towards Rotherham, witnessed the construction of vast steel works to the point that this area

¹⁶ R. J. Childs, 'Sheffield Before 1843', in Binfield, (ed.), *History of the City of Sheffield*, 10.

¹⁷ J.R. McCulloch, *A Dictionary, Geographical, Statistical and Historical, of the Various Countries, Places and Principal Natural Objects in the World*, (1851), II, 678., Quoted in D. Cannadine, 'Victorian Cities: How Different?' in Rodger and Morris, *The Victorian City* (Longman, Harlow, 1993), 119.

¹⁸ See Engels on Manchester. F. Engels, *The Condition of the Working Class in England* (Oxford University Press, 1993).

from the mid-nineteenth to the mid-twentieth century, was 'along with Pittsburgh, the most concentrated centre for steel production in the world.'¹⁹

With few level areas, the hilly topography of the town funnelled the development of its transportation and industrial developments into a cramped space. Sheffield is skirted on three sides by hills and moors with the Don Valley to the East. It is overshadowed by Hallam Moor, Sky Edge and Pitsmoor. The only possible site for the railway was a half mile wide gap running through the town, south-west-to north-east. By the late nineteenth century this level area contained a canal, two through railways, two goods termini, a mineral line and sidings, main roads, a gas works, as well as a number of industrial undertakings.²⁰ The peculiar physical structure of the city at the foot of the Pennines, has prevented the establishment of a major airport, and has meant that, although Sheffield has a definable city centre, the surrounding roads have to navigate steep hillsides. The geographer R.N.R Brown noted in the 1936 that;

from the heart of the town roads radiate outwards, mainly along the river valleys, but a few climb the steep ridges. Thus the branch roads diverge as they leave the city, and cross roads are few, winding and steep. There is no place for circular boulevards in the town. The circular bus routes afford the suggestion of switch-back railways.²¹

Even after incorporation in 1843 a variety of small bodies continued to administer different aspects of the town, including the Town Trustees, Improvement Commissioners, The Cutlers Company and the Town Burgesses. They operated in an entirely uncoordinated fashion and were generally overwhelmed by the colossal task of urban environmental management. A survey of urban living conditions published by *The Builder* in 1861 noted how the physical state of the town, reflected the weak form of civic governance. In comparison to other northern and midlands towns;

Sheffield in all matters relating to sanitary appliances is behind them all. These rivers that should water Sheffield so pleasantly, are

¹⁹ G. Tweedale, *Steel City: Entrepreneurship, Strategy and Technology in Sheffield, 1743-1993* (Clarendon, Oxford, 1995), 5.

²⁰ D. Smith, *Conflict and Compromise: Class Formation in English Society, 1830-1914* (Routledge and Kegan Paul, London, 1982), 25.

polluted with dirt, dust dung and carrion; the embankments are ragged and ruined; here and there over run with privies; and often the site of ash and offal heaps-most desolate and sickening objects ... the results of these investigations prove that, although Sheffield possesses a medal of honour conferred at the hands of the Emperor of the French, it is devoid of the decencies of civilisation as it was in the Dark Ages.²²

Sheffield was both a late development and a late developer. David Hey reminds us that there is a history to Sheffield prior to the incorporation of the Borough in 1843, and that the layout of the centre of the town relates to its medieval market, as do the origins of several place names such as the areas known as Park and Manor.²³ Hey also reflects on the insularity of the town in terms of its popular surnames which have been passed on for centuries and are common to Sheffield, but which do not appear in other parts of the country.²⁴ This insularity has often been cited as an indication that Sheffield appears to be more like a village than a city. A report into the outbreak of smallpox in 1887-8 noted how; 'the population of Sheffield is, for so large a town, unique in its character, in fact it more closely resembles that of a village than a town, for over wide areas each person appears to be acquainted with every other person, and to be interested with that others concern'.²⁵ The insular nature of the place was recognised a generation later by a clergyman who noted that Sheffield had 'scarcely yet emerged from the status of an overgrown village, with a highly parochial mentality.'²⁶

The popular notion among commentators that Sheffield was more like a village than a city, was partly due to the homogenous nature of the population that came looking for work. The town was not a port nor a communications centre, it was not a railway town and therefore was not a place that people would come to know by being *en route* to other destinations. When the railway link from London came to Sheffield, it

²¹ R.N.R. Brown, 'Sheffield its Rise and Growth', *Geography*, 21, (1936), 175-84. 182

²² *The Builder*, 219, (1861), cited in S. Pollard, *A History of Labour in Sheffield* (Liverpool University Press, 1959), 13.

²³ D. Hey, 'Continuities and Perceptions', in C. Binfield, (ed.), *The History of the City of Sheffield* (Sheffield, 1993), 7.-16.

²⁴ The 1986 telephone directory for Sheffield showed 144 Broomheads (only one was recorded in Peterborough), and 239 Staniforths, (only one was found in Portsmouth). *Ibid.* 9.

²⁵ *Report on an Epidemic of Smallpox at Sheffield During 1887-8*, (Parliamentary Papers, LXV, 1889), 286.

²⁶ W. Odom, *Fifty Years of Sheffield Church Life, 1866-1916* (Northend, Sheffield, 1917).

was late in the century, in 1870 and Sheffield stood at the end of the Midland branch line. R.E. Leader noted in 1917 'anyone coming here, was brought by some special intent, not as a mere item in some larger journey.'²⁷ The absence of a wide range of trades and a very narrow commercial base, meant the Sheffield lacked the cosmopolitan benefits that could come from a mobile shifting population. On the whole, those who were immigrants to Sheffield from the eighteenth century onwards, were largely drawn from the neighbouring counties of Derbyshire, Lincolnshire, Nottinghamshire and the rest of Yorkshire.²⁸ In the middle of the nineteenth century, two thirds of Sheffield's population were locally born.²⁹ In 1901 10.3 % of the population were from the North Midland Counties of Cheshire, Warwickshire and Staffordshire, 4.6 % were born in Lancashire, while Scots and Irish born immigrants formed only 1.6 % of the population.³⁰ This characteristic short-distance migration pattern of the population of Sheffield continued to be feature well into the twentieth century, and it was a notable feature of the life histories of many of the key protagonists involved in Sheffield politics between the wars.³¹

Sheffield was granted city status in 1893, (in the same year as Leeds) and became the largest city in Yorkshire and the fourth largest city in the country. Sheffield was an *atypical* Victorian city. Its appearance lacked the dramatic sense of civic grandeur that was associated with the age of the great Victorian cities. In Joseph Chamberlain's Birmingham central slums were famously cleared for the construction of Corporation Street with its large scale office blocks and department stores, with its Law

²⁷ R. E. Leader, 'Our Old Roads' Paper read before The Hunter Archaeological Society, 1917, cited in P. Abercrombie, *Sheffield A Civic Survey* (Liverpool University Press, 1924), 6.

²⁸ E.J. Buckatzsch, 'Origins of Immigrants into Sheffield 1624-1799', *Economic History Review*, II, 3, (Autumn, 1950), 303-306.

²⁹ R. Dennis, *English Industrial Cities of the Nineteenth Century* (Cambridge, 1984). Table 2.3

³⁰ Pollard, *Labour*, 185.

³¹ Ernest Rowlinson (Leader Sheffield City Council 1926-1941) moved as a rail worker from Chesterfield to Sheffield. H. Mathers, in J. Bellamy and J. Saville, (eds.), *Dictionary of Labour Biography vol. VI* (Macmillan, 1982), 235. William Asbury (Deputy Leader, Chairman of the Health Committee, 1926-1942) was born in Wakefield and settled in Sheffield after marrying in 1918. Obituary, *The Times*, 27 May 1961. C.H. Wilson (Leader Sheffield Borough Council Labour Group, 1919-1923, MP for Attercliffe 1922-1931) was born in Mansfield Woodhouse, Nottinghamshire. H. Mathers, in J. Bellamy and J. Saville, *Dictionary of Labour Biography, vol. IX* (Macmillan, London, 1993), 272-275. George Fletcher, (Baker, Organiser of Sheffield Communist Party) was born in Lincolnshire and

Courts at one end and civic square at the other with a magnificent Town Hall and a statue of Queen Victoria. As Helen Meller states 'there was no doubt in the minds of the Birmingham Town Council, serving their city as volunteers in local government, imbued with the message of the 'civic gospel' that they were displaying citizenship.'³² Civic pride, in the case of Sheffield, was more of a mentality that was rooted in notions of craft and graft, it was a state of mind that was based heavily on associations with the workplace and in particular with skilled metal work. Conventional Victorian civic pride was epitomised by the building of stately town halls, it involved a sense of civic competition and rivalry where the city fathers enthusiastically approved plans for the building of gothic and neo-classical town halls with the grandest ornate architecture. Where Bradford, Leeds and Wakefield competed for the town hall with the longest frontage, in Sheffield the competitive edge found its expression in craftwork and industry. During his research for *The Road to Wigan Pier*, Orwell found that: 'Sheffield is held to lead London in everything, e.g. on the one hand the new housing schemes in Sheffield are immensely superior, and on the other hand the Sheffield slums are more squalid than anything London can show.'³³

Richard Burns, in his essay *The City as not London*, published in the 1990s, explains how in Sheffield;

only a handful of buildings achieve any degree of distinction .. if Sheffield pleases the eye – which it often does – it is because of its situation not its buildings. Even those buildings which universally act as the focus of civic pride seem in Sheffield to suggest only our distaste for display. Our cathedral is a converted parish church, and looks it; our railway station is even worse. It is as if the architects and engineers of this city that is not London have been overawed.³⁴

established Fletcher's bakery in Sheffield in 1902. D. Martin, in J. Bellamy and J. Saville, *Dictionary of Labour Biography vol. IX* (Macmillan, London, 1993). 83.

³² H. Meller, 'Urban Renewal and Citizenship: The Quality of Life in British Cities, 1890-1990,' *Urban History*, 22, 1, (1995), 63-84, 63.

³³ G. Orwell, 'The Road to Wigan Pier Diary', in *The Collected Essays, Journalism and Letters of George Orwell* (Penguin, Harmondsworth, 1968), 191.

³⁴ R. Burns, 'The City as Not London', in M. Fisher and U. Owen, (eds.), *Whose Cities?* (London, 1991), 62-70, 68.

The understated architecture of Sheffield is partly a legacy of the type of small scale industry that was located in the city centre with the larger scale industry kept away from view in the Don Valley. The city was devoid of the grand temples of Victorian commerce that added to the civic grandeur of the great urban commercial centres. Victorian Sheffield did not have the corn exchange of Leicester and Leeds, the wool exchange of Bradford, the customs houses of Liverpool or Bristol, or the grand central library building of Manchester. Neither did Sheffield possess the giant warehouses and mills of the towns of Lancashire and the West Riding.

In many ways Sheffield appeared to be behind other towns and cities and often seemed to be catching up with developments that had already taken place in other urban centres. Feudal patterns of land ownership were unusually long lasting in Sheffield. The Duke of Norfolk, (who was also the Earl of Arundel and Surrey and Earl Marshall of England), continued to own much of the city centre until the very end of the nineteenth century. The Duke of Norfolk owned the town markets from medieval times until 1899 when they were sold to the Council.³⁵ It was almost the twentieth century before Sheffield had its first purpose built town hall. Until 1897 the civic affairs of Sheffield were conducted in a series of offices scattered throughout the city centre. By the time Sheffield Town Hall was eventually opened, it was almost half a century after the opening of Leeds town hall.³⁶

In terms of its class structure, Sheffield also possessed some distinctive features. For instance, a key part of the urbane and 'civic' nature of Victorian cities was fostered by the growth of clubs and associations that formed middle class civil society.³⁷ In this regard, Sheffield was remarkably lacking for a town of its size. Victorian associations such as the Athenaeum movement thrived in cities like Leeds, Bristol, Birmingham and Manchester but were spectacularly unsuccessful in Sheffield in the middle years of the

³⁵ The Duke of Norfolk was also the first Lord Mayor of the City in 1897, and he presented Sheffield with its first public park, Norfolk Park in 1847. D. Martin, 'Introduction' in Binfield, *History of the City of Sheffield*, 5. G. Cherry, *Cities and Plans the Shaping of Urban Britain in the Nineteenth and Twentieth Centuries* (Edward Arnold, London, 1988), 47.

³⁶ A. Briggs, *Victorian Cities*, (Penguin, London), 237.

³⁷ For associational life in Victorian Leeds see R.J. Morris, *Class, Sect and Party: The Making of the British Middle Class: Leeds, 1820-1850* (Manchester, 1990).

nineteenth century.³⁸ As a town predisposed to manufacturing and metal work, Sheffield simply lacked a sizeable urban middle class. In 1851 Bristol had 89.4 per thousand of its population engaged in literary, professional, artistic, mercantile, transport and communications occupations, Birmingham had 65.8, per thousand, while the figure for Sheffield was 41 per thousand.³⁹ The dominance of manufacturing industry in Sheffield was significant to an even greater extent than the other great metal town in Victorian England, Birmingham. In 1871 Birmingham saw 199.4 per thousand of its workers engaged in metal and engineering, compared to a figure of 264.2 per thousand for Sheffield.⁴⁰ Where middle class associations failed to get off the ground in Sheffield, Labour organisations thrived. Sheffield had 60 Trades Unions listed in 1861 with 10 different grinders unions.⁴¹ There were 56 sick clubs with a membership of 11,000 in 1843.⁴² The city had an array of radical and political newspapers, two Trades Councils and two co-operative societies. As late as the 1960s, more people were employed in manufacturing industry in Sheffield than any other sector.⁴³

A comparison with the more aspirational civic features of Leeds, Sheffield's nearest rival, illustrates the differences between the two places. The West Yorkshire city became a municipal entity much earlier than Sheffield, the granting of the Leeds charter took place over two centuries before Sheffield, in 1626.⁴⁴ Leeds was physically situated in a position that made communications with other places much easier. As a regional centre for commerce, the early development of Leeds had a snowball effect, as textile trade attracted investment finance and a wide array of industries began to serve

³⁸ A. White, 'Class Culture and Control: the Sheffield Athenaeum Movement and the Middle Class, 1847-64', in J. Wolff and J. Seed, (eds.), *The Culture of Capitalism* (Manchester, 1988), 3-115.

³⁹ S. Pollard, 'Labour', in C. Binfield, (ed.), *History of the City of Sheffield*, (Sheffield, 1993), 260.

⁴⁰ D. Smith, *Conflict and Compromise: Class formation in English Society, 1830-1914* (London, 1982), 72.

⁴¹ Birmingham had 40% higher population with a total of 43 unions. Of the Sheffield unions 30 held weekly meetings, 15 met fortnightly and 12 met on a daily basis. Smith, *Conflict and Compromise*, 41.

⁴² Dr G. Calvert Holland noted that 'with the exception of the grinders, the working classes, as a body, in this town are superior in intelligence and physical condition to those of any other manufacturing district.' S. Pollard, 'Labour', in C. Binfield, (ed.), *History of the City of Sheffield* (Sheffield, 1993), 263.

⁴³ Only Middlesbrough, another steel town, had proportionally more workers in manufacturing in the 1960s. W. Hampton, *Democracy and Community: A Study of Politics in Sheffield* (Oxford, 1970), 43.

Leeds. The diversity of trades and commerce in Leeds was a significant factor that was missing from Sheffield's history. Leeds also benefited from being physically at the centre of a geographical region placing that city at the top of an urban hierarchy. In the same way that Manchester was a regional town serving Rochdale, Stockport, Burnley and Oldham as part of the cotton metropolis, Leeds was connected in a similar way to its satellites in the woollen textile industry such as Dewsbury, Batley, Halifax and Huddersfield. Sheffield was far more geographically isolated than all other industrial cities, only Rotherham continuously joined Sheffield, making Sheffield the largest city in the country that was not a conurbation.

The physical isolation of Sheffield adds to the notion of a city that looks in on itself, rather than to a region. Sheffield was frequently seen as an insular place, as a city unreceptive to outside influences and ideas. This view was evident well into the twentieth century. A Ministry of Health inspector who investigated the city's Public Health Services in 1934 recorded that :

the people are in the main of a stubborn nature very independent, very self willed, capable of being led with care but not easily driven, very intolerant of any situation of autocracy and with a keen sense of the value of money.⁴⁵

Violet Markham, the social reformer originally from Chesterfield, visited Sheffield on behalf of the Assistance Board to report on the functioning of social services after the Blitz in December 1940. Markham noted that 'the idiosyncrasies of the Sheffield Corporation have long been known to me. They are a self-sufficient, self-satisfied body, dominated by a certain type of Labour politics and they are very unreceptive to ideas from outside.'⁴⁶

For this characteristically insular and parochial city, paradoxically its commercial success depended on global connections and international markets.

⁴⁴ W. Hampton, *Democracy and Community: A Study of Politics in Sheffield* (Oxford University Press, 1970), 27.

⁴⁵ PRO MH 66/1079 Ministry of Health Survey of Public Health Services in the County Borough of Sheffield, 1934, 7.

Tweeddale has pointed out the inter-dependent relationship between the industrial development of the United States of America and the development of the city of Sheffield.⁴⁷ Sheffield was not a basic metal work town, but an industrial complex featuring a bewildering array of specialised skills, practices and metal work trades. Minute subdivisions of labour occurred in the trades of the grinders, hafters, forgers, shapers and others who operated a flexible outworker system which allowed for a high degree of flexibility and an ease of adaptability to quickly take on and incorporate technical innovations into working practices. In the world of cutlery and tool manufacturing trades, Sheffield had the competitive edge.

From the latter part of the nineteenth century and well into the twentieth century, large numbers of workers remained employed in cutlery and edge tool manufacturing at the same time as engineering and steel production took off. The development of this dual nature to the Sheffield economy, with the 'light trades' of cutlery manufacture and the 'heavy trades' of steel production, prompted the comment that late nineteenth century Sheffield, constituted two very different towns occupying the same space; [one based on] a light industrial craft workshop and [the other] a factory based steel industry.⁴⁸ The two distinctive elements of industry in the city resulted in separate trade union organisations and Sheffield developed two separate Trades Councils that only combined into one body in 1920. By that date there were around 70,000 employees in the large steelworks.⁴⁹ The different character of the two sides of industry in Sheffield, and the different styles of industrial relations that were found in the large scale steelworks and in the smaller scale cutlery manufacturers, was reflected in the political character of the municipal wards where these different industries were located. For example, the syndicalist communist Shop Stewards movement that developed at the end of the First World War, was made possible by the mass labour conditions found in the

⁴⁶ Report on Sheffield, Violet Markham Papers British Library of Political and Economic Science, 8/36.

⁴⁷ G. Tweedale, *Sheffield Steel and America: A Century of Commercial and Technological Interdependence* (Cambridge, 1987).

⁴⁸ T.J. Caulton, 'The Tentacles of Slumdom: A Case Study of Housing and Urban Structure in Sheffield, 1870-1914' (unpublished University of Sheffield Ph.D. thesis, 1980), 541.

⁴⁹ Tweedale, *Steel City*, 6.

large scale heavy industrial factories of the East-End, where the distance between capital and labour was the greatest.⁵⁰

The steel industry itself should not be seen as monolithic. Research into the economic and business history of the city has shown the continued importance of many small firms to Sheffield's business structure during the late nineteenth century and early twentieth century.⁵¹ The steel industry was a diverse sector, and steel production in Sheffield developed along specialised lines. The main division in the British steel industry was between bulk steel production and special steel production. Bulk steel production was seen in South Wales and Middlesbrough, it sought economies of scale, as well as proximity to sea ports in order to facilitate the importation of iron-ore and the export of manufactured outputs. Specialist steel production, meaning the invention and manufacture of specialist steel to specific order, was Sheffield's forte. As with the cutlery trade before it the steel industry developed along lines that demanded a high degree of skill. Sheffield alloy steels and stainless steels became increasingly sought after for use in technological innovations and were used in almost every aspect of life throughout the twentieth century. As Tweedale states 'Some of us will even have our lives saved, (or perhaps ended), by alloy steels. Most of which were discovered and developed in Sheffield'.⁵² This unusual city with an unusual industrial and geographical basis and a peculiar class structure developed what Pollard has referred to as an 'unusual working class'.⁵³

The insular nature of the place together with its small middle class, meant that Sheffield had a relatively small pool of civic leaders to draw on. The result of this was that the same individuals frequently served on the administrative bodies of the city. This small pool of public servants was a notable feature of the political and health and

⁵⁰ For an example of industrial radicalism see, J.T. Murphy, *The Workers Committee: An Outline of its Principles and Structure* (First Published by Sheffield Workers Committee, 1917. Reprinted London Pluto Press, 1972).

⁵¹ M.J. Lewis, 'The Growth and Development of Sheffield's Industrial Structure, 1880-1930' (unpublished Sheffield Hallam University Ph.D. thesis, 1989)

⁵² Tweedale, *Steel City*, 15.

⁵³ S. Pollard, 'Labour' in C. Binfield, (ed.), *The History of the City of Sheffield* (Sheffield 1993), 263.

welfare bodies of the inter-war years.⁵⁴ One of the outcomes of having this small pool of long serving civic leaders was that personal contacts enabled a high degree of formal and informal liaison between the members of key institutions, such as the hospitals, the Trades Council, the University and the local authority. The implications of this situation in health administration in Sheffield in the 1930s, will be examined in later chapters. Inter-war civic leaders such as Ernest Rowlinson and William Asbury, had long records of public service, as Sheffield politicians. These political actors of Sheffield's Labour movement, consolidated their position as executive urban administrators and politicians through an almost unbroken tenure as Leader and Deputy Leader of Sheffield City Council from the 1920s to the 1940s. Consequently the concerns of their political careers were played out through Sheffield issues - improvements for the welfare of the inhabitants of the city and the improvement of the fabric of the borough. The representation of the Sheffield Labour movement in Westminster and in Government in the inter-war years, was seen through the election of A.V. Alexander as MP for Hillsborough in 1924 and 1929 who was considered to be removed from life and events in Sheffield.⁵⁵

⁵⁴ William Asbury was Deputy Leader of Sheffield City Council, 1926-1942, as well as simultaneously serving as chairman of the Health Committee, the Public Assistance Committee, and The District Smoke Abatement Committee. He was Chair of the Air Raid Precaution Committee, a Poor Law Guardian, a member of the Royal Commission on Unemployment 1932, and signature of the minority report. He was also a subscriber of the Sheffield Women's Welfare Clinic. Ernest Rowlinson was Leader of Sheffield City Council from 1926 to 1942, the Chairman of two committees including Education and a member of six others. He was Chairman of the Education Committee of the Association of Municipal Corporations, and he sat on the Ray Committee on Local Government Expenditure. Shortly before his death Rowlinson was a member of the Nuffield Provincial Hospitals Trust. *Sheffield City Council Minutes, 1926-1942, passim, Annual Report of Sheffield Federated Trades and Labour Council, 1920-1930, passim.*, J. Bellamy and J. Saville, (eds.), *Dictionary of Labour Biography, vol. VI* (Macmillan, London, 1982), 235. *Annual Report of Sheffield Women's Welfare Clinic, 1933 FPA A4/A 14.1*, Contemporary Medical Archive Centre, Wellcome Institute for the History of Medicine, London.

⁵⁵ As the Co-operative Party Member for Hillsborough, A.V. Alexander served as Private Secretary to Sidney Webb at the Board of Trade in the 1924 Labour Government and as First Lord of the Admiralty in the 1929-1931 Labour Government. He held the same post during the Second World War and in the post-war Labour Government. In 1946 he was made Minister Without Portfolio. D. Butler and A. Sloman, *British Political Facts, 4th ed.* (Macmillan, 1975), 16, 18, 27, 33, 34. Tilley notes how Alexander was an infrequent visitor to Sheffield and was socially removed from the city and his constituents. His strong relations with the Royal family saw him become the unofficial Minister with responsibility for Royal finances. J. Tilley, *Churchill's Favourite Socialist: A Life of A.V. Alexander* (Hollyoake, Manchester, 1995).

In the second quarter of the twentieth century there was a very real sense that local government was *the* potential agent of change. Able politicians sought Council seats, and the roles and responsibilities taken on by the local authority in the years before the Second World War, meant that the local government in Sheffield was interventionist and far more dynamic than simply acting as the agent of delivery for the policies of central government. The immediate implementation of progressive policies by the Sheffield Labour Party in 1926, was partly a reaction to the apathy of previous administrations. An examination of the nature of the development of local government in Sheffield helps us to understand why the challenge from Labour to govern the city in a more active, a more systematic and in a more 'municipally minded' way, appealed to the electorate in the 1920s.

Government and Politics

The frequent charge from commentators that Sheffield lacked a sense of civic pride can be related to its somewhat late development as a defined unit of local government. Deep political divisions existed in the town in the mid-nineteenth century, over the proposed incorporation of Sheffield as a municipal borough. Derek Fraser has noted how in 1838 the presence of a non-municipalising anti-charter movement in Sheffield managed to raise a petition with 15,300 signatures, while those proposing incorporation managed to attract only 9,600 signatures, (after scrutiny these were reduced to 4,589 and 1,970).⁵⁶ The initial application, was therefore denied and the matter of transforming the collection of Townships into a unitary municipality was not raised again for another five years. The slow movement towards incorporation highlights a reluctance in Sheffield to cede powers to new forms of representative democracy. This hesitancy was rooted in the strong identity of the communities that made up the town. There were six townships, or large villages that eventually came to constitute the urban administrative unit of Sheffield, all of which had well developed individual 'neighbourhood' identities and a sense of place that was not easily rescinded

⁵⁶ D. Fraser, *Power and Authority in the Victorian City* (Blackwell, Oxford, 1979), 139.

to government by a civic municipality.⁵⁷ Each of the townships had its own vestry and highways board.

Opposition to political reform that entails a radical change in the way that a place is governed can reflect the fears of a community over the surrender of smaller forms of government (which may or may not be any longer viable) for the introduction of larger units of administration. In nineteenth century Sheffield the concern of those opposed to the incorporation of the borough, was that a dreaded 'urban elite' would be formed if the town became a municipality. Samuel Roberts, a Tory objector to incorporation, warned the population that 'by means of a Corporation you will be raising up an aristocracy among you and also creating a set of masters over you.'⁵⁸ Radical politicians, such as Isaac Ironside leader of a Sheffield Chartist group known as the Democrats also expressed a suspicion of higher forms of government. A reluctance to see powers transfer from the neighbourhood to the Town Council was evident, as well as an opposition to anything that could be construed as central Government dictat.

The effect of the delay was to hinder any movement towards addressing the appalling living conditions that rapid urbanisation and industrialisation had visited on Sheffield. Yet, the objection to incorporation can be read as a defence of the rights of localities to decide their own affairs, this attitude of local versus central, of keeping power in the hands of the people, was one that persisted in the city into the 1920s and beyond.

The town charter was eventually granted in 1843 and the first local elections were held in November. However, the new Town Council was constrained by its lack of powers and by the territorial rivalries between the various bodies. Compared to other incorporated Towns, Sheffield Council took its time in finding its legitimate spheres of influence. The continued existence of the hotchpotch of authorities after 1843 and the

⁵⁷ For administrative purposes, the parish had been split into six townships, which were coterminous with the boundaries of the new borough, the distinctive hilly topography also served to define these areas as distinct from each other. The six townships on incorporation were Attercliffe and Darnall, Brightside-Bierlow, Ecclesall-Bierlow, Nether Hallam, Upper Hallam and Sheffield. A.D.H, Crook, 'Population and Boundary Changes, 1801-1981,' in C. Binfield, (ed.), *History of the City of Sheffield*, vol. 2 (Sheffield, 1993), 482.

⁵⁸ D. Fraser, *Power and Authority*, Ibid.

impotence of the fledgling Borough Council, meant that the new local government structure was 'a regime in search of a role'⁵⁹.

The Town Trust was not a rate levying body but was (and remains) a charitable organisation established by the Lord of the Manor, Thomas de Furnival in the thirteenth century to administer municipal functions for the benefit of the town. At the end of the nineteenth century, the Town Trust introduced a form of Victorian paternalist urban improvement to Sheffield with the opening of the Botanical Gardens. The Town Trust continues to own the Botanical Gardens today. Without the ability to raise a local rate, however, the Town Trustees were unable to cope with the urban problems associated with the rapid expansion of the area. If the Town Trust attempted to undertake street improvements, it soon found the expense of urban environmental management was beyond the means of charity.⁶⁰

A Sheffield Improvement Bill was first proposed in 1851 and included provision for the improvement of sewerage, building regulations, the control of smoke and highways improvements. It included options for the purchase of utilities such as gas and water supplies and for the creation of municipal cemeteries and markets. The drawback was that the Bill envisaged the raising of loan of half a million pounds and the setting of an improvement rate of 2s 6d. The issue split the Chartists and a resolution was passed declaring that 'it is not expedient at the present time to consider the most efficient means of improving the borough.'⁶¹ The improvement of the borough was therefore delayed. Local Government Act functions were adopted by the Council in 1864 and by-laws were introduced that banned the building of back-to-back housing, introduced a minimum width for streets, as well as minimum heights for rooms and the installation of windows that opened. Arrangements also had to be made for the creation open space and the provision of drainage to roads and houses.⁶²

⁵⁹ B. Barber, 'Sheffield Borough Council, 1843-1893', in Binfield, *History of the City of Sheffield*, 25.

⁶⁰ R. Childs, 'Sheffield Before 1843', in Binfield, *History of Sheffield*, 13.

⁶¹ *Sheffield Independent*, quoted in A. Briggs, *Victorian Cities* (Penguin, 1968), 237.

⁶² Craven, 'Housing Before the First World War', 70.

It was in the last decade of the nineteenth century, under a Conservative council that the provision of municipal services began to take shape. The era of gas and water municipal socialism in British urban history took place later in Sheffield than in other towns. In Sheffield the water supply remained in the hands of a joint stock company until 1888, and the gas supply remained in private hands until nationalisation of the gas supply in 1948.⁶³ The municipalisation of the water supply was a direct result of the failure of private finance to ensure safety standards. The Sheffield Flood of 1864 saw the Dale Dyke Reservoir burst its banks leading to the country's worst peacetime disaster with the loss of 240 lives. Conservative and Liberal Councillors gave evidence in support of the municipalisation Bill, as did Ironside. The Council was granted permission to take over ownership of the water supply and with the authorities of Derby, Leicester and Nottingham developed the Derwent Valley Water Board in order to build reservoirs at Howden and Derwent. The latter reservoir was completed in the 1940s.⁶⁴ The parochial attitude of some, mainly Liberal town councillors opposed this reform. The *Sheffield Independent*, expressed the Liberal opposition to the decision to take control of the water supply. Such attitudes were recognised as petty minded provincialism by the leading Liberal MP for Sheffield Brightside, A.J. Mundella who wrote:

I see a pretty state of things in your Municipality. Everything is mean, petty, and narrow in the extreme. What a contrast to Leeds! Sheffield would do well to spend half a million on improvements. A better Town Hall might be followed by better Town Councillors and more public spirit.⁶⁵

This late and limited movement into municipalisation resulted in the purchase of the town market in 1899, as well as the tramways and the electricity supply.⁶⁶ Both the Conservative and Liberal Parties included supporters and opponents of municipalisation. However from the turn of the century the Council adopted a policy of 'Economy' and retrenchment rather than develop further this notion of civic improvement. After water, electricity and the markets, the only other municipalisation

⁶³ Barber, 'Sheffield Borough Council', 46.

⁶⁴ J. Cass, 'Water Supply', Binfield (ed.), Sheffield, 119.

⁶⁵ D.E. Fletcher, 'Aspects of Liberalism in Sheffield, 1849-1886' (unpublished University of Sheffield Ph.D. thesis, 1972), 91. cited in Barber, 'Sheffield Borough Council', 51.

⁶⁶ Mathers, 'City of Sheffield', 54.

scheme before the Labour victory of 1926 was the establishment of a municipal milk service which ran from 1919-1922.⁶⁷ Part of the Labour Party campaign in the 1920s included the municipalisation of the milk supply, however, once Labour won the 1926 local election the milk supply was left in private hands, possibly due to opposition from the city's two co-operative societies.⁶⁸ The condition of the milk supply in Sheffield became a major concern of the Medical Officer of Health for Sheffield in the 1920s and will be examined in Chapter 2.

The issue of Housing in Sheffield Before 1914

One of the largest challenges that faced early twentieth century politicians and administrators in Sheffield as elsewhere, was the poor state of housing. The lack of municipal controls in the nineteenth century allowed over 38,000 back-to-back houses to be constructed by unregulated speculative builders in the city.⁶⁹ In 1841 there were 22,770 houses in the borough and the average distribution of people per household, at around 5 was lower than comparable figures for Liverpool and Manchester.⁷⁰ A tradition developed in Sheffield for families to live in individual houses. The large numbers of cellar dwellings seen in nineteenth century Liverpool were not a feature of Sheffield's housing history.⁷¹ It was the back-to-back house that was the predominant housing form of nineteenth century Sheffield. The areas of back-to-back terraced housing, found typically in the east end of the city, have been described architecturally by Crooke as, 'giant units of a black and smoky encampment that dwarfed the cutlery industry and its workshops scattered all over the traditional city ... hundreds of streets of shoddy houses soon blackened by smoke spread up the sides of the valley itself.'⁷²

⁶⁷ *Sheffield Year Book*, (Sheffield, 1919 and 1923).

⁶⁸ Sheffield Labour Party, 'A Progressive Charter for Sheffield', *Sheffield Co-operator*, November, 1926

⁶⁹ Barber, 'Sheffield Borough Council, 1843-1893', 44.

⁷⁰ Average distribution of people per household in 1841 was 5.78 in Manchester and 6.67 in Liverpool. A.M. Craven, 'Housing Before the First World War' in C. Binfield (ed.), *History of the City of Sheffield* (Sheffield, 1993), 65-75. 65.

⁷¹ For Liverpool see A. Hardy, 'Urban Famine or Urban Crisis? Typhus in the Victorian City', *Medical History*, 32, (1988), 401-425.

⁷² P. Crooke, 'Sheffield', *Architectural Design*, (September, 1961), 381.

Back-to back houses were a characteristic feature of housing in the north of England, they were seen particularly the West Riding, and were not generally found further south than Birmingham.⁷³ These houses were typically one small room on top of another 'the typical ground floor area in Sheffield being 150 square feet, giving rooms of about 12 square feet.'⁷⁴ Pollard has described how the standard Sheffield workman's cottage:

was built of brick, made cheaply from local clay and was covered with local slate. It had a cellar, a living room on the ground floor, a "chamber" on the first floor and generally an attic or second bedroom on the second floor. The cellar was not normally inhabited. The daily activities of the family were concentrated in the living room, which served as a kitchen, scullery, dining room, living room, as wash room and bathroom and on wet days clothes were hung up in it to dry. The room was usually paved with flags, its fireplace was fitted with an oven for baking , with a side boiler for hot water ... in the chamber a room with a boarded floor and fireplace, slept husband and wife and the younger children. The attic at the top was a low room ... it formed the sleeping apartment for the older children and, if necessary, the lodger.⁷⁵

These terraced houses were joined on three walls by neighbours. The house fronted either on the street to into a yard which was accessible through a narrow passage built under the first floor rooms and was the depth of two of the houses. By the time that the by-law was introduced prohibiting the building of back-to-back houses in Sheffield in 1864, it was estimated that there were 38,000 dwellings of that type in the city. There were 17,000 back to back houses remaining in 1914.⁷⁶ Both social and economic reasons lead to the dominance of the back-to-back-house as a building form. One of the principal requirements of nineteenth century housing was that it be cheap and within walking distance of the place of work. Sheffield employers in the east end, the large steel works, were not known for building housing for their workers, this was therefore left to speculative builders and small-time investors who generally owned less than fifty dwelling houses.⁷⁷ Small time landlords were typically those who could least

⁷³ J. Burnett, *A Social History of Housing* (London, 2nd Ed. 1986), 74.

⁷⁴ J. Burnett, *A Social History of Housing* (London, 2nd Ed. 1986), 75.

⁷⁵ S. Pollard, *A History of Labour in Sheffield* (Liverpool, 1958), 18.

⁷⁶ Pollard, *A History of Labour in Sheffield*, 100, 190.

⁷⁷ Pollard, *A History of Labour in Sheffield*, 101.

afford repairs and improvements. Orwell pointed out how small time landlords were characteristically worse than wealthy ones:

It goes against the grain to say this but one can see why this should be so. Ideally the worst type of slum landlord is a fat wicked man, preferably a bishop, who is drawing an immense income from extortionate rents. Actually, it is a poor old woman who has invested her life savings in three slum houses, inhabits one of them and tries to live on the rent of the other two.⁷⁸

The apocryphal story that Sheffielders are said to have discovered for the first time that the sky was blue, during the General Strike, when the chimneys of the Don Valley were dormant, highlights the environmental conditions of life in a heavy industrial city.⁷⁹ The chimneys of the steel works produced so much filth and pollution in the 1920s, that soot and smoke was estimated to cut out twenty per cent of natural sunlight in the industrial area of Attercliffe, when measured against the 'residential' south-west.⁸⁰ Although the term 'residential' refers to the villas and suburbs of the west of the city, industry and residences for workers were closely integrated. In the centre housing was found alongside tool and cutlery works, and in the east end houses were packed around steel works.⁸¹

In terms of sanitation Sheffield had a reputation as a 'privy midden town.' A sub-committee of the Health Committee stated in 1889, 'This pest hole in the ground called a midden ... is often within a few yards of the doors and windows of the houses in which a great portion of the poor people live. It is around and about this hole that the children play. The old privy midden system as it exists in Sheffield is without a redeeming feature'.⁸²

⁷⁸ G. Orwell, *The Road to Wigan Pier* (London, 1966), 50.

⁷⁹ H. Meller, *Towns, Plans and Society in Modern Britain* (Cambridge University Press, 1997).

⁸⁰ P. Abercrombie, *Sheffield a Civic Survey* (Liverpool University Press, 1924), 5.

⁸¹ Pollard, *Labour*, 20.

⁸² Sheffield Council Health Committee Sub-Committee, *Report on Disposal of Refuse*, (Sheffield 1889), 17.

A meeting of the Social Science Congress in Sheffield in 1865 was shocked at descriptions of the privy midden system in the city, where up to 60 people shared one privy.⁸³ In 1873 the Council accepted that night soil and ashpits should be emptied free of charge. In 1875, Sampson Morley the superintendent of Woodside Lane depot, was in charge of 60 horses and carts, 50 sweepers and a large number of 'nightmen'. 'Scavenging,' the emptying of privies and ashpits into piles on the street to be collected by cart, was carried out between the hours of 2 and 9.30 a.m. The nightsoil was sold to farmers as fertiliser.⁸⁴ The condition of the housing stock in the city was a major problem. A series of reports in the *Sheffield Independent*, in the 1870s described the poor condition of even new housing developments in areas such as West Bar and St Philips Road, as Sidney Pollard stated 'virtually everywhere the picture was essentially the same: working class families struggling to lead decent lives in conditions of unimaginable dirt and neglect.'⁸⁵ Sheffield Council began to address the town's sanitation problems in the 1880s and 1890s with the development of a sewage works at Blackburn Meadows, and with the Sheffield Corporation Act of 1894 by which property owners were compelled to install adequate water closets in all new houses. When in the 1880s, Sheffield's Medical Officer of Health produced reports that detailed poor sanitation in many districts, the Council's solution to this embarrassment was censorship. The offending passages on sanitation were initially struck out of the annual publication, then for a period of five years the entire Annual Report of the Medical Officer of Health went unpublished.⁸⁶ The general mortality rate for Sheffield was higher than the national average throughout the latter half of the nineteenth century. This was often attributed to the prevalence of 'unhealthy trades'. A report of 1866 stated that 'the disastrous influence of certain employments upon the duration of human life are more marked here than perhaps in any other manufacturing district in the kingdom.'⁸⁷

⁸³ *Sheffield Independent*, 23 October 1865, in S. Pollard, *A History of Labour in Sheffield*, 94.

⁸⁴ Shaw, 'Aspects', 106.

⁸⁵ Pollard, *Labour*, 94.

⁸⁶ No Annual Reports of the MOH for Sheffield were published from 1879-1885.

⁸⁷ *Quarterly Review*, April 1866, p386. Cited in S. Pollard, *Labour*, 100.

The incidence of disease and high mortality rates in areas with large amounts of back-to-back housing was therefore not 'due to bad housing as such, but to the inadequacy of the water and drainage and no doubt to the polluted atmosphere.'⁸⁸ The yards of each block of houses were not always paved, and contained the shared privy middens which had to be emptied by night soil men. There were 37,000 middens emptied in Sheffield in 1887. In 1888 there were 4,300 water closets in Sheffield supplied by the water works department, 700 of these were shared.⁸⁹ The agents operating on behalf of the Duke of Norfolk let large amounts of land in the east of the city for the building of housing yet they did little to direct the layout of buildings. The lack of restrictive covenants and control meant that building was cheap and the space between Sheffield and Rotherham was quickly filled by housing and industry in the areas of Tinsley, Carbrook, Brightside and Attercliffe. Between 1861 and 1901 the population of Brightside and Attercliffe went from 37,282 to 124,895, a far greater rate of increase than that for the city as a whole.⁹⁰

Housing reform became *the* dominant issue in politics and local elections in the city by the turn of the century. However, neither the Liberals nor the Tories showed any great desire to instigate municipal housing schemes if it meant subsidising house building from the rates. Some experimental steps were taken by the Council in the years before 1914 into the area of municipal housing schemes, yet these early efforts were little more than show-piece developments and did not constitute a solution to the housing problem. A conference was held in the city in 1899 on 'The Housing of the Poor in Sheffield', which directly led to the formation of The Sheffield Association for the Better Housing of the Poor. W.C. Leng the Conservative editor of the *Sheffield Telegraph*, chaired the meeting. This Association suggested that a very limited degree of municipal action was necessary, such as curbs to restrict the jerry builder, that working class houses should be bought by the Council for renting, and that 'rotten houses falling into decay should be taken by the local authority and demolished without compensation.'⁹¹

⁸⁸ J. Burnett, *A Social History of Housing* (London, 2nd Ed. 1986), 88.

⁸⁹ J.M. Furness, *Record of Municipal Affairs in Sheffield, 1843-1893* (Sheffield, 1993), 405.

⁹⁰ Craven, 'Housing Before the First World War', 72.

⁹¹ *Sheffield Independent*, 9 October 1899.

Under the Housing of the Working Classes Act of 1890, which allowed local authorities to build on land as well as clear slums, the role of the Medical Officer of Health was strengthened as he was now given the authority to condemn property. By 1894 the first venture by the Council into the provision of council housing was undertaken. A modest project was drawn up concerning little over 5 acres of land in an area in the northern part of the inner city known as The Crofts. Around 1,250 people lived in this area. The costs incurred were huge due to the compensation paid to landlords, and the redevelopment was not completed until 1907.⁹² Due to the small area selected for redevelopment only 124 flats could be built on the site at Hawley Street to cater for those moved from slum housing. The high price paid for the site had to be recovered in rent payments, which placed the rental of the new dwellings well beyond the reach of those that the scheme had displaced. From then on the issue of greenfield development sites rather than building on reclaimed land was favoured in Sheffield. Under Part II of the 1890 Act, 300 houses were condemned between 1891 and 1901. Forty of these houses were demolished, the rest being closed down or repaired.⁹³

The expense incurred by the Crofts development area, illustrates one of the major problems that was faced by local authorities when they began to provide council housing. The issue was not just one of clearing the slums, but being able to provide affordable housing for those tenants that had to be re-housed. Before 1914 there was a housing shortage in Sheffield even though 5000 houses remained empty. Rents in the 1890s for a back-to-back house were 3s to 4s whereas for newly built houses it was 5s to 6s.⁹⁴ In Liverpool, where there policy was to build inner city flats and tenements the Council housing stock stood at 2,322 dwellings by 1912.⁹⁵ It was this qualitative difference which made housing policy in Sheffield distinctive.

Sheffield was one of the first local authorities to use part III of the 1890 Housing of the Working Classes Act to provide housing estates away from the city centre. Transport was crucial here, in particular the electric tramway municipalized in 1896 and

⁹² S.M. Gaskell, 'Sheffield City Council and the Development of Suburban Areas Prior to World War I', in S. Pollard and C. Holmes, *Essays in the Economic and Social History of South Yorkshire* (Barnsley, 1976), 187-201.

⁹³ A.D.K. Owen, *A Report on the Housing Problem in Sheffield* (Sheffield, 1931), 11.

⁹⁴ Pollard, *Labour*, 189.

electrified in 1899. The tram routes allowed workers to live away from the centre of the city and new housing estates were built by private contractors around the tram termini at Woodseats and Hillsborough. The development of the tram system encouraged the process of suburbanisation in Sheffield which unlike earlier developments in the outer reaches of London, meant only a matter of two or three miles travelling to the place of work. The Corporation's first involvement in the building of suburban housing estates was in 1900 when it acquired a 60 acre site to build council housing at Wincobank in the north-east of the city. This scheme was developed in a number of phases.

The Conservatives proposed that the land should be leased to private speculators to deal with, as their preferred municipal housing scheme was for the housing of the working classes in city centre flats. The Liberals, following Labour pressure for houses rather than flats, attempted a municipal building programme on the Wincobank site along garden city lines.⁹⁶ The Liberal Party gained control of the Council for the first time in twenty years in 1901. 230 houses were built at Wincobank by 1914 on what became known as the 'Flowers estate' due to the names of the streets. A further 617 houses were built at Wincobank by 1919. The progressive style of these council houses won national attention.⁹⁷ The idea of municipal housing in the city had gained momentum, yet the polarised nature of Sheffield with a middle class south-west and working class north-east, was further maintained in housing policy. When the Council attempted a similar municipal housing scheme in the West of the city in the residential district of High Storrs, there was outspoken opposition from Liberal and Conservative Councillors such that the Council abandoned the scheme.⁹⁸

⁹⁵ J. Burnett, *A Social History of Housing* (London, 2nd Ed. 1986), 164.

⁹⁶ A.D.H. Crook, 'Needs Standards and Affordability After 1914', in C. Binfield, (ed.), *History of the City of Sheffield* (Sheffield, 1993), 76-99. 77.

⁹⁷ The Secretary of the Housing Reform Council described the estate as one 'of the best examples of municipal cottage building in Great Britain', quoted in R. Hebbelthwaite, 'The Municipal Housing Programme in Sheffield Before 1914', *Architectural History*, 30, (1987), 142-61, 150.

⁹⁸ The residents who were opposed to working class housing developments adjacent to middle class villas were Arnold Muir Wilson a Conservative Councillor from Whitley Wood Hall and a Liberal Alderman John Wycliffe Wilson. The latter commented 'High Storrs was too good a neighbourhood for working people.' H. Mathers, 'The City of Sheffield 1893-1926', in C. Binfield, (ed.), *History of the City of Sheffield*, (Sheffield, 1993), 53-78, 62.

In the east of the city, the earliest part of the Wincobank estate became something of a show piece. In 1907 a competition was held featuring the individual housing designs of 42 different architects. Yet, as the town planner Patrick Abercrombie, pointed out, the scheme was an architectural novelty and somewhat of a distraction from the fundamental point of municipal housing, which was to address the problem of adequately housing the urban poor.⁹⁹ The influence of the Wincobank estate featured in council housing history. John Tudor-Walters was one of the judges of the competition, and the street layout of the estate was designed by Alexander Harvey, the architect of Cadbury's Bourneville settlement. Its concentric arrangement of curved streets, crescents and avenues was highly influential on the design of pre-World War II housing estates.¹⁰⁰ For all its historical significance, the crucial aspect of the Wincobank estate as municipal housing was that it did not feature subsidised rents. At 5s to 7s 6d per week, they were beyond the means of those poor Sheffielders living in the worst housing.

The inability of Sheffield Council to adequately deal with the housing problem put the issue at the centre of local politics by the turn of the twentieth century. The Council established a Development Committee in 1917 with the brief of examining the narrow industrial base, the possible reasons for the inability to attract new forms of industry and the housing issue. The first act of the Development Committee was to commission Patrick Abercrombie to provide a survey of the city and suggest a development plan which was published in 1924. Abercrombie's imaginative and wide-ranging scheme was never implemented, yet his appointment indicates that the local authority recognised that the problems of unfettered growth in the nineteenth century demanded imaginative solutions in the twentieth century. The extent to which municipal action should be the main engine of reform was at the centre of political discourse.

⁹⁹ R. Hebblethwaite, 'The Municipal Housing Programme in Sheffield before 1914', *Architectural History*, 30, (1987), 142-61, 153.

¹⁰⁰ R. Hebblethwaite, 'The Municipal Housing Programme in Sheffield before 1914', *Architectural History*, 30, (1987), 142-61, 154.

Political Parties

Conservatives – patriotism and Empire

In the late nineteenth century the Conservatives were in the ascendancy in Sheffield. The *Sheffield Telegraph*, under the editorship of William (W.C.) Leng courted the working class Tory vote as well as that of manufacturers. Leng was instrumental in establishing Conservative clubs in working-class areas such as the east end and the central wards as well as areas that would be considered prime Tory wards such as the south-western suburbs of Ecclesall and Hallam.¹⁰¹ Sidney Webb's caricature of a typical Conservative town councillor at the end of the nineteenth century reflects the position of the Conservatives in Sheffield at a time when calls for collective action were increasingly being made;

The individual Town Councillor will walk along the municipal pavement, lit by municipal gas and cleansed by municipal brooms with municipal water and seeing the municipal clock in the municipal market that he is too early to meet his children from the municipal school hard by the county lunatic asylum and municipal hospital, will use the national telegraph system to tell them not to walk through the municipal park, but to come by the municipal tramway to meet him in the municipal reading room in the municipal art gallery, museum and library, where he intends to consult some of the national publications in order to prepare his next speech in the municipal town hall in favour of the nationalisation of the canals and the increase of the government's control over the railway system. "Socialism Sir" he will say "don't waste the time of a practical man by your fantastic absurdities. Self-help sir, individual self help, that's what's made our city what it is."¹⁰²

In Sheffield, William Leng went one step further than Webb's caricature of a town councillor and began to appropriate the language of municipal socialism. He justified the cost of improvement schemes on the grounds that in these matters, he 'was

¹⁰¹ Mathers, H. 'The City of Sheffield 1893-1926', in C. Binfield, (ed.), *History of the City of Sheffield*, (Sheffield Academic Press, 1993), 59.

¹⁰² S. Webb, *Socialism in England* (Aldershot, 1987, 1st published 1890), 116-117.

not ashamed to say he was a Socialist.¹⁰³ The Sheffield Conservative newspaper editor, William Leng's attempt to appropriate the term 'Socialism' indicates a shift in electioneering tactics where the promotion of collective action by the municipality was seen as acceptable and a response to need. The traditional electioneering tactic of the Conservatives was based on an appeal to patriotism and Empire with a key emphasis on the vital role that industry played in Sheffield as a centre for the manufacturing of armaments. When Leng died in 1902, the Conservative group lost its momentum and failed to produce a strong response to the changing mood of politics in the city. Despite Leng's steer to address calls for municipal action in certain areas, the Conservatives did not make further attempts to build on the municipalisation schemes. A space was therefore made for the Labour Party to fully develop its ideas of municipal socialism. The Labour cause in the 1920s and 1930s was promoted through a lively press with a range of newspapers published by the Independent Labour Party – *The Sheffield Guardian*, the Trades Council – *The Sheffield Forward* and the Co-operative society's *Sheffield Co-operator*. In 1926 *The Sheffield Co-operator* had a circulation of 30,000.¹⁰⁴ Branch Labour Party newspapers included Attercliffe's *The Labour News* and *The Park and Heeley Gazette*. As well as a thriving Labour press the city had two daily liberal newspapers, the *Sheffield Mail* and the *Sheffield Independent* both of which supported the call for municipal intervention. The *Sheffield Mail* included a column by the leader of the Labour Group, Ernest Rowlinson from 1923, that provided a weekly platform for the Labour Party to highlight the shortcomings of the anti-Labour Council.¹⁰⁵

Liberals – a split party

In 1901 the Liberal Party won a majority on the City Council, yet the party failed to develop a united front. It was the issue of municipalisation that split the Liberal Party in Sheffield. Some key Liberals championed the expansion of municipal services and

¹⁰³ *Sheffield Daily Telegraph*, 1889, quoted in Mathers *ibid.* 59.

¹⁰⁴ A. Thorpe, 'The Consolidation of a Labour Stronghold, 1926-1951', in Binfield, (ed.), *Sheffield*, 86.

¹⁰⁵ The ILP published the *Sheffield Guardian*, from 1906-1916, the Co-operative movement published the *Sheffield Co-operator*, which appeared monthly from 1922. The Trades Council newspaper, the *Sheffield Forward*, was issued monthly from 1921-1927 and from 1938. Attercliffe Labour Party issued its own newspaper *The Labour News*, in the early 1920s, the *Park and Heeley Gazette*, appeared from 1926-1939. Holdings at Sheffield Local Studies Library.

keenly promoted civic improvement, others with more economising leanings championed rate cuts and were set against any policies that would lead to increased municipal expenditure.

The crisis for Liberalism in Sheffield came to a head in the 1920s with the defection of leading members of the party to Labour. The leadership of the Liberal Party in Edwardian Sheffield under William Clegg expressed individualism but did not offer a positive programme. Clegg's tactics were based on his obsession with the negative cause of 'anti-socialism'. Using the same tactic that the Conservative Leng had done before him, Clegg explicitly appropriated the language of 'socialism' in an effort to appease calls for greater local state action combined with a concerted effort to portray the Labour movement as dangerous extremists. A Clegg speech from the 1920s was recorded as stating that:

Speaking for himself he was a Socialist. But there was a great difference between his Socialism and that spurious kind enunciated by Mr Keir Hardie and his followers in Sheffield. True Socialism meant the provision of those things which were necessary for the benefit and advantage of the people as a whole, and which could not be adequately supplied by private enterprise, and which it should be the duty of the municipality to have control of. Spurious Socialism was that which preached the confiscation of other people's goods without payment by force-, which did away with the natural ambition of individual men, which meant the levelling down of individuals instead of the levelling up and the nationalisation of various things without paying for them.¹⁰⁶

Fletcher's study of Yorkshire Labour politics noted how Liberalism in Sheffield lost its appeal as it 'never found expression in civic pride.'¹⁰⁷ The Imperialist Economisers in the Liberal Party ultimately joined up with the Conservative Party in an effort to counter the appeal of the Labour Party. Leading progressive Liberals moved to Labour. The most high profile being C.H. Wilson whose father and grandfather had both been Liberal M.P.s and owners of Sheffield Smelting Company. Wilson left the

¹⁰⁶ Speech reported in H. Keeble Hawson, *Sheffield The Growth of a City, 1893-1926* (Northend, Sheffield, 1968), 291.

Liberals to join the Labour Party in 1918, after agonising over the decision and consulting the Liberal MP Charles Trevelyan for advice.¹⁰⁸ This coup saw Wilson immediately elected Leader of the Sheffield City Council Labour Group, a development considered by the Conservative *Sheffield Telegraph* designed to provide a veneer of respectability whilst hiding the extremist policies of socialists in the Labour party. The *Sheffield Telegraph* reported that Wilson had been 'made Leader in the hope that such eminently respectable figure-head would divert the attention of the community from the real aims of those who profess to follow him'.¹⁰⁹ When Wilson was elected Labour MP for Attercliffe in 1922, it opened the way for Ernest Rowlinson - the President of the Sheffield Trades and Labour Council - to become leader of the Labour Group on the Council.¹¹⁰

Steps towards joining the Sheffield Liberal and Conservative Parties into a single 'Citizens Alliance' began in 1913 for the Poor Law Guardian elections. The arrangement was extended to municipal elections after the First World War with William Clegg as leader until 1926 and the joined Liberal-Conservative arrangement was a feature of local politics for the whole of period under consideration. The main effect of the operation of the Citizens Alliance was the polarisation of politics in Sheffield along the lines of Labour and anti-Labour options. It created a situation where Liberalism in Sheffield had no separate identity other than through its allegiance in the anti-socialist pact. The effect was that in Sheffield Liberalism was a spent force for the period.

The Citizens Alliance under Clegg promoted itself as an apolitical organisation, made up of experienced businessmen who could be safely trusted with the running of the affairs of the city. Its candidates were promoted as the elite of the city, as men experienced in matters of commerce and management in stark comparison to the Labour

¹⁰⁷ D.E. Fletcher, 'Aspects of Liberalism in Sheffield, 1849-1886' (unpublished University of Sheffield Ph.D. thesis, 1972), 194.

¹⁰⁸ Letter to C.P. Trevelyan, 25 March 1918, Trevelyan Papers, University of Newcastle upon Tyne, quoted in B. Barker, 'Anatomy of Reformism: The Social and Political Ideas of the Labour Leadership in Yorkshire', *International Review of Social History*, 18, (1973), 5. Trevelyan was Liberal MP for Elland 1899-1919, he lost the seat as an ILP candidate.

¹⁰⁹ *Sheffield Daily Telegraph*, 28 October 1922.

¹¹⁰ J. Bellamy and J. Saville, (eds.), *Dictionary of Labour Biography*, vol. VI (MacMillan, London, (1982), 235.

Party dominated by the Sheffield Trades and Labour Council, a body which the Citizens Alliance never failed to remind the public, included Communists. In the run up to the 1923 municipal election the *Sheffield Mail* quoted the Citizens Alliance Honorary Secretary asking 'is it not better to entrust the affairs of the city to men who can make a success? Rather than to amateurs who intoxicate themselves with a maze of words and fantastic notions.'¹¹¹ The *Mail* warned that 'Rowlinson and the rest of them, may dance to the Communist tune at a later date'.¹¹²

The Citizens Alliance adherence to a low-rate policy from 1918-1926 limited the scope for municipal action, this together with an ill-advised reform of the system of rate collection from tenants, gifted the Labour Party the opportunity to publicise the short comings of the Citizens Alliance and to promote the Labour cause as the party of municipal service provision and fair administration. In Sheffield the rates of private renting tenants were 'compounded', that is, collected by the landlord as part of weekly rent payments, the onus being on the landlord to pass on the rates for the tenant to the Council. In an attempt to allow landlords to increase rents frozen since wartime rent controls The Citizens Alliance decided to make the payment of rates the responsibility of the tenant, by ending the compounding system and introducing a new system where tenants were required to make rate payments in twice yearly lump sums. In an era where there was little provision for workers to set aside savings to meet bills, the somewhat predictable result was a surge in rates arrears and the subsequent issuing of hundreds of summonses for non-payment. By 1927 £693,000 was owed in rates arrears and 289 people had been imprisoned for non-payment of rates.¹¹³

This allowed the Labour Party to campaign on a promise of 'honest finance' and pledge a return to compounding. As well as the disastrous end of compounding, the Citizens Alliance had introduced a policy in 1925 where profits from municipal trading were transferred to the general rate account. The policy saw £70,000 transferred in 1925, £122,738 in 1926, and after Labour were elected at the end of that year £65,000 was transferred in 1927 and £36,960 in 1928 marking the last year that the profits from

¹¹¹ *Sheffield Mail*, 24 October 1923.

¹¹² *Sheffield Mail*, 23 October 1923.

¹¹³ A. Thorpe, 'The Consolidation of a Labour Stronghold, 1926-1951', in Binfield, (ed.), *Sheffield*, 88.

municipal trading were used to lower the rates.¹¹⁴ The Conservative-dominated Citizens Alliance Council had left itself open to attack when it was revealed that profits from the municipal tram service had been used to expand the University and the Rifle Club, at a time when public health and building schemes had been suspended during the First World War.¹¹⁵

In February 1927 Labour made an effort to place the finances of the city on a firmer footing by launching a £1.5m stock issue and increasing the rates by 10 per cent from 18s 2d in the pound to 20s 2d in the pound. The Labour Council openly stated that that this new fiscal arrangement would finance the promised increased level of services. The new Labour Council also brought in consultants to provide expert advice on efficient local government administration and streamlined and modernised the Council committee system that had seen little change since the days of incorporation in the mid-19th century.¹¹⁶

Labour – “The Creation of a Real Socialist Commonwealth”

The Sheffield Labour Representation Committee was founded in 1903. From its earliest days the Sheffield Labour Party was concerned with issues of policy beyond those of rank and file trade union issues. The Sheffield LRC promoted municipal reform and called for slum clearance, the provision of social housing and efforts to address the problem of unemployment though the introduction of direct employment schemes run by the municipality.¹¹⁷ Labour Party politics in Sheffield was rooted in a variety of interests and traditions ranging from the Independent Labour Party, syndicalist ideologies and trade union based factional interest as well as like C.H. Wilson, Lib-Lab voices.¹¹⁸ Co-ordinating the various strands within the local labour movement into a

¹¹⁴ *Sheffield Independent*, 29 December 1930.

¹¹⁵ H. Mathers, ‘The City of Sheffield 1893-1926’, in C. Binfield, (ed.), *History of the City of Sheffield*, (Sheffield Academic Press, 1993), 71.

¹¹⁶ A. Thorpe ‘The Consolidation of a Labour Stronghold 1926-1951’, in C. Binfield, (ed.), *The History of the City of Sheffield* (Sheffield, 1993), 90.

¹¹⁷ Minutes of Joint Meeting of Federated Trades Council and Labour Representation Committee, 5 June 1903, Sheffield City Archives, LD1626.

¹¹⁸ For an examination of the development of the strands of left wing politics in Sheffield and the influence of Lib-Labism, Labour-Socialism and Socialist-Syndicalism see C. Burke, ‘Working Class Politics in Sheffield 1900-1920’ (unpublished Sheffield City Polytechnic Ph.D. thesis, 1983).

coherent party line and an agreed election programme was no mean feat. One sign that the Labour movement was capable of discipline was the coming together of the city's two trades councils in to one body in 1920. The Lib-Lab Sheffield Federated Trades Council representing the light trades, merged with the more socialist inclined Sheffield Trades and Labour Council associated with the 'heavy' trades of engineering and steel works.

The First World War marked a turning point in the fortunes of local Labour parties in many places in Britain.¹¹⁹ In Sheffield the War gave the party the opportunity to increase its representation on public bodies and Council committees, for example Labour members served on the City Council Food Control Committee, while maintaining pressure on the City Council to embark on widespread municipalisation schemes.¹²⁰ The distinctive feature in Sheffield, compared to other places, was that the Labour Party was able to consolidate its position and achieve sustained electoral successes. Labour had made little electoral headway in Sheffield before the First World War, holding only two Council seats in 1913 and polling 18.8 per cent of votes cast. In 1919 Labour polled 45 per cent of the vote, and won 12 seats.¹²¹ A combination of factors produced this result. The franchise in Sheffield was almost doubled by the 1918 Representation of the People Act.¹²² The First World War had also stirred up some politicisation of the workforce and had fostered an unusual degree of industrial militancy. Without directly associating an increase in industrial militancy with an increase in the Labour vote, it is possible to view the attitudes of ordinary Sheffielders after the War captured in an early social survey into citizenship carried out by the Saint

¹¹⁹ Labour increased their vote in Liverpool in 1919, improving their representation from 7 to 20 seats on a Council of 105. Although they did not control the Council until 1955. Labour also took a number of County Councils in 1919 where coal mining dominated, holding Durham, Glamorgan and Monmouthshire until 1922. By 1937 Labour had gained control of 77 English and Scottish municipalities. T. Adams, 'Labour and the First World War: Economy, Politics and the Erosion of Local Peculiarity', *Journal of Local and Regional Studies*, 10, 1, (1990), 25. J. Rowett, 'The Labour Party and Local Government: Theory and Practice in the Inter-War Years' (unpublished University of Oxford D.Phil. thesis 1979). Appendix 10, 381. S. Davies, *Liverpool Labour: Social and Political Influences on the Labour Party in Liverpool, 1900-1939* (Keele, 1996).

¹²⁰ H. Mathers, 'The City of Sheffield 1893-1926', in C. Binfield, (ed.), *History of the City of Sheffield*, (Sheffield Academic Press, 1993), 71.

¹²¹ *Sheffield Independent*, 3 November 1913, 3 November 1919.

¹²² 58.5 per cent of the adult population of the city were enfranchised in 1911. R. McKibbin, 'The Franchise Factor in the Rise of the Labour Party', in R. McKibbin, *The Ideologies of Class: Social Relations in Britain, 1880-1850*, (Oxford, 1990), 74.

Philip's Settlement Education and Economics Research Society. The group, described as - church workers, school teachers, fitters and clerks, based at St Philip's YMCA interviewed 408 women and 408 working class Sheffield men. The results of the survey were published in 1919 in a volume titled *The Equipment of the Workers: An Enquiry into the Adequacy of the Adult Manual Workers for the Discharge of their Responsibilities as heads of Households, Producers and Citizens*.¹²³ Common themes from these interviews were expressions of general discontent with the lack of radical social reconstruction after the war, with some talk of an expected imminent revolution as well as expressions of dissatisfaction with both the government and with local employers. The general sentiment expressed by respondents in the survey was that after the sacrifices of the War, significant social change was called for, delivered though the mechanism of the collective provision of services. Typical of the attitudes expressed in the survey were those of Mr Dalson a 27 year old engineer and member of the National Union of General Workers. Dalson praised the co-operative 'movement at every opportunity. As for socialism he professed to believe that it was the only means of establishing the Kingdom of God on Earth'.¹²⁴ The Saint Philips Settlement Education and Economics Research Society claimed that the findings in Sheffield were universally applicable to the country and projected that in the next 30 years:

...eight millions of workers, each of them effective in trade union, co-operative society, local and national politics; will be the makers of English history from 1920 to 1950; upon a bridge made of their stalwart backs our children will cross from the shame and wretchedness of today to the land in which the dreams of humanity are coming true.¹²⁵

¹²³ Saint Philips Settlement Education and Economics Research Society, *The Equipment of the Workers: An Enquiry into the Adequacy of the Adult Manual Workers for the Discharge of their Responsibilities as heads of Households, Producers and Citizens* (George Allen and Unwin, London, 1919).

¹²⁴ Saint Philips Settlement Education and Economics Research Society, *The Equipment of the Workers: An Enquiry into the Adequacy of the Adult Manual Workers for the Discharge of their Responsibilities as heads of Households, Producers and Citizens* (London, 1919), 136.

¹²⁵ Saint Philips Settlement Education and Economics Research Society, *The Equipment of the Workers: An Enquiry into the Adequacy of the Adult Manual Workers for the Discharge of their Responsibilities as heads of Households, Producers and Citizens* (London, 1919), 14.

In the General Election of 1922 Labour gained Attercliffe, Brightside and Hillsborough, and went on to hold these seats in the elections of 1923 and 1924. The support for the 1926 General Strike in Sheffield was such that where Trades Councils in other towns encouraged workers to join the strike, the strength of solidarity of the Sheffield Trades and Labour Council had to persuade workers in essential services to stay at work.¹²⁶ Thorpe questions the effect of the General Strike as a decisive factor in the Labour victory of 1926 – noting that the miners in Sheffield were located in the wards of the East End that had already elected Labour Councillors.¹²⁷ A crucial turning point for Labour in Sheffield was the capture of previously Liberal wards in central areas such as Neepsend, Walkley and Crookesmoor where the voters were less likely to be steel workers or miners and more likely to be engaged in the smaller scale light trades of cutlery and tool manufacturing. These areas had been the centre of working class Liberalism since before the First World War.¹²⁸

With a base of 12 Council seats out of a Chamber of 64 in 1919, Labour steadily increased its hold winning 22 seats in the election of 1923, and 24 seats in 1925, which put them in a good position to take control of the council the following year. After a battle to oust the Citizens Alliance from an unrepresentative hold on the Aldermanic bench, Labour secured a majority hold on the Council with 38 seats in 1926.¹²⁹ The Labour Party had benefited from a lack-lustre opposition and the appeal of its programme founded on the promotion of municipal socialism. Labour had campaigned for the direct employment of workers by the Council, the municipalisation of public services, including a municipal bank, municipal housing schemes, and the municipalisation of the hospital service.¹³⁰ Some of these aims were to prove achievable, while the more ambitious proposal of Councillor Alf Barton for a municipal

¹²⁶ S. Benton, 'Sheffield', in M. Morris, *The General Strike* (London, 1976), 426-464.

¹²⁷ A. Thorpe, 'The Consolidation of A Labour Stronghold, 1926-1951'. in C. Binfield, (ed.) *The History of the City of Sheffield* (Sheffield Academic Press, Sheffield, 1993), 87.

¹²⁸ Before the First World War there was only one socialist candidate (who was heavily defeated) in these three wards in 12 contests between 1910 and 1913. See T. Adams, 'Labour and the First World War: Economy, Politics and the Erosion of Local Peculiarity?', *Journal of Local and Regional Studies*, 10, 1, (1990), 23-47, 44.

¹²⁹ *Sheffield Independent*, 3 November 1923, 3 November 1925, 10 November 1926.

¹³⁰ Sheffield Federated Trades and Labour Council, *Annual Report* (Sheffield, 1925). Sheffield Labour Group, *Six Years of Labour Rule* (Sheffield, 1932). *Sheffield Forward*, November 1924.

currency, illustrates the enthusiasm in the Labour movement for municipalisation schemes.¹³¹

The Leader of the new Labour Council, Ernest Rowlinson, declared in 1927 that 'In Sheffield we are hoping to make our local contribution to bringing about a real Socialist Commonwealth.'¹³² In terms of candidate selection, deciding which wards to contest in local elections and in drafting manifestos, The Sheffield Trades Council was the effective executive of the Borough Labour Party. After Labour won the 1926 local election Communist elements on the Trades Council complained that City Council policy was being made by the Labour Group without reference to the Trades Council. In 1927 a motion to have the Executive Committee of the Trades Council attend all meetings and vote on all decisions of the City Council Labour Group was defeated, among calls that the Trades Council was being used, 'as a jumping off ground for second rate politicians'.¹³³ George Fletcher, Communist Organiser for Sheffield and the founder of Fletcher's Bakery was a Trades Council delegate and a Poor Law Guardian. Fletcher believed that the united Sheffield Trades Council should operate as the executive body of the Labour led City Council and stated in the *Sheffield Independent* that 'we [The Trades Council] should accept that we do control the affairs of the city. While we cannot do it constitutionally through our own body we can delegate men to do it for us. We don't need these men there in order that they may have Councillor before their name but because they should carry out the policy of the Trades and Labour Council.'¹³⁴

Despite the demands from the far Left that the City Council should be operated under auspices of the Trades Council, and despite the scaremongering of the Citizens Alliance that a Communist agenda would be pursued, Sheffield Council under Labour control in the 1920s 1930s and 1940s avoided flirtation with extremist policies. It followed a moderate programme founded on municipal schemes that had already proved successful in Sheffield. The Labour Party published a *Municipal Charter for Sheffield* in 1926 that clearly outlined its purpose to the electorate: 'What the Citizens [Alliance] did

¹³¹ *Sheffield Independent*, 10 December 1919.

¹³² E. Rowlinson, 'The Triumph of Municipal Enterprise', *Labour Magazine*, 6, (8), (1927).

¹³³ *Sheffield Independent*, 23 February 1927.

¹³⁴ *Sheffield Independent*, 23 February 1927.

with water, we want to do with coal, milk education and other things.’¹³⁵ A significant shift had occurred in Sheffield, where the levers of municipal power were in the hands of working class representatives and where Sheffield developed a reputation as a Labour city.

At the start of the twentieth century the Liberal Leader of Sheffield City Council, William Clegg, a prominent lawyer was known locally as: “the uncrowned King of Sheffield ... at the end of the [First World] War he stood unchallenged, not only as the leader of his Party and of the Council, but as ‘the man above all else was “Sheffield” and had made Sheffield what it was.’”¹³⁶ By the Second World War it was William Asbury, an LMS railwayman, Shiregreen council house tenant, Chairman of the Health and Public Assistance Committees and Deputy Leader of the Council, who was given the exact same mock title, ‘the uncrowned King of Sheffield’ in a government report into the state of the City Council’s organisation during the aftermath of the Blitz during the Second World War.¹³⁷

Conclusion

This chapter has described how the geography of Sheffield in terms of its location, landscape and topography made for an unusual city. The chapter discussed how industry was central to its development and how rapid urbanisation in the nineteenth century led to issues of city governance in health and housing that early twentieth century local government found difficult to deal with. In many senses Sheffield was an atypical Victorian City. As neither a port, nor a financial, trading or administrative centre Sheffield lacked a developed administrative and commercial class. As Sidney Pollard has noted the well-organised trades and labour bodies meant Sheffield had an ‘unusual working class’.¹³⁸ Factors such as religious or ethnic divides, important to the development of other towns, were not significant features in the development of Sheffield.

¹³⁵ *Sheffield Co-operator*, December, 1927.

¹³⁶ H.K. Hawson, *Sheffield the Growth of a City, 1893-1926* (Northend, Sheffield, 1968), 318-319.

¹³⁷ Report of a visit to Sheffield District Office, New Years Day 1941, Violet Markham Papers deposited at the British Library of Political and Economic Science, London School of Economics. Markham Papers, 8/36.

The chapter has examined political debates over the extent that the state, and in particular the local state, should be involved in the provision of services. It has examined the events in politics that led to the Labour party taking control of the Council in 1926. Dennis Smith notes that by the early twentieth century Sheffield ‘was weakly defended by the bourgeoisie.’¹³⁹ The creation of the Liberal and Conservative Citizens Alliance saw a polarisation in politics in Sheffield and where the Alliance offered retrenchment and ‘economy’, Labour offered a proactive policy agenda. The Labour Party campaigned on a platform of municipal socialism in the 1920s with a sense that Local government could be a viable agent of change. The city was not unusual in seeing Labour gains after the First World War, what was unusual was that Labour in Sheffield was able to consolidate its position and remain in office.

How a Labour Council dealt with issues of health and housing through the administration of a major English city are issues that are explored in the following chapters. The next chapter examines public health policy in Sheffield in the 1920s. The chapter examines how the political complexion of the Council had a bearing on the policies pursued. The growth of local government powers in the early twentieth century provided greater scope for appointed public officials as well as elected members to influence policy. At times the views and the policies of politicians and officers of the Council could come into conflict.

¹³⁸ S. Pollard, ‘Labour’ in C. Binfield, (ed.) *The History of the City of Sheffield* (Sheffield, 1993), 263.

¹³⁹ D. Smith, *Conflict and Compromise: Class Formation in English Society, 1830-1914* (London, 1982), 243.

Chapter 2

Public Health Policy in Sheffield in the 1920s

Introduction

Building on the literature review and the preceding examination of the development of Sheffield, this chapter examines public health policy in Sheffield in the early twentieth century with a focus on the 1920s. The chapter explores the development of the Health Department and the key role of Medical Officers of Health in influencing Council health policies including open air schools, infectious disease treatment, tuberculosis and the milk supply. John Welshman's case study of municipal medicine in Leicester noted that the importance of Medical Officers of Health in the administration of health care in the twentieth century has been neglected.¹ Welshman noted that in general the work of Medical Officers of Health in Britain, particularly after 1900, has had a negative press from medical historians, but, the case against has been made without in-depth local analysis of their actions as effective promoters of social medicine. As Welshman states 'the case against MOsH remains unproven' until further work at the local level is done.²

The election of the Labour Council in 1926 brought to prominence William Asbury as Deputy Leader of the Council and Chairman of the Health Committee. The 1926 local election coincided with an outbreak of smallpox in Sheffield in the winter of 1926/1927. The episode tested the resources of the city and brought to the fore significant differences between Asbury, who was ideologically opposed to medical intervention through smallpox vaccination and Frederick Wynne the city's Medical Officer of Health. Examination of the episode illustrates striking differences of opinion at the top of Sheffield's public health administration.

¹ J. Welshman, *Municipal Medicine: Public Health in Twentieth Century Britain* (Peter Lang, Oxford, 2000), 34.

² J. Welshman, *Municipal Medicine: Public Health in Twentieth Century Britain* (Peter Lang, Oxford, 2000), 34.

Sheffield Medical Officers of Health

As with the slow movement to incorporation, Sheffield was not quick to appoint a Medical Officer of Health. The Public Health Act of 1848 empowered local authorities to appoint a Medical Officer of Health (MOH). However, the first MOH for Sheffield was not appointed until the 1872 Public Health Act made such appointments compulsory.³ Taking up the post of MOH in Sheffield was a professionally precarious career choice. The presentation of investigative work in the Annual Report into the health of the town was unlikely to paint Sheffield in a favourable light. Any suggestions for improvements that would require public expense, tended to be particularly unwelcome. Sheffield's first MOH, Dr Francis T. Griffiths, took up the position on a full-time basis with a salary of £600, between 1872 and 1878. However, relations between Griffiths and the City Council did not run smoothly. At a meeting of the BMA in 1876 the Medical Officer of Health made an ill advised satirical speech about the Council. Griffiths mocked the small minded nature of the Town Councillors stating that 'they would have Nowt that cost Owt!'⁴ Griffiths' tenure ended after six years, his insistence of producing annual reports that highlighted the insanitary nature of parts of Sheffield, which he had hoped would encourage the Council to engage in urban redevelopment and improvement hastened his demise.⁵ The attitude of the Council in health matters reflected its general policy in the nineteenth century, of limited municipal action and a desire to keep costs to a minimum. In 1879 Dr Thomas Whiteside Himes was appointed as MOH, this time the post was offered on a part-time basis with a salary at £300 per year, half that received by Dr Griffiths. The post was offered to Himes on a temporary basis renewed annually providing the opportunity for the Council to monitor the activities of the Medical Officer of Health.⁶

³ C. Shaw, 'Aspects of Public Health', in Binfield, (ed.), *History of the City of Sheffield* (Sheffield Academic Press, Sheffield) 109. C. Hamlin, *Public Health and Social Justice in the Age of Chadwick* (Cambridge, 1997).

⁴ C. Shaw, 'Aspects of Public Health', in Binfield, (ed.), *History of the City of Sheffield* (Sheffield Academic Press, Sheffield), 109.

⁵ Griffiths produced a report on the insanitary nature of the Porter Brook in 1876, and recommended road and other improvements in a report compiled under the Artizans and Labourers Dwellings Improvement Act 1875. C. Shaw, 'Aspects of Public Health', in Binfield, (ed.), *History of the City of Sheffield* (Sheffield Academic Press, Sheffield), 109.

⁶ Shaw, 'Aspects', 110.

These early steps of the Borough into public health management were inauspicious, however the appointment of John Robertson who served as MOH in Sheffield from 1897 to 1904 marked a change. Under Robertson the Health Department of the City Council was restructured. Robertson was appointed on a full time and permanent basis. Robertson was an able public health department administrator, who was keen to combine his scientific training with the practical aspects of public health work. He was described as a 'great lab man, very much at home and very happy when busy at the bench and engaged in scientific research.'⁷ His postgraduate thesis was concerned with the conditions governing the cause and distribution of consumption (tuberculosis of the lungs) in England and Wales.⁸ As a public health professional Robertson was instrumental in developing medical education at Sheffield University where he established the bacteriology department and lectured on bacteriology and on public health. His obituary in the *Journal of the Royal Sanitary Institute* stated that Robertson: 'showed a colossal activity and earned a reputation in every respect deserved, as one of the most enthusiastic and highly skilled, qualified and experienced Medical Officers of Health ... he was so completely believed in and trusted by the local authority and the people that any suggestion he had to offer was practically certain of acceptance. Very many of the schemes now generally in operation throughout the country originated in Sheffield.'⁹

In 1904 one of Robertson's last acts as MOH in Sheffield was to persuade the Council to introduce the practice of the compulsory notification of tuberculosis, eight years ahead of compulsory national legislation.¹⁰ From Sheffield, Robertson went on to national prominence as a long serving MOH for Birmingham and was knighted for his services to Public Health in 1925. His replacement in Sheffield, Harold Scurfield, served as MOH until 1920. Scurfield continued Robertson's approach combining his work as a scientist with practical public health administration. At the 1908 BMA conference on industrial respiratory diseases Scurfield presented a paper based on his

⁷ 'Obituary of Sir John Robertson', *Journal of the Royal Sanitary Institute*, vol. VII, No 8, (February, 1937), 170-172.

⁸ 'Obituary of John Robertson', *Journal of the Royal Sanitary Institute*, (February, 1937), 170-172.

⁹ *Journal of the Royal Sanitary Institute*, (February, 1937), 172.

¹⁰ F.B. Smith, *The Retreat of Tuberculosis, 1850-1950* (Croom Helm, London, 1988), 68.

analysis of mortality figures of various occupations in Sheffield.¹¹ Scurfield pushed the Council to adopt a more proactive attitude to improving the health of the town. His Annual Report for 1913 looked back at the lack of Council activity in the Victorian era and concluded that Sheffield had a 'large amount of arrears in sanitary work'.¹² Scurfield summarised the prominent health disadvantages in Sheffield, pointing out that wages for women were lower than average, that there was a large number of back-to-back houses in the city and that that 25 per cent of tuberculosis cases were found to be resident in this type of housing. He noted that that 20 per cent of houses in the city had privy middens as opposed to water closets, that 20 per cent of houses used fixed ash pits for refuse, and that those employed in the tool and cutlery grinders trade were particularly susceptible to respiratory diseases, including tuberculosis. Finally, in an expression of the belief in the health benefits of fresh air and sunshine, Scurfield noted that in 1913, 25 per cent of the natural supply of sunshine was cut off in certain industrial areas of the city, particularly Attercliffe.¹³

Sheffield Health Department's innovative work on tuberculosis became a long lasting trait; Ministry of Health inspectors in the 1930s though, saw the focus on tuberculosis as disproportionate and at the expense of other areas of health care such as maternity and child welfare.¹⁴ In evidence to the Royal Commission on the Poor Laws in 1909 Scurfield stated the case for greater state involvement in health matters arguing that the medical work of the Poor Law authorities should be brought under local authority control in a bid to end the pauper taint. This was a full twenty years before the policy was enacted. Scurfield argued that full-time salaried medical practitioners should be appointed under the local authority, with health managed in the same way as education policy.¹⁵ John Derry in his book *The Story of Sheffield* published in 1914 recognised that innovative work was happening stating that 'The Health Committee is more talked of, very properly than almost any other committee ... Sheffield is constantly swept by fresh breezes from the Derbyshire moors and the death rate on the western side

¹¹ H. Scurfield, 'Industrial Diseases Caused by Dust', *The Lancet*, 8 August, (1908), 394-395.

¹² Sheffield, Medical Officer of Health Annual Report, 1913.

¹³ Sheffield, Medical Officer of Health Annual Report, 1913.

¹⁴ PRO MH 66/1076

¹⁵ *Royal Commission on the Poor Laws and the Relief of Distress*, Appendix Vol.4, (London, 1909), qu 41884-42046.

of the city is always low, on the other hand, the old part of the town includes many streets and courts where the people are densely crowded, and some of the trades, particularly grinding, are unhealthy, and consumption is very common.’¹⁶ The reference to the health benefits of fresh air was a common feature of contemporary accounts and had a clear bearing on policy-making. Differential death rates for the better off and poorer areas of the city were published and had a bearing on policy, the prime example being the Edwardian open air schools movement.

A measles epidemic in Sheffield in 1911 resulted in the deaths of 600 children. Fatalities occurred throughout most areas of the city, with the exception of the affluent western suburbs of Ranmoor, Broomhill, Ecclesall and Nether Edge - where no deaths from measles were recorded.¹⁷ For the Medical Officer of Health and the local press the blame lay squarely with the parents. The *Sheffield Telegraph* noted in January 1911 that ‘mothers refuse to realise the virulence of the disease and refuse to take precautions.’¹⁸ The *Sheffield Telegraph* interpreted the greater prevalence of measles in poorer districts as a problem of the behaviour of mothers, rather than as a problem of poverty or general health inequalities. After reports of mothers deliberately seeking to infect their children by holding measles parties, the *Sheffield Telegraph* admitted that there was a general lack of sanitation in many Sheffield homes but ‘the severity of the present epidemic is due to parental ignorance than to anything else. It is criminal for mothers to encourage their babies to catch measles’.¹⁹

Where mothers accepted the disease as an unpleasant, but inevitable part of childhood, the medical authorities and the *Sheffield Telegraph* believed that the actions of working class women were born out of ignorance serving only to encourage the spread of disease. Anne Hardy notes that the tactic of publicly blaming mothers and school children for the spread of disease was commonplace in the early twentieth century adopted as a means for authorities to be seen to be addressing health concerns without embarking on any serious intervention that directly trespassed ‘on domestic

¹⁶ J. Derry, *The Story of Sheffield* (Pitman, London, 1914).

¹⁷ *Sheffield Telegraph*, 14 March 1911.

¹⁸ *Sheffield Telegraph*, 24 January 1911

¹⁹ *Sheffield Telegraph*, 2 March 1911.

ground and on the independence of the family'.²⁰ One policy development where direct intervention was put into practice was the open air schools policy – an examination of the policy illustrates that efforts were made to apply modern science based principles to health care, while traditional notions of the health benefits of fresh air were also part of the mix.

Open Air Schools and the School Medical Service

Edwardian debates over the health of the nation and the need to improve national efficiency following the poor quality of recruits to the Boer War are well known.²¹ The government response was to set up a committee to investigate possible reasons for physical deterioration and to suggest ways in which to address the problem. The Interdepartmental Committee on Physical Deterioration, reported in 1904. Among its 50 recommendations were the compulsory medical inspection of school children, the provision of school meals for primary school children and the creation of educational establishments in the countryside to restore the health of urban children who were suffering from the debilitations of city life.²² The Liberal Government introduced the medical inspection of school children in 1907 leading to the introduction of School Medical Services to be run by local authorities under the direction of an appointed health official – the Schools Medical Officer (SMO). Many local authorities combined the duties of the post of SMO with those of the existing role of the Medical Officer of Health, however in some areas, including Sheffield, the two posts were separate. The appointment of Dr Ralph Williams as Sheffield's first SMO saw Sheffield become one of a handful of local authorities to pioneer open air schools.

A report in the *Birmingham Post* in 1910 described how these institutions were 'for the purpose of providing recuperative treatment as well as instruction for the anaemic and badly nourished child - usually the product of the slums - who is unable to profit fully by the teaching given in ordinary elementary school.'²³ The philosophy

²⁰ A. Hardy, *Health and Medicine in Britain Since 1860* (Basingstoke, Palgrave, 2001), 43.

²¹ A. Hardy, *Health and Medicine in Britain Since 1860* (Basingstoke, Palgrave, 2001).

²² Interdepartmental Committee on Physical Deterioration, HMSO (1904).

²³ *Birmingham Post*, 25 June 1910.

behind open air schools was first developed in Germany, where ‘feeble’ children from deprived areas were temporarily removed from their usual habitat and exposed to the outdoors for fresh air, good food and rest. Temporary exposure to a better environment together with an improved diet was considered beneficial to build up the child’s strength and therefore improve immunity to disease. Historians hold different interpretations of the meaning of Edwardian open air schools policy. In the 1970s Turner and Cruikshank portrayed open-air schools as positive step, marking a new scientific era in preventive medicine with rigorous data collected to monitor gains in weight and height.²⁴ This interpretation sees open air schools as leading the way in modern education policy for the provision of school meals, setting up residential facilities and introducing school transport. In the 1990s Linda Bryder offered a more sceptical view, interpreting open air schools as intrusive, paternalistic ventures that promised health improvements for a few by placing deprived children in ‘wonderlands of buttercups and daisies’ – when the real issue, not being addressed by policy-makers - was widespread malnutrition.²⁵ The Sheffield example shows that there is some merit to both interpretations of open air schools.

Sheffield established an open air school in June 1909 at Whitely Woods following the opening of similar institutions in London in 1907 and Bradford, and Birmingham in 1908. Williams provided an account of the initiative in Sheffield for the journal *Public Health*.²⁶ The Sheffield school operated under a system where the Schools Medical Officer sent a circular to the head teachers of schools within walking distance of the Leopold Street tram terminus in the town centre, asking Headmasters to recommend the most ‘anaemic and poorly nourished’ children attending their school.

Williams collated the data, inspected 100 children aged 9-13 and selected 50 pupils for the open-air school. Their homes were visited ‘in order to impress on the parents the necessity of sending the children to bed early, keeping their bedroom

²⁴ D. Turner, ‘The Open Air School Movement in Sheffield’ *History of Education*, 1, 1, (1972), 58-80. M. Cruikshank, ‘The Open-air School Movement in English Education’, *Pedagogica Historica*, 17, (1977), 62-74.

²⁵ L. Bryder, ‘Wonderlands of Buttercup, Clover and Daisies’, in R. Cooter, (ed.), *In the Name of the Child: Health and Welfare 1880-1940* (Routledge, London, 1992), 72-89.

²⁶ R.P. Williams, ‘The Sheffield Open Air Recovery School’, *Public Health*, (23) March 1910.

windows open, and allowing them to go to sleep in afternoons on Saturday and Sunday if possible.²⁷ The most 'debilitated children' were taken out of the town centre to a wooded area five miles away to be received in the school from early in the morning to 6 in the evening.²⁸ The school ran for a session of 19 weeks from the opening in June 1909. The children received three meals, for which parents contributed a fee on a sliding scale ranging from 6 pence to 2s 6d, they received 3 hours and 45 minutes of school teaching, and the remainder of the day included instruction in gardening, housewifery and nature study.²⁹ Deck chairs were provided for two hours of open-air rest that took place after the midday meal. The children were also provided with toothbrushes, combs and towels and given lessons in personal hygiene. They took two showers per week with soap and loofahs provided by the school. In a public address at Victoria Hall Sheffield in November 1910, Dr Williams described how the open air school was designed on a 'shed' principle where three sided classrooms were open on the south side.³⁰ In his annual report of 1913 Dr Williams estimated that 5-6000 children in Sheffield suffered from malnutrition, which he claimed was 'rarely due to insufficient food. In my opinion the principal causes of malnutrition are improper food, insufficient sleep, and foul air due to closed windows.'³¹

By 1921 the Whitely Woods School had 100 places.³² A second open-air school was opened in 1919 at Springvale House, Park Lane that was open all year. In 1920 the Council acquired a former prison camp of 'hutments' on the fringes of the moors at Redmires with the intention of expanding the open air school accommodation of the city, yet support for the project appears to have waned by the 1920s and the Redmires camp was mainly used as reserve accommodation for the isolation of infectious disease cases.³³ The SMO in 1931 stressed that 'these youngsters are not tubercular but merely delicate.'³⁴ While open air schools were introduced with the aim of building up sickly children, they increasingly became associated with the treatment of pulmonary

²⁷ R.P. Williams, 'The Sheffield Open Air Recovery School', *Public Health*, (23) March 1910, 216.

²⁸ *Morning Post*, 6 August 1910.

²⁹ R.P. Williams, 'The Sheffield Open Air Recovery School', *Public Health*, (23) March 1910, 217.

³⁰ *Sheffield Telegraph*, 12 December 1910.

³¹ *Sheffield Daily Telegraph*, 14 March 1914. In 1920 8 cases of malnutrition were recorded. *Sheffield Telegraph*, 30 June 1920.

³² *Sheffield Independent*, 28 June 1921.

³³ *Sheffield Telegraph*, 1 June 1920.

tuberculosis. Children suspected of suffering from the early stages of tuberculosis were selected by the Health Department for the open-air school with the intention of arresting the disease in its early stages. In 1910, three of the 50 children in the original cohort sent to Whitely Woods were there due to tuberculosis of the lung attended, nine of the 50 had 'Doubtful Tuberculosis of the Lung' and two were categorised as having tuberculosis of the glands.³⁵ Ralph Williams argued that the policy was preventative and meant less of a burden for ratepayers to send children to open air schools in the early stages of tuberculosis, rather than wait for the disease to develop to its full stages where the local authority would be obliged to provide sanatorium treatment.³⁶

Williams played down the tuberculosis aspect of the open-air school stating that the children attending suffered from 'lowered vitality' rather than tuberculosis, however it was clear that by the 1930s tuberculosis was a significant element of the enrolment policy. In 1930 John Rennie was appointed Medical Officer of Health, Rennie had been the city Tuberculosis Officer since 1912. In the 1930s 30 places were reserved at the schools for young patients who were attending the Schools Tuberculosis Dispensary.³⁷ Williams promoted the venture in the press and in health journals, he also produced ever more detailed statistical reports for the Council on the improvement of the health of the children who attended the open-air schools, compiling charts of increased height and weight. His report of the first year of operation of the school recorded that 17 children had been 'cured' and that the rest of the intake, bar one child, had 'improved'.³⁸ The average weight increase in the first year was recorded as 5lbs.³⁹ Medical records were kept for all the children, their teeth were examined on arrival by the senior dental surgeon of The Royal Hospital, and their eyesight was also tested. Williams used the data to argue that 2000 places ought to be provided in such schools for Sheffield children.⁴⁰ Williams resigned his post as SMO in Sheffield to become Senior Assistant Medical Officer, and subsequently Medical Officer at the Board of Education.⁴¹ His

³⁴ *Sheffield Daily Telegraph*, 10 February 1931.

³⁵ R.P. Williams, 'The Sheffield Open Air Recovery School', *Public Health*, (23) March 1910, 217.

³⁶ R.P. Williams, 'The Sheffield Open Air School', *British Journal of Tuberculosis*, 1911, 15.

³⁷ D. Turner, 'The Open Air School Movement in Sheffield' *History of Education*, 1, 1, (1972), 58-80, 67.

³⁸ School Medical Officer for Sheffield, *Special Report*, 1909.

³⁹ School Medical Officer for Sheffield, *Special Report*, 1909.

⁴⁰ School Medical Officer for Sheffield, *Special Report*, 1911.

⁴¹ D. Turner, 'The Open Air School Movement in Sheffield' *History of Education*, 1, 1, (1972), 58-80, 67.

successor as School Medical Officer, Dr Thomas Chetwood continued the policy of open-air schools, and called for every school in the city to have at least one open-air classroom where one side of the room would be missing.⁴² The influence of the open-air school movement was seen in the design of Sheffield schools built between the wars with large windows, open quadrangles and verandas. Chetwood was as much of a fresh air fanatic as Williams and persisted the notion that 'late hours and imperfectly ventilated sleeping rooms are the very common causes of bad nutrition in children of school age.'⁴³

The closer inspection of school children in Sheffield resulted in large numbers being labelled by the SMO reports as 'dirty'. The School Medical Service Annual Report for Sheffield of 1921, cites 5,600 children as 'dirty,' causing the *Sheffield Telegraph*, to state that 'there is absolutely no excuse for it ... this undesirable condition is due to the unmitigated laziness on the part of the parents.'⁴⁴ The lack of washing facilities in back-to-back houses without baths was not discussed, neither were the tons of soot that fell on the east end in particular throughout the period.⁴⁵ In 1922 only 24,452 houses in the city had a fixed bath with running hot water as opposed to tin bath in front of the fire, by 1939, after the 1930s building programme, the number of Sheffield houses with fixed baths was 77,235.⁴⁶ *The Sheffield Daily Telegraph* showed little understanding of the rhythms of working class life, where laundry had to be fitted in around the belching smoke of the steel works. Witness accounts from the time report that keeping a house and family clean was an arduous task in the east end of Sheffield in the inter-war years. Housewives had to rise at 4a.m on Mondays in order to heat water in a copper to wash clothes, curtains and bedding with a tub, washboard and dolly stick. The washing had to be hung out to dry and brought back in before the furnaces of the steel works were lit at 7a.m. Keeping a clean house was a full time job when lace curtains had to be replaced twice a week or turn shades of yellow, green and purple. Being 'on top' of this work

⁴² *Sheffield Daily Telegraph*, 28 June 1921.

⁴³ *Sheffield Daily Telegraph*, 28 June 1921.

⁴⁴ *Sheffield Daily Telegraph*, 29 June 1921.

⁴⁵ The Council opened five municipal wash houses (laundries) in the 1930s at Upperthorpe, Wincobank, Heeley, Brightside and Attercliffe. Public slipper baths were opened in Corporation Street in 1869, Attercliffe 1879, Upperthorpe 1896, Glossop Road 1898, Brightside 1899, Park 1905, Heeley 1909 and Wincobank 1931. Shaw, 'Aspects', 111.

⁴⁶ Shaw, 'Aspects'. 112.

was a sign that families, and women in particular, were coping with the stresses of running a household in an industrial city. Attercliffe residents could walk down terraced streets surrounding the steel works and note who was 'on top' and who wasn't by the state of net curtains and the cleanliness of the step.⁴⁷ In 1923 the Annual Report of the School Medical Service estimated that 7 per cent or 7-8,000 'dirty' children could be found in Sheffield.⁴⁸ The *Sheffield Telegraph* placed the blame firmly in the hands of the parents who it recommended should be jailed, the Telegraph did at least recognise that, 'the fact the 93 per cent go to school clean is a credit to the community. It is a filthy hole this city of ours and there is plenty of excuse for going about unwashed since to keep really clean, means washing once every hour at least.'⁴⁹

The movement into a more interventionist Schools Medical Service was not welcomed by the Citizens Alliance. The Citizens Alliance Alderman, W.F. Wardley complained at the increasing cost of the School Medical Service in 1922 after looking at the staff list for the department he 'wondered whether the Service was for Sheffield only or for several other towns as well.'⁵⁰ In the year of the Geddes Axe and Government cuts in public expenditure, Wardley suggested that 'the axe' ought to be taken to the department. Under Chetwood the Schools Medical Service expanded throughout the 1920s. By 1928 the department had eight full time Assistant SMOs, four part time specialist Officers, six full time dentists, 27 school nurses and eight dental assistants under the Schools Medical Officer.⁵¹

Public Health in Sheffield in the 1920s

The appointment of Dr Fredrick Wynne as Medical Officer of Health in 1921 saw the arrival of a dynamic and colourful character described as a man who had 'strong views and had unlimited moral courage in giving expression to these to the discomfort of many who did not agree with him.'⁵² Wynne's character and style of public health

⁴⁷ Information from interview by author with Bill Moore, Attercliffe resident in the 1920s and 1930s.

⁴⁸ *Annual Report of the School Medical Officer for Sheffield, 1923.*

⁴⁹ *Sheffield Daily Telegraph*, 28 April 1922.

⁵⁰ *Sheffield Daily Telegraph*, 3 May 1922.

⁵¹ Annual Report of the School Medical Officer for Sheffield, 1928.

⁵² Obituary of Frederick Wynne, *Journal of the Royal Sanitary Institute*, 50, 12, (June 1930), 747-8.

management meant that he was not afraid to challenge the opinions and perceptions of Councillors and local businessmen in the pursuit of better public health.

Frederick Wynne was a published novelist, a columnist for the *Manchester Guardian* and a playwright with work performed at the Gaiety Theatre, Manchester.⁵³ This literary and theatrical side to his character saw Wynne perform a public relations role as a lively propagandist for the promotion of a modern twentieth century public health service concerned with environmental issues as well as the health of the individual. In an early radio broadcast in 1927, he declared that ‘the notion that the Medical Officer of Health spends his time smelling drains is erroneous.’⁵⁴ He stated that the Health Department was there to protect the most defenceless classes of society such that ‘if there was no poverty, no ignorance and no greed, there would be no need for any health department.’⁵⁵ In a lecture at Sheffield University in 1927, comparing public health work in the 1840s to that of the 1920s, Wynne directly addressed those in the City wary of the growing clinical side of public health work, stating that the ‘primary work of the Health Department was to deal with the environment of public life, the houses people lived in, the atmosphere they breathed, everything that they had to eat and drink and the removal of waste products. Some seemed to think that they ought not to pass on to the other task of dealing with the individual until this work was cleared up.’⁵⁶ Wynne was aware that that public health in the 1920s was in a transition stage, moving from its original focus on the environmental concerns of sanitation towards an interventionist policy directly addressing the health of the individual.

As with many industrial towns, Sheffield suffered a serious decline in trade in the inter-war years. Although never designated ‘Special Area’ status like South Wales or the North East, Sheffield reached a peak of 60,000 registered unemployed in 1932.⁵⁷ The relationship between unemployment and ill health was a controversy of the 1930s

⁵³ Wynne published two novels, *Fortunes Fool* and *Digby's Miracle*. His play ‘*Subsidence*’ examined the effects of mining subsidence on a Lancashire farming family. Obituary of Frederick Wynne, *Journal of the Royal Sanitary Institute*, 50, 12, (June 1930), 747-8.

⁵⁴ *Sheffield Independent*, 11 February 1927.

⁵⁵ *Sheffield Independent*, 11 February 1927.

⁵⁶ *Sheffield Independent*, 11 February 1927

⁵⁷ A.D.K., Owen, *A Survey of Unemployment in Sheffield* (Sheffield, 1933).

and remains a controversial issue among historians.⁵⁸ In the 1920s Fred Wynne was concerned with the effect of unemployment on the state of the health of Sheffield's workforce. In his Annual Report of 1927 he stated that 'poverty and unemployment were the main causes of ill-health'.⁵⁹ However in his own inimitable style he was also concerned about the health effects of a resumption in trade:

the effect of prolonged unemployment is inevitably to get a man out of training for his job and to engender a mental state in which the effort of a return to the routine of hard daily work becomes intolerable to any but the firmest wills. If we could have in the immediate future a general resumption of employment I am convinced we should have also an unheard of loss of times and wages as a result industrial fatigue ... and regretfully anticipate seeing this reflected in the sickness rate of the city during the first period of resumption.⁶⁰

Wynne was not shy of criticising aspects of life in Sheffield that others, especially the employers and the employed had long taken for granted as the daily realities of working life in an industrial city. His reports were never anodyne and bureaucratic, but lively documents that illustrated the unhealthy realities of life in the city. In 1927 Wynne complained that while overall tuberculosis death rates had fallen, among grinders death rates from tuberculosis in Sheffield had not declined for 44 years citing poor working conditions in the small workshops as a cause that was unlikely to be remedied until factory conditions were introduced that could allow health and safety concerns to be taken up. His Annual Report for 1927 noted that:

the conditions under which many men in the cutlery trade are employed are still profoundly unsatisfactory. They will never be, in my opinion, as they should be until the present antiquated organisation of this trade is reformed, and the system of giving out-work to the lessees of little dark insanitary "wheels" is abandoned in favour of large and economically organised factories with proper supervision and adequate ventilation. It is at

⁵⁸ C. Webster, 'Health, Welfare and Unemployment During the Depression', *Past and Present*, No 109, (1985), 204-230. Also D. F. Smith, 'Commentary: The Context and Outcome of Nutrition Campaigning in 1934', *International Journal of Epidemiology*, 32, (2002), 500-502.

⁵⁹ Sheffield Medical Officer of Health, Annual Report, 1927.

⁶⁰ Sheffield Medical Officer of Health, Annual Report, 1925.

present impossible to prevent the practice of spitting in these places, ventilation ducts are frequently blocked up to prevent "draughts" and the dry racing of grindstones is sometimes practiced. The practice of having three stones run "tandem" fashion means that men employed on the hindermost stones are often working almost in the dark which promotes uncleanness and lowers the individual's resistance to disease.⁶¹

For Wynne a break from these conditions as well as less spare money to spend on unhealthy practices meant that unemployment could be 'healthy for those employed in unhealthy conditions and can lead to reduction in the consumption of alcohol and perhaps even a restricted and more carefully chosen diet.'⁶² In evidence to a House of Lords Select Committee on The Sheffield Corporation Bill, in 1928 Wynne described the position of public health work in Sheffield, commenting on the increased involvement of the Council in the provision of personal health services:

... it is a city that is difficult to administer because it grew up very rapidly and at a very bad time largely its growth was in the nineteenth century, and we have five valleys and a heritage of slum property, much of which is decayed. Sanitation has been going on very strenuously and very steadily for a number of years, but we still have many arrears and we have to make the best of the conditions as we find them. Even in the short time that I have known the city I can consciously say that I have seen tremendous improvements not only in the sanitation but improvements in connection with dwellings that we have been able to carry out, involving the near obliteration of all privy middens, as well as the paving of many courts and yards. We have also developed ... personal services. Child welfare work has increased so much that we have had to put up a new and very expensive building, opened by the Minister of Health. We see in the average of 1000 children a week. They are supplied at cost price with dried milk, with free medical advice and where there is poverty, the dried milk is free. We have developed our maternity services. We have by arrangement with the Board of Guardians taken over part of one of their hospitals and converted it into a maternity hospital with 32 beds and eight pre-natal beds and inaugurated pre-natal clinics. We started with one session week, now there are five sessions a week and these are now crowded. The work will have to extend because the more

⁶¹ Sheffield Medical Officer of Health, Annual Report, 1927.

it gets known by working class women, the more popular it seems to become, and it has already had its effect in a reduction in the number of still births that take place. Our tuberculosis work is very highly developed under a full time Tuberculosis Officer, with his staff of qualified medical men, and we have a number of tuberculosis hospitals and a very large tuberculosis dispensary. Tuberculosis has declined in Sheffield more than any other town in the last ten years.⁶³

Data from MOH reports for Sheffield illustrates Wynne's point about the increased work of the Department. The tuberculosis work of the Health Department was an area of high activity during the 1920s. As Table 2.1 below shows the numbers of patients referred to the Tuberculosis Dispensary increased dramatically in the 1920s. The number of X-rays taken annually at the Tuberculosis Dispensary in 1921 was 845 by 1929 the number had more than quadrupled to 2,822.⁶⁴ A good working relationship between the Health Department and local doctors was held responsible for the fact that 91.48 per cent of all cases of tuberculosis of the lung were referred to the municipal dispensary and were either visited by dispensary staff or in attendance at the dispensary in 1929.⁶⁵

Table 2.1 Total Attendances at Sheffield Tuberculosis Dispensary 1918-1927⁶⁶

1918	34,043	1923	56,650
1919	36,033	1924	54,264
1920	51,605	1925	55,992
1921	53,525	1926	54,125
1922	53,716	1927	59,266

As Wynne stated, the maternity and child welfare services were also boosted in the period. The number of attendances made by women at the Maternity Clinic was 2,094 in 1927, the number almost doubled between 1928 and 1929 from 5,126 to

⁶² Sheffield MOH, AR, (1925), 12.

⁶³ Minutes and Proceedings taken before the House of Lords Select Committee on the Sheffield Corporation Bill, HMSO, (1928), Evidence of F. Wynne.

⁶⁴ Sheffield City Council Hospitals Sub-Committee Minutes, 20 November 1930. SCA39/50.

⁶⁵ Sheffield Medical Officer of Health Annual Report, 1929.

⁶⁶ Figures from Sheffield City Council Tuberculosis Dispensary Summary of Work Done, Hospitals Sub-Committee Minutes, 17 January 1929, SCA 39/50.

9,412.⁶⁷ Infant mortality rate is used as a health indicator for general overcrowding and poor environmental conditions. The infant mortality rate in Sheffield was above the national average for England and Wales throughout the 1920s and only from 1933 did the city's IMR level improve and stay below the national average.⁶⁸ In terms of the weighting of staff to the various activities of the Health Department, there was an apparent bias towards the tuberculosis service. Alongside John Rennie, as Deputy Medical Officer of Health and Tuberculosis Officer for the Borough, there were five full time Assistant Tuberculosis Medical Officers and a full time Surgical Tuberculosis Medical Officer. By comparison the nine Assistant Medical Officers for Maternity and Child Welfare, were all employed on a part-time basis.⁶⁹ A full time Doctor with responsibility for midwifery was eventually appointed in 1930 to attend antenatal classes at the municipal City General Hospital and Nether Edge Hospital once appropriated by the Council from the Poor Law Guardians.

While the clinical work of the department was expanding, the pace of environmental improvement through better sanitation and refuse collection also quickened in the 1920s. The conversion of the city's great number of privy middens to water closets was virtually complete by 1928.⁷⁰ However, this did not mean that each individual house had its own water closet, rather, blocks of houses had access to shared facilities. Under an additional water closet scheme, landlords could repay the Council for carrying out conversion work, 2000 water closets were provided through the scheme in 1929.⁷¹ The peak year for 'additional water closets' was 1932 with 5,607, and by 1936 the number of additional water closets that it was necessary for the Council to provide in the City had fallen to 264.⁷² Refuse collection was also modernised in the 1920s. Waste disposal via fixed ashpits was abolished in 1929, when Section 352 of the Sheffield Corporation (Consolidation) Act 1918 was invoked. 1,685 fixed ashpits were abolished in 1929 with 3,437 moveable refuse bins introduced. Although it took the rest

⁶⁷ Sheffield Medical Officer of Health, Annual Report, 1929.

⁶⁸ Sheffield Medical Officer of Health, Annual Reports, 1920-40.

⁶⁹ Sheffield Medical Officer of Health, Annual Report, 1926. Public Health Staff as at December 1 1926.

⁷⁰ Sheffield Medical Officer of Health, Annual Report, 1928.

⁷¹ Sheffield Medical Officer of Health, Annual Report, 1929.

⁷² Sheffield Medical Officer of Health, Annual Report, 1936.

of the 1930s to completely remove the fixed ashpits from the city. By 1936 only 49 ashpits required removing to be replaced by 105 moveable bins.⁷³

Public health in Sheffield in the early twentieth century therefore saw improvements in environmental health at the same time that personal services through the inspection of school children, open air schools and the development of the Tuberculosis service were being expanded. The key appointments of Williams as Schools Medical Officer, Robertson, Scurfield and Wynne as MOH and Rennie as Tuberculosis Officer guided important changes to the clinical services work of the Health Department. Opportunities provided by national legislation were used to expand the health policy of the Council. With Wynne as Medical Officer of Health for the 1920s, this period of transition for public health was a lively one in Sheffield where the work of the MOH and the Health Department had a higher profile. Wynne was more inclined to promote medical intervention into the personal circumstances of citizens, he was prepared to challenge the views of members of the Labour Council and push for the application of legal requirements of businesses and farmers to adhere to health regulations. Wynne's interventionist stance over the quality of the milk supply and smallpox vaccination are used to illustrate the debates in the 1920s over the legitimate involvement of the local state in health matters.

Public Health and the Milk Supply

Medical opinion in the early twentieth century had accepted the reality of the transfer of disease from animals to humans through studies proving that the tuberculosis bacillus was transferred through infected milk causing tuberculosis of the bones and joints of children. The 1911 Royal Commission on Tuberculosis had settled the causal debate for the medical profession.⁷⁴ Translating this medical finding into robust public policy however proved difficult. The history of milk regulation in the middle decades of the twentieth century is one of piecemeal legislation and local discretion. F.B. Smith estimated that in the 1930s 2000 infants died each year of tuberculosis transmitted from

⁷³ Sheffield Medical Officer of Health, Annual Report, 1936.

milk.⁷⁵ However, there was a policy vacuum with piecemeal legislation and the application of regulations generally left to farmers to comply. In Sheffield in the 1920s, the dynamic Medical Officer of Health showed a willingness to stand up to vested interests, apply a systematic application of available regulations and go beyond the letter of the law. Wynne noted in 1927, 'In view of recent knowledge it is surely time that profit earning from the sale of dirty disease-producing milk should be illegal, but this has not been achieved from existing legislation.'⁷⁶ The medical world had accepted the link between tuberculous milk and disease in humans, however those in the commercial milk trade had contested the validity of medical opinion. Dairy farmers, milk wholesalers and milk vendors lobbied against greater regulations in the sale and production of milk. The majority of milk sold in Sheffield remained untreated, or 'raw' milk until the 1960s. Only in 1949 was legislation introduced whereby local authorities could insist on the pasteurisation and sterilization of milk, the practice became common in Britain during in the 1950s and became compulsory in Sheffield in 1962.⁷⁷ The Sheffield co-operative societies - the Brightside and Carbrook and Sheffield and Ecclesall took a more progressive approach and requested licences to sell 'Pasteurised' milk that were granted by the Health Committee in 1928.⁷⁸ From the late 1920s the co-operative societies treated the Co-op's milk at their Dairy at Broughton Lane.

In 1920s Sheffield Frederick Wynne as Medical Officer of Health took on the milk producers and retailers. Wynne was affronted by the lax way that milk was sold by retailers in 'loose' form from churns in the same premises where other goods would be sold including coal. In an article in the *Journal of the Royal Sanitary Institute* (following his address to the Annual Conference) in 1928, Wynne described how the

⁷⁴ P. Atkins, 'White Poison? The Social Consequences of Milk Consumption, 1850-1930', *Social History of Medicine*, 5, (1992), 225.

⁷⁵ F.B. Smith, *The Retreat of Tuberculosis, 1850-1951* (Croom Helm, London, 1988), 185.

⁷⁶ Sheffield Medical Officer of Health, Annual Report, 1927.

⁷⁷ It was in the 1950s under The Milk (Special Designations) Act of 1949 that the Ministry of Agriculture Fisheries and Food allowed local authorities for the first time to render compulsory the use of special designations on sales of milk, including pasteurization. J. Phillips and M. French, 'State Regulation and the Hazards of Milk, 1900-1939', *Social History of Medicine*, 12, 3, (1999), 371-388. From 1962 only pasteurised, sterilized or farm-bottled milk from tuberculin tested herds could be sold in Sheffield. C. Shaw, 'Aspects of Public Health,' in C. Binfield, (ed.) *History of the City of Sheffield* (Sheffield, 1993), ft11, 510.

⁷⁸ Sheffield City Council Health Committee Minutes, 13 November 1928, SCA 112/29.

Chairman of the Sheffield and District Cowkeepers and Dairymen Association, Tom C. Fletcher, had publicly denounced the Health Committee as being 'precious' for insisting that loose milk should not be sold from premises where coal was also distributed.⁷⁹ The Milk and Dairies (Amendment) Act of 1922 gave local authorities the power to check the condition of milk vendors and refuse to award registration certificates to retailers who failed to comply with hygiene regulations. However, under Wynne's leadership the Health Department took a pro-active stance and surveyed farms, wholesale premises, and milk shops in order to investigate both the conditions that dairy cattle were kept in, and the condition of milk after it left the farms and before it reached the vendor and the consumer. This was beyond the remit of the legislation.

Through inspections Wynne was not surprised to find that that high numbers of cattle were found to have tuberculosis, when the animals were known to be kept in poor conditions. In 1928, Wynne described a Sheffield dairy farm he had recently visited where cows were constantly covered in manure as no labourer had been employed to keep them clean. When the state of the cattle was brought to the attention of the farmer's son, he was described as being 'obviously uneasy' about the situation; Wynne stated that 'some waft of a breeze from the twentieth century had impinged on his conscience'.⁸⁰ However when questioned about the possible health risks of keeping cows in a filthy state, the 70 year old farmer replied 'Nowt o't soort. It keeps 'em warm.'⁸¹ Wynne described the incredulity felt by the farmer that local authority officials might have the power to take away his herd for slaughter if tuberculosis was found. The 1920s saw a strengthening of the local authority's hand in dealing with farmers who had tuberculous cows. The Tuberculosis Order of 1925 made it compulsory for farmers to notify the local authority if cows were discovered to have thickened udders, if they became emaciated, or if they began to suffer from a chronic cough.⁸²

⁷⁹ F. Wynne, 'The Present Condition of the Milk Supply', *Journal of the Royal Sanitary Institute*, vol. XLIX, No1, (July, 1928), 3-9.

⁸⁰ F. Wynne, 'The Present Condition of the Milk Supply', *Journal of the Royal Sanitary Institute*, vol. XLIX, No1, (July, 1928), 4.

⁸¹ F. Wynne, 'The Present Condition of the Milk Supply', *Journal of the Royal Sanitary Institute*, vol. XLIX, No1, (July, 1928), 4.

⁸² J.S. Lloyd, (Chief Veterinary Inspector for the City of Sheffield), 'Tuberculosis in Milk as Affected by Recent Legislation', *Journal of the Royal Sanitary Institute*, XLVIII, (1927), 319-327.

Cow's milk was a notable means by which tuberculosis was spread, yet there was no widespread application of the technology of heat treatment and refrigeration in the 1920s. Vendors were well known to dilute milk in order to make it go further, so that milk in the 1920s was a potentially dangerous substance. As Wynne stated, 'milk is a culture medium for the streptococci which are responsible for toxaemia, which at present we somewhat illogically differentiate as scarlet fever, puerperal fever, erysipelas and septicaemia.'⁸³ He also stressed that milk was a host for diphtheria plus B-coli and 'its cousins in the typhoid group'. For Wynne, the solution was not the widespread pasteurisation of milk, which he thought offered 'only partial protection', instead he advocated the dehydration of fresh milk in order that it would be sterilised. Wynne argued that 'the bulk of milk produced in this country might be dried, and practically all our milk problems would be solved.'⁸⁴ Wynne felt that, aside from the sterilization aspect of dehydration, dried milk would be easier and cheaper to store and transport. One of the main functions of maternity and child welfare clinics was to ensure that milk was available to mothers at cost price. In Sheffield, nursing mothers attending the Maternity and Child Welfare Clinics were offered only dried milk.

In the Sheffield press in the late 1920s, Tom Fletcher of the Sheffield and District Cowkeepers and Dairyman's Association declared his objection to the increasingly interventionist policy that was being pursued by the MOH and the Council. Fletcher believed that the actions of the local authority were needlessly harsh and that the authority did not recognise the realities of making a living in the business of farming and food production. Fletcher believed that 'one cannot but think that the City Fathers are a little hard in their regulations with regard to the keeping of cows.'⁸⁵ As an independent farmer, Fletcher objected to the Council taking any interest in the way that cows were kept. He also attempted to shift the blame for the contamination of milk further down the production line, believing that more attention ought to be paid to 'the produce of those cows after it leaves the milkman.'⁸⁶ Roland Cranshaw, the Vice

⁸³ F. Wynne, 'The Present Condition of the Milk Supply', *Journal of the Royal Sanitary Institute*, vol. XLIX, No1, (July, 1928), 5.

⁸⁴ F. Wynne, 'The Present Condition of the Milk Supply', *Journal of the Royal Sanitary Institute*, vol. XLIX, No1, (July, 1928), 6.

⁸⁵ *Sheffield Daily Independent*, 24 January 1929.

⁸⁶ *Sheffield Daily Independent*, 24 January 1929.

President of the Association of Milk Dealers in Sheffield, objected to the Health Department's application of medical and scientific theory in the tightening up of regulations concerning milk production. Cranshaw stated 'without attempting to hold a pistol to the head of anyone. I do say that Sheffield suffers particularly from theory in the field of medical and health committees. Their regulations are based on theory and not on practice.'⁸⁷ In questioning the legitimacy of the Council to regulate milk production Cranshaw stated 'I do not know if they [the Council] have a mandate for these things but they have started going out into territory over which they have no right at all.'⁸⁸ As this was twenty years before The Milk (Special Designations) Act of 1949 allowed local authorities to insist on regulations relating to the conditions of the sale and production of milk, Cranshaw had a point, but Wynne continued his campaign to improve the milk supply in Sheffield.

In a reply to Wynne's address to the Royal Sanitary Institute in 1928, J. Newton, a representative of the Manchester branch of the National Farmers Union, was of the opinion that the government and local authorities were 'harassing farmers by crippling legislation based on unproved theories.'⁸⁹ Newton stated that 'the greatest injustice had been done to the British milk producer by the incessant shrieking that milk was responsible for disease'.⁹⁰ Newton challenged the findings of the Royal Commission of 1911 and the acceptance that tuberculosis was transmitted from cows to humans through milk, claiming that Robert Koch had come near to smashing the theory that tuberculosis was carried in milk with the discovery that human and bovine bacillus were distinct, and that these 'separate bacilli were each incapable of transmitting tuberculosis from man to animal or animal to man, and therefore there was no fear of tuberculosis from milk.'⁹¹ As late as 1939, only 48 per cent of the milk in Sheffield was pasteurised and thus guaranteed safe from tuberculosis. Untreated or 'raw' milk remained on sale in Sheffield into the 1930s and 1940s, and in 1939 eight per cent of raw milk tested by the Health Department was reported as being infected with tuberculosis.⁹²

⁸⁷ *Sheffield Daily Independent*, 24 January 1929.

⁸⁸ *Sheffield Daily Independent*, 24 January 1929.

⁸⁹ J. Newton, 'Reply to F. Wynne', *Journal of the Royal Sanitary Institute*, (July, 1928), 12.

⁹⁰ J. Newton, 'Reply to F. Wynne', *Journal of the Royal Sanitary Institute*, (July, 1928), 12.

⁹¹ J. Newton, 'Reply to F. Wynne', *Journal of the Royal Sanitary Institute*, (July, 1928), 12.

⁹² Shaw, 'Aspects', 112.

As Phillips and French state, 'the 1922 [Milk and Dairies Amendment] Act was an acknowledgement that overall quality was unacceptable. But by leaving the task of securing much-needed improvements to farmers, the state abdicated real responsibility in an area of major public importance.'⁹³ In Sheffield, the MOH was not prepared to leave the farmers to be unregulated and get away with keeping cattle in unhealthy conditions. In 1926 the local authority had 993 milk samples analysed at the Bacteriological Department of the University of Sheffield, of which 65 were found to be tuberculous, leading to Magistrates Orders being taken out against the offending farmers.⁹⁴ Wynne's stance over the milk supply, seeking better conditions for cattle by stretching the letter of the law and not being afraid to upset vested interests illustrates his scientific approach to his public health work in Sheffield. He was trained in Manchester and was MOH for Leigh and Wigan before moving to Sheffield in 1921.⁹⁵ John Pickstone's work on health policy in the North West has noted the prominent laboratory bias of public health medicine in Manchester and its region at the time, boosted through the close association between Manchester University medical students, the Medical Officers of Health and the clinicians in the region.⁹⁶ The question of the legitimate role of the state in the control and eradication of disease proved to be a controversial issue in Sheffield in the 1920s. A further example of this was the debates between William Asbury and Frederick Wynne over the smallpox epidemic which broke out in Sheffield in the winter of 1926/27 at the same time that Labour won the local election.

⁹³ J. Phillips and M. French, 'State Regulation and the Hazards of Milk, 1900-1939', *Social History of Medicine*, 12, 3, (1999), 387.

⁹⁴ J.S. Lloyd, (Chief Veterinary Inspector for the City of Sheffield), 'Tuberculosis in Milk as Affected by Recent Legislation', *Journal of the Royal Sanitary Institute*, XLVIII, (1927), 319.

⁹⁵ Obituary of F.E. Wynne, *Journal of the Royal Sanitary Institute*, 50, (1930), 747-748.

⁹⁶ The Professor of Pathology and Bacteriology at Manchester Medical School in the early twentieth century, was Sheriden Delepine. He is attributed with promoting a definite scientific and laboratory bias in public health education at the time when Wynne was training in Manchester and practicing in Lancashire. Pickstone notes that in the 'Manchester district from the 1880s, and particularly in the Edwardian period, there was considerable collaboration between University medical students, Medical Officers of Health and clinicians.' J.V. Pickstone, *Medicine and Industrial Society: A History of Hospital Development in Manchester and its Region, 1752-1946* (Manchester University Press, 1985), 226-227.

The Sheffield Smallpox Epidemic of 1926/1927

In the winter of 1926/1927 there was an epidemic of smallpox in Sheffield, with over 700 notified cases and one death. Epidemics of smallpox in Britain in the nineteenth century had occurred primarily in cities and the disease, so called to disassociate it from 'Great Pox' or syphilis, was most severe in children. It was a highly infectious disease and was spread to contacts through the air. It was therefore most commonly found in densely populated districts, but it was a threat to the whole population. The smallpox issue was of such importance to the government that highly unusual statutory measures were taken to control the disease, which led to what one historian has dubbed 'a Victorian NHS.'⁹⁷ The first Vaccination Act of 1840 was permissive, Poor Law Guardians were to arrange for medical practitioners to provide vaccination on a request basis. A number of large-scale nineteenth century smallpox epidemics led to calls for greater compulsion in vaccination and eventually to the 1871 Vaccination Act which saw the introduction of compulsory infant vaccination. The Act required every local Board of Guardians to appoint a Vaccination Officer to supervise vaccination of all infants under 4 months old, to prosecute defaulters under the threat of fines and imprisonment and to arrange for qualified medical practitioners to carry out vaccinations. The Poor Law was the only national administrative framework available for the government to use. However, the application of the Vaccination Acts tended to be lax. This was due to number of factors.

The government's use of the infrastructure of the Poor Law to implement vaccination was problematic. Firstly, doctors were highly independent practitioners and had deeply held concerns over the perception of their status, they were not keen to appear to be working under the authority of non-medical Poor Law Guardians. Secondly, the public were also not well disposed towards associating with a scheme that was administered by the Poor Law authorities, due to deeply held popular notions relating to the stigma of pauperism. Finally, as the administration of poor relief was the main concern of Boards of Guardians, very few parents were prosecuted for failure to

⁹⁷ R. Lambert, 'A Victorian NHS,' *Historical Journal*, 5, (1962), 1-18.

have their infants vaccinated. As well as these administrative concerns, a body of opinion had built up which strongly objected to compulsory vaccination on both health and ideological grounds. This had led to anti-vaccinationism becoming a political issue and to the election of anti-vaccinators onto Boards of Guardians. In Keighly in 1876 seven Guardians were arrested and imprisoned for refusing to implement vaccination. In Leicester in 1885 a mass anti-vaccination demonstration took place where an effigy of Edward Jenner was thrown to the crowd and a copy of the Vaccination Acts was burned.⁹⁸ There was much suspicion over the efficacy of vaccination.⁹⁹ In 1898, the concept of 'conscientious objection' was introduced into English law as parents were allowed to refuse to have their children vaccinated if they presented their objection before two magistrates.¹⁰⁰ A further Act in 1907 allowed conscientious objection on a simple declaration to one magistrate. After the Victorian epidemics the incidence and the virulence of smallpox had waned. In the early years of the twentieth century the amount of severe smallpox 'variola major' was very small and was mainly due to cases brought in from abroad 'which had escaped through the net of the port sanitary authorities.'¹⁰¹

The most severe outbreak of smallpox in Sheffield occurred in 1871-1872 and resulted in 1,002 deaths.¹⁰² In 1888 the Lodge Moor Isolation hospital had been rapidly constructed on the edge of Sheffield to deal with a smallpox epidemic of 7,066 cases, of which 680 were fatal.¹⁰³ From 1893 to 1921 Sheffield was free from smallpox, and Lodge Moor hospital was used as an isolation hospital for other infectious diseases. After a period of dormancy the incidence of smallpox began to rise in Sheffield and in

⁹⁸ C. Charlton, 'The Fight Against Vaccination: The Leicester Demonstration of 1885', *Population Studies*, 30, (1983), 60-66.

⁹⁹ Naomi Williams stresses the need to differentiate between inoculation and vaccination. 'The former, practised throughout the late eighteenth and early nineteenth centuries involves puncturing the skin with the live smallpox virus to induce a mild form of the disease which then produces life long immunity. Vaccination, developed by Edward Jenner in the late 1790s, uses lymph from a cowpox vesicles, however its protection wears off over time. Recently innoculated persons are highly infectious and may give rise to a particularly severe form of smallpox in others.' N. Williams, 'The Implementation of Compulsory health legislation: Infant Smallpox Vaccination in England and Wales, 1840-1890', *Journal of Historical Geography*, 20, 4, (1994), 396-412, 410.

¹⁰⁰ E.P. Hennock, 'Vaccination Policy Against Smallpox, 1835-1914: A Comparison of England with Prussia and Imperial Germany,' *Social History of Medicine*, 11, 1,(1998), 49-71.

¹⁰¹ W. Frazer, *A History of English Public Health, 1834-1939* (Balliere, Tindall and Cox, London, 1950), 370.

¹⁰² C. Shaw, *A Review of Infectious Diseases in Sheffield*, (Typescript, Sheffield Central Library, 1993).

¹⁰³ C. Shaw, *A Review of Infectious Diseases in Sheffield*, (Typescript, Sheffield Central Library, 1993).

its surrounding counties in the 1920s. Eleven cases of smallpox were notified in the city in 1922.¹⁰⁴ A handful of smallpox cases occurred in the next two years.¹⁰⁵ In Sheffield, Wynne the MOH, acted as City Vaccination Officer, The City Council Town Clerk's Department was responsible for bringing prosecutions for failure to vaccinate, and the local authority Public Health Department was the body which put into practice emergency measures to deal with the disease.

Wynne described the procedure for handling the incidence of smallpox in Sheffield in the mid-1920s, 'In all these cases there was early diagnosis, immediate notification, confirmation of diagnosis, hospitalisation of patients, isolation of immediate contacts and very active supervision of remote contacts, disinfection of premises and all infected material.'¹⁰⁶ However, Wynne felt that the 'very success of our efforts produced a false sense of security'.¹⁰⁷ Sheffield, as elsewhere, remained a largely unvaccinated town. In 1925 the number of smallpox notifications began to rise. Two boys who visited Middlesbrough were said to have been the source of an outbreak of 44 cases of smallpox in 1925. In this instance there was no early diagnosis, no doctor was called as the boys were felt to have chicken-pox and were sent to school. No further cases were reported until October 1926 when, as Wynne stated 'It became at once apparent that this time we were the subject of a massive infection'.¹⁰⁸ The 1926 outbreak occurred in the industrial east end of the city in Attercliffe. A 'Spot Map' of the incidence of small pox cases in Sheffield in 1927 was constructed by the MOH using a pin for each case. The map appeared in the 1927 Medical Officer of Health Report and clearly shows the localised nature of the epidemic in Attercliffe, as well as illustrating how the epidemic was spread out from Attercliffe along the tram routes.¹⁰⁹

As the smallpox hospital was being used for tuberculosis cases there were only 20 places in the city for the isolation of smallpox cases. The Health Department

¹⁰⁴ Sheffield MOH, AR, 1922.

¹⁰⁵ There were 3 notified cases of smallpox in 1923 and 4 in 1924. Sheffield MOH, Annual Reports, 1923 and 1924.

¹⁰⁶ F. Wynne, 'The Administrative Control of Smallpox', *Journal of the Royal Sanitary Institute*, (1928), 118-125.

¹⁰⁷ F. Wynne, 'The Administrative Control of Smallpox', *Journal of the Royal Sanitary Institute*, (1928), 118.

¹⁰⁸ F. Wynne, 'The Administrative Control of Smallpox', *Journal of the Royal Sanitary Institute*, (1928), 119.

¹⁰⁹ Sheffield Medical Officer of Health, Annual Report, 1927.

therefore made use of the 'hutment' camp at Redmires where over 800 people were isolated. Complaints were made about the poor state of the isolation accommodation and about the practice of fumigating houses where cases were notified with *IZAL*.¹¹⁰ In the earlier, smaller outbreaks of the disease seen in 1920-1925, the initials and full addresses of those infected with smallpox were published in the MOH Annual reports.¹¹¹ This was not the case in the epidemic of 1926/1927, however, the notion that this outbreak was a spatially specific problem related to the working class industrial district of the Attercliffe area of the city was made clear.

As the epidemic advanced through the winter, the isolation accommodation in the city for smallpox cases was soon full and arrangements were then made to isolate patients in a room in their own homes. The Health Department under Wynne undertook a very active policy. The contacts of those infected had their house key confiscated and were accommodated in isolation cottages, they were vaccinated and their homes were fumigated with *IZAL* disinfectant.¹¹²

Over October 1926 to February 1927 - 700 smallpox cases were notified. The epidemic created public alarm and a sudden increase in the number of people seeking vaccination. Wynne used the local press to promote the case for a large scale vaccination programme, stating in January 1927 that there was:

the possibility, amounting almost to a certainty, of a severe epidemic of smallpox on a large scale, for the disease has now passed from a mild form to the virulent nature of forty years ago. I fear that the disease may resume its old original virulence and that we may have cases suffering from disfigurement, serious illness and possibly fatal results. The epidemic is affecting persons of all ages and without a general re-vaccination we have no security whatever against an epidemic on a huge scale.¹¹³

¹¹⁰ *Sheffield Independent*, 21 January 1927.

¹¹¹ Sheffield Medical Officer of Health, Annual Report, passim, 1922-1925.

¹¹² The Health Department received complaints about the poor state of the isolation accommodation and the fact that the fumigation of the houses and possessions of those isolated, had resulted in ruined curtains, sheets and blankets. *Sheffield Independent*, 21 January 1927.

¹¹³ *Sheffield Independent*, 12 January 1927.

Wynne stated that because the strain of smallpox in the epidemic of the 1920s was the milder form of the disease, 'variola minor' there had been difficulties in controlling its spread, as people had often been ill and contagious for some time without realising that they had smallpox. In the midst of the epidemic the Sheffield newspapers publicised 'Sensational Evidence' of cases brought by the Town Clerk's Department against negligent parents who had allowed their children to mix socially, when they should have been isolated and registered as suffering from smallpox. In one case a mother and father from Attercliffe were each fined for 'exposing their children' to the community when suffering from smallpox, and the father was also fined for failing to notify the cases to the Medical Officer of Health.¹¹⁴

Wynne's propaganda emphasised that the vaccination procedure was a free service for the public that was available to all. The result of his campaign was that 100,000 people, a fifth of the city's population, were vaccinated against smallpox between 1925 and 1927. Wynne claimed that the disease had not appeared in people who had been vaccinated in the last ten years and that those who had been vaccinated as infants showed milder symptoms. He was adamant that smallpox vaccination was essential. The newspapers reported how the police were keeping public order as massed ranks of people appeared outside doctor's surgeries in the rush for vaccination.¹¹⁵ The doctors employed as public vaccinators, opened their surgeries for 12-14 hours, and were forced to open their surgeries until after midnight to cope with the demand. Calls were put out for extra nurses.¹¹⁶ At the largest steel works vaccinations were carried out *en masse*.

Vaccination in the 1920s, was no modern injection with a hypodermic syringe. It was much more like a minor operation. Calf lymph was applied to three or four fairly large abrasions made on the patient's leg or arm with a lancet.¹¹⁷ Sheffield employers

¹¹⁴ *Sheffield Independent*, 15 January 1927.

¹¹⁵ In January 1927 at the height of the epidemic the *Independent* reported that 700 people were vaccinated in one day. The police were called the following week to keep order when queues for vaccination reached 400-500 people. *Sheffield Independent*, 17 January 1927. *Sheffield Independent*, 20 January 1927.

¹¹⁶ Sheffield Medical Officer of Health, Annual Report, 1927.

¹¹⁷ There is no available description of the practice of vaccination in Sheffield in the 1920s, however there was a simultaneous outbreak of the disease in the North-East of England, thought to be the source of the Sheffield infection. After complaints from William Whitley the County Medical Officer for Northumberland to Sir

reported heavy absenteeism due to the after effects of vaccination, with one firm reporting 250 female staff absent due to vaccination in February 1927.¹¹⁸ The recently vaccinated, were marked out by displaying red bands or red ribbons on their arm.¹¹⁹ Perhaps a lingering sign of folk memories of being infectious through smallpox inoculation.

As the headline of the 14 January 1927 edition of the *Sheffield Independent* declared that there was 'No Need To Panic' the sense of emergency heightened.¹²⁰ The attitude of the rest of the city towards Attercliffe was one of increasing fear. The measures taken to isolate the epidemic saw all the Sheffield hospitals cancel patient visiting hours. Municipal tramcars were fumigated, and every library book issued and all public buildings were disinfected. An English Schools Shield football match due to be played in Darnall, the district adjoining Attercliffe, between Grimsby and Sheffield was postponed on the advice of the Grimsby MOH.¹²¹ An Attercliffe brass band had a planned radio broadcast cancelled on the grounds that 'the players came from the infected district'.¹²² Pubs in Attercliffe closed due to the landlords and their families contracting the disease, yet in an effort to contain the disease, they were quickly allowed to reopen. Sheffield schools including those in Attercliffe were kept open in the belief that 'there was less danger of contagion for the children than there would be if the schools were closed and they were free to roam the streets.'¹²³ Evidently the policy of the MOH and the Council was to contain the disease in the district from which it originated. The publicity surrounding the epidemic attracted cranks, one was reported to

George Newman the Chief Medical Officer, the Ministry of Health investigated the smallpox vaccination technique as carried out by Dr Bruce the Medical Officer of Health for Ashington in 1927. The Ministry investigator recorded that: 'no attempt is made to sterilise the area on which vaccination is made. I saw Dr Bruce perform two such vaccinations. When I protested that the arm should be prepared by cleansing with methylated spirit, Dr Bruce asked the patient why she should be insulted by suggesting her arm was dirty. He wilfully ignored the question of surgical cleanliness. When the arm has been scarified and the lymph is applied, Dr Bruce blows the lymph from the tube with his mouth and does not use a blower. On completion of the operation, no protective dressing is applied.' Report of W.V. Shaw 8 March 1926, PRO MH 52 211 Ashington Urban District Council Failure of Medical Officer of Health to deal with smallpox, 1926-1927. As a result of the investigation Dr Bruce was given three months notice to terminate his services.

¹¹⁸ *Sheffield Independent*, 2 February 1927.

¹¹⁹ *Sheffield Independent*, 22 January 1927.

¹²⁰ *Sheffield Independent*, 14 January 1927.

¹²¹ *Sheffield Independent*, 20 January 1927.

¹²² *Sheffield Independent*, 13 January 1927.

¹²³ *Sheffield Independent*, 14 January 1927.

have written to the Medical Officer of Health offering to provide secret miracle cures for smallpox for the sum of £500.¹²⁴

In January of 1927 Dr Vernon Shaw, a Medical Officer from the Ministry of Health, was sent to Sheffield to inspect the arrangements for dealing with the smallpox epidemic. Shaw stated publicly that 'it is no longer a medical matter, it is something which vitally affects the trade and commerce of the city. I would urge every citizen to co-operate cheerfully with the local authorities in carrying out any instructions or advice which may be given.'¹²⁵

The epidemic coincided with major political change in Sheffield. The election of the Labour Party as the majority party on the Council in November of 1926 saw William Asbury become Deputy Leader of the Council and Chairman of the Health Committee. Asbury was deeply committed to the cause of anti-vaccinationism and the crisis provided a platform to express his philosophy which was diametrically opposed to the ideas of the Medical Officer of Health, Frederick Wynne. In one of his first appearances in the City Council Chamber as Chairman of the Health Committee, Asbury brought up the case of a young woman who had to have her arm amputated after an adverse reaction to smallpox vaccination. The Medical Officer of Health immediately refuted the notion that vaccination was dangerous, he investigated the claim with surgeons at The Sheffield Royal Infirmary finding it to be false.¹²⁶ However Asbury had achieved publicity for the cause of anti-vaccination.

It was unusual in British cities in the late 1920s for such debates to be so significant. The issue of vaccination had died down once legislation had been made more permissive in 1897. Even in towns like Leicester, where the matter had been very controversial, a settlement had been reached where the Medical Officer of Health and the Council supported a policy of early diagnosis and isolation without recourse to vaccination, a policy which became known as 'The Leicester Method'.¹²⁷ In Sheffield

¹²⁴ *Sheffield Independent*, 20 January 1927.

¹²⁵ *Sheffield Independent*, 14 January 1927.

¹²⁶ *Sheffield Independent*, 3 and 4 February 1927.

¹²⁷ S.M.F. Fraser, 'Leicester and Smallpox: The Leicester Method', *Medical History*, 24, (1980), 315-332.

leading members of the Labour movement took a stance against vaccination without offering an alternative medical approach. *The Sheffield Forward*, the newspaper of the Sheffield Trades Council, opposed vaccination on the grounds that it was irrelevant, dangerous and merely a form of profiteering for drug companies and the medical profession. The February 1927 edition of *The Sheffield Forward*, stated that the only epidemic Sheffield suffered from was 'poverty and the distress of the last sixth months.'¹²⁸ The Trades Council newspaper questioned the insistence of the MOH for vaccination, and stated that the local press had refused to publish letters putting the case of anti-vaccinationism. *The Sheffield Forward* believed that people were being scared into being vaccinated and that 'the psychological effects will no doubt make more people susceptible to disease.'¹²⁹ In an effort to smear the medical profession, the paper reported that a local doctor had said that it would be a good thing if the first twenty people infected with the disease had died so that universal vaccination would take place. The response of the Trades Council newspaper was to suggest that 20 Anti-Labour Guardians should be infected with the disease 'so that the unfortunate unemployed man would no longer have to attempt to keep himself, his wife and child on 27s a week.'¹³⁰

In February 1927, *The Marvels of Modern Medicine*, an anti-vaccinationist book by Elliot Fitzgibbon was reviewed in the *Sheffield Forward*. The reviewer stated that:

here we glimpse something of the methods by which commercial interests behind the great fakes of vaccine and other forms of physical dope have made fortunes out of the subjection of the public to the wiles of the modern medicine man. We are shown that Jenner and Pasteur, great names before whom all medical knees bow, were themselves utterly unqualified medically and that their marvellous theories have no more substantial basis than the current capitalistic views of finance and politics. The administration of vaccination and other forms of physical assault have not succeeded in banishing disease, but there is no attention to quite other sanitary conditions. Even the 'germ theory' of disease is yet thoroughly unscientific and it is not at all established on such a firm foundation as is determined in real sciences. Not until socialism is achieved will we be free of the horrors of

¹²⁸ *Sheffield Forward*, 27 February 1927.

¹²⁹ *Sheffield Forward*, 27 February 1927.

¹³⁰ *Sheffield Forward*, 27 February 1927.

commercialised medicine, with its vaccines and vivisection, and all the loathsome practices, some of which are unprintable here in which this pseudo-scientific spirit practices on the bodies of men.¹³¹

It is not known who wrote the review however, it was William Asbury who carried the same anti-vaccination, anti-medical, pro-social reform message to a national platform. When the emergency was over, Asbury and Wynne were invited to address a debate on the Sheffield outbreak of smallpox at the 1927 Annual Conference of the Royal Sanitary Institute. The exchange of opinion was published in the Society's journal. Wynne's address dismissed the claims of the anti-vaccinators that smallpox vaccination led to adverse reaction stating that he had personally vaccinated 2,000 troops in a three week period in the army 'without a single reaction more severe than normal'. He noted that 'a certain class of patient attributes every ailment among their offspring to vaccination and the children inherit this condition. I once had a case in which a young woman attributed her pregnancy to vaccination in infancy.'¹³² Wynne recognised that issues of liberty and democracy were at stake in the vaccination debate and saw that as 'universal vaccination appears to be impossible under modern conditions of Democracy in this country, the Government should have powers in conjunction with smallpox to declare any area an "infected area" and to prescribe any measures in that area which they believed necessary after consultation with their expert advisors.'¹³³ Wynne acknowledged the view of the MOH for Leicester, Dr Killick Millard, that complete vaccination of the whole community was an unattainable ideal. However, Wynne believed that 'if this is an impossible ideal in a normal population, it is not and should not be allowed to be, impossible of attainment in an infected population.'¹³⁴

Wynne and Asbury had different interpretations for the fact that the epidemic was limited to Attercliffe. For Wynne this was proof that the work of the Health

¹³¹ *Sheffield Forward*, 27 February 1927.

¹³² F. Wynne, 'The Administrative Control of Smallpox', *Journal of the Royal Sanitary Institute*, (1928), 118-125.

¹³³ F. Wynne, 'The Administrative Control of Smallpox', *Journal of the Royal Sanitary Institute*, (1928), 121.

¹³⁴ Wynne complained about the end of compulsion in vaccination policy, stating that the 1871 Act had given rise to 'the Conscientious objector who has never been asked to produce any evidence of being in possession of a conscience'. Wynne, 'Smallpox', 121, 122.

Department in conjunction with medical practitioners had been effective in containing the disease. Asbury's interpretation of the outbreak being located in Attercliffe was that insanitary housing conditions had made the inhabitants of Attercliffe more susceptible to disease. From Asbury's perspective, vaccination was an irrelevance and a mere palliative which only served to direct attention away from the main social and educational issues facing the new Council and the Health Committee. Asbury asked:

How much longer is this fetish for vaccination to be allowed to continue? Smallpox is a filth disease and like all zymotics is amenable to sanitation. Our job is to work for a decent standard of life for the working class, place them in clean and healthy surroundings, and make them fully acquainted with the laws of personal hygiene.¹³⁵

Asbury felt that widespread vaccination in the late nineteenth century had been proved to be ineffective against smallpox, but that the practice had been, and was still being promoted due to 'the efforts of a small body of medical men, who apparently realised that the establishment of the practice would mean places of position and remuneration to themselves'.¹³⁶ He stated that 'By passing compulsory vaccination laws Parliament lulled the local authorities into the belief that there would be no more smallpox'.¹³⁷ Asbury, like Wynne, argued his case over vaccination through the use of science. Asbury referred to papers in the *Lancet* which linked smallpox vaccination with encephalitis. He argued that the 'variola minor' strain of smallpox that occurred in the 1920s produced 'an entirely negligible disease' and that other diseases such as measles and whooping cough were far bigger killers, but that the government and the medical profession appeared to be obsessed with smallpox.¹³⁸ In a clear jibe at Wynne, Asbury stated that there was no need to spend vast sums of public money arranging to isolate cases of smallpox and that 'left to themselves ... they would die out, they would not be noticed if it were not for the mania to push vaccination which has seized so many of our medical officials today'.¹³⁹ On his part, Wynne felt that anti-vaccinationists espoused 'the rhetoric of the illiterate ... they present some interesting psychological

¹³⁵ W. Asbury, 'The Case Against Vaccination', *The Journal of the Royal Sanitary Institute*, 148

¹³⁶ W. Asbury, 'The Case Against Vaccination', *The Journal of the Royal Sanitary Institute*, 141.

¹³⁷ W. Asbury, 'The Case Against Vaccination', *The Journal of the Royal Sanitary Institute*, 143.

¹³⁸ W. Asbury, 'The Case Against Vaccination', *The Journal of the Royal Sanitary Institute*, 149.

phenomena of which I am trying to make some study'.¹⁴⁰ The tension between Asbury the newly elected politician responsible for directing health policy in Sheffield and the senior medical official responsible for the implementation of health policy was plain.

Asbury's views illustrated how the issues of health, housing, and poverty were inextricably linked in the mindset of Labour politicians in Sheffield between the wars. Labour Party election material in the 1920s featured health, housing and social policy at the forefront of campaign material.¹⁴¹ In the local election campaign of October 1926, the Labour Party declared that it was 'pledged to unfettered extension and development in every phase of municipal activity' and that its intentions when in office would be 'to abolish slums, provide public wash houses, obtain powers to ensure the purity of the water supply, to build houses under municipal enterprise and to let houses and schools be built by direct labour.'¹⁴² William Clegg, the Leader of the Citizens Alliance reacted to these calls for municipal action by stating that the 'Socialist Party policy is largely impractical and impossible to carry out'.¹⁴³ One of the first acts of the Labour Council in November 1926 was to restructure the Health Committee. Membership was increased from 15 to 21 Councillors, and the remit of the Health Committee was expanded to take in parks and burials, weights and measures and for the first time the responsibility for the care of the 'mentally defective'. The Citizens Alliance objected strongly to reform on the grounds that the reformed Health Committee would be too unwieldy. Ernest Rowlinson, the Leader of the Labour Group pointed out that the Citizens Alliance had been playing games with the Labour Group throughout the 1920s, not only had Labour been denied its quota of Aldermen by the Citizens Alliance, the one committee that the Citizens Alliance had allowed a fair representation, in fact a majority of Labour Councillors had been the Care of the Mentally Defective Committee. Rowlinson stated that this 'was meant as an insult but we took it as a compliment.'¹⁴⁴

¹³⁹ W. Asbury, 'The Case Against Vaccination', *The Journal of the Royal Sanitary Institute*, (1928), 149.

¹⁴⁰ F. Wynne, 'The Administrative Control of Smallpox', *Journal of the Royal Sanitary Institute*, (1928), 121.

¹⁴¹ Labour called for slum clearance, house building, more maternity and child welfare clinics and an extended tuberculosis service. See 'Co-operative Labour Policy of Civic Government: A Progressive Charter for Sheffield Ratepayers', *Sheffield Co-operator*, November 1926.

¹⁴² *Sheffield Independent*, 15 October 1926.

¹⁴³ *Sheffield Independent*, 15 October 1926.

¹⁴⁴ *Sheffield Forward*, February, 1927.

The tension between Asbury and Wynne spilled over to the Annual Report of the Medical Officer of Health. It was not standard practice for the Chairman of the Health Committee, a politician, to write a Foreword to the Medical Officer's Annual Report. However, in the first annual report to be published after the smallpox epidemic in 1928 Asbury took the opportunity to assert the authority of the elected Councillor responsible for the Health Committee. Asbury called for an expansion of the role of the local authority in improving the health of the population via better housing stating that it was of little use removing people to hospitals and sanatoria for short periods if they were to be returned to unhealthy living conditions he also explicitly stated that expanded municipal employment through direct labour schemes should be considered part of the improvement of the city's health. For Asbury the aim of the Labour Council was clearly to improve the economic position of 'the great mass of our fellow citizens' in order that they could afford good food and clothing and strengthen their resistance to disease.¹⁴⁵

The episode illustrates how the ideology of the Left questioned the right of the central state, backed by the medical profession to frame the city's approach to health care. For Asbury the key lesson was that the role of the local state was to improve the health of the population through the provision of better housing. When Wynne appeared before a House of Lords Select Committee enquiry into the 1928 Sheffield city boundary extension, the MOH was asked directly whether the recent Labour majority on the Council had resulted in 'a tendency to extravagance and improper spending as contrasted with the previous [Citizens Alliance] administration'.¹⁴⁶ Wynne replied that 'those now responsible have allowed certainly more money to be spent on the public health service, but in what I think everyone would agree, is in an economical direction. At the same time as far as my department is concerned they have kept as tight a hand on the finances and done as much to prevent any leakage or extravagance as any other party.'¹⁴⁷

¹⁴⁵ Sheffield MOH, Annual Report, 1928.

¹⁴⁶ Minutes and Proceedings taken before the House of Lords Select Committee on the Sheffield Corporation Bill, HMSO, (1928), Evidence of MOH F. Wynne.

¹⁴⁷ Minutes and Proceedings taken before the House of Lords Select Committee on the Sheffield Corporation Bill, HMSO, (1928), Evidence of MOH, F. Wynne.

Conclusion

This chapter has examined the development of the Health Department in Sheffield, it has noted how Sheffield was slow to appoint Medical Officers of Health until compelled to do so by national legislation. However the appointment of key individuals in the early twentieth century resulted in pioneering work in the field of local authority health care. The introduction of tuberculosis notification was ahead of national legislation and the Council introduced innovative policies such as open air schools. The skills, abilities and personality of health professionals was important. Frederick Wynne as Medical Officer of Health showed leadership and an independence of mind as a communicator for public health messages of cleanliness, overcrowding, and the food supply in broadcasts, press interviews and in the range of issues highlighted in the MOH Annual Reports for the 1920s. Wynne also showed public health leadership in his stance against Asbury over smallpox vaccination and was prepared to take the lead in the pursuit of the better health of the population by standing up to vested interests in the milk trade.

The disagreement over smallpox vaccination brought ideological differences over the causes of disease to the fore. The ensuing debate at the start of Labour's term in office illustrated Asbury's views of how municipal socialism would be used to improve the health of the City. Chris Hamlin has stated how in the twentieth century the public health movement lacked 'the utopianism of nineteenth century public health, the notion of public health as a means of transforming society'.¹⁴⁸ The research on Sheffield in the 1920s has shown how this notion of the public health being capable of transforming society was relevant to some places in the 20th century. A reforming Health Committee expanded the remit of public health and signalled how the machinery of municipal government would be used to improve the lives of citizens. The following chapters examine how this vision of the Labour Council elected on a platform of municipal action operated in public health in Sheffield the 1930s, in hospital policy and in housing.

¹⁴⁸ Hamlin, 'State Medicine in Great Britain' in D. Porter, (ed.), *The History of Public Health and the Modern State* (Rodopi, Amsterdam, 1994), 154.

Chapter 3

Public Health Policy in Sheffield in the 1930s

Introduction

In her analysis of the development of community medicine in the twentieth century, Jane Lewis argued that public health officials generally failed to create a sufficient professional philosophy between the wars.¹ Lewis has argued that the 1930s were a time when ‘public health’s sphere of influence grew substantially but with little philosophical underpinning.’² Lewis saw this failure as a major contributing factor in the eventual loss of curative health services by local authorities in 1948, and eventually the replacement of the office of Medical Officer of Health with community physicians in 1974. This chapter analyses the extent to which local factors shaped a distinctive public health policy in Sheffield in the 1930s. It adds local detail to the argument of Charles Webster that contrary to the view of some historians - that Labour came late to policy interest in health care – health was an important aspect of Labour party policy in the 1930s.³

The Labour Party dominated municipal politics in Sheffield from 1926, forming the majority party on the Council in all but one year in the 1930s. As well as the municipal socialism programme of the Labour Council, the administrative practices of the Health Department were important here and the abilities, professional interests and experience of key personnel such as the Town Clerk, the Medical Officer of Health and the Medical Superintendent of the city’s hospitals all played a significant role in shaping

¹ J. Lewis, *What Price Community Medicine?: The Philosophy, Practice and Politics of Public Health since 1919* (Brighton, 1986).

² J. Lewis, *What Price Community Medicine?: The Philosophy, Practice and Politics of Public Health since 1919* (Brighton, 1986), 26.

³ Webster has challenged the view held by a number of historians including Eckstein, Pater and Fox that Labour was peripheral to the development of health services between the wars only finding an interest in health once the debates around the introduction of the NHS took off in the 1940s. See C. Webster, ‘Labour and the Origins of the National Health Service’, in Rupke, N. A. (ed.) *Science, Politics and the Public Good*,

health policy. The interplay between public health officials and elected politicians will be examined. The chapter assesses the provision of key services in the 1930s such as Tuberculosis, Maternity and Child Welfare and Venereal Disease – hospitals will be examined in the following chapter.

Health Indicators

Compared to the national average and to the worst of the distressed areas, some health indicators for Sheffield were relatively good for the 1930s.⁴ In 1935 the Infant Mortality Rate in Sheffield was 52/1000 live births when the average for England and Wales was 57. The IMR at the same time was 92 in Sunderland and 114 in Jarrow. Death rates for Tuberculosis declined in Sheffield in line with national trends, whereas in Merthyr Tydfil TB rates were 60 per cent above the national average, 92 per cent higher than average in Sunderland and 180 per cent higher in South Shields.⁵ Where IMR improved, Maternal Mortality Rates remained stubbornly high in Sheffield into the 1930s. Despite the lower than average TB death rate, Sheffield had long had a policy of high TB notification and referral for treatment, a policy that was criticised by the Ministry of Health.

The Health Department in Sheffield in the 1930s was well staffed, as well as the Medical Officer of Health and the Deputy Medical Officer of Health the Department had a wide complement of subordinate officers. In 1934 there were 26 health visitors known locally as 'Inspectresses', three whole-time male TB inspectors who held Sanitary Inspectors Certificates, (the Senior one was also a Radiographer at the TB Dispensary),

(London, 1988), 184-202.

⁴ Special Area status was granted to North East Boroughs in 1934 where overcrowding, high infant mortality and high unemployment were prevalent. These areas were also blacklisted by the Government in terms of approval being granted for loans for improvement and capital expenditure schemes. See S.V. Ward, 'Implementation Versus Planmaking: The Example of List Q and the Depressed Areas 1922-39', *Planning Perspectives*, (1986), 1, 3-26.

⁵ MOH for Sheffield Annual Report, 1935.

there were five Superintendents and 26 District Sanitary Inspectors, as well as 44 clerical staff- the Sanitary Inspectors.⁶

In general municipal medicine in the period has been overlooked by historians. Through the analysis of local and national documents pertaining to the introduction of the 1929 Local Government Act, this chapter aims to go some way towards overcoming this gap for the case of Sheffield. The 1929 Act ended the operation of Boards of Guardians in Poor Law administration and allowed County Borough Councils to appropriate former poor law hospitals and develop them as fully functioning municipal general hospitals. Capturing the opinion of the Ministry of Health on the operation of health and welfare policy in Sheffield in the 1930s is possible through the analysis of previously underused surveys carried out by the Ministry of Health in the 1930s to assess the extent of action taken by local authorities under powers introduced by the Act. It is important to note that despite central government scrutiny, the scope for local agency in health policy in the 1930s was significant. The powers of the Ministry of Health were limited and its role was largely advisory. Local authorities were more than the passive recipients of central government edicts and analysis reveals that local action, trends and preferences had a significant influence on health policy.

The 1929 Local Government Act

Where the National Health Service Act of 1946 has long been recognised as instigating a radical step change in the history of health reform, The 1929 Local Government Act has only recently begun to receive due attention from historians.⁷ This is

⁶ PRO MH 66/1076.

⁷ The significance of the 1946 NHS Act and the introduction of tax funded, universal, free at the point of use health care is widely covered, see; C. Webster, *The Health Services Since the War: Volume 1, Problems of Health Care: The National Health Service before 1957* (London HMSO, 1988). A. Oakley and S. Williams (eds.) *The Politics of the Welfare State* (UCL Press, London, 1994). A. Hardy, *Health and Medicine in Britain Since 1860* (Palgrave, Basingstoke, 2001). N. Timmins, *The Five Giants: A Biography of the Welfare State* (Fontana, London, 1995). Surprisingly few historians have examined the significance of the 1929 Local Government Act. For a national picture of poor law reform see J.P. Bradbury, 'The 1929 Local Government Act: the formulation and Implementation of Poor Law (health care) Exchequer Grants Reform for England and Wales (outside London)' (unpublished PhD Thesis, University of Bristol, 1991). For the national

surprising as the 1929 Act was a significant development in the history of twentieth century health services. The Local Government Act of 1929 was a wide ranging piece of legislation which not only revised the boundaries of urban and rural district councils, it also allowed County Borough Councils to 'appropriate' Poor Law institutions. The Act also reformed the municipal grant system introducing a block grant and reformed industrial rates. In London the permissive health care elements of the Act were used in an attempt to build up a comprehensive hospital and health care system free from any Poor Law association.⁸ The Act increased County Borough health powers and the duties of local authorities expanded significantly. In 1948, when local authorities were about to lose a number of significant health-related powers that had been offered by the 1929 Act, one commentator noted that the intention of the Act was to be a significant milestone transferring power to local government, but recognised that it was likely to be remembered in retrospect as marking a short lived era of increased local control:

the Local Government Act of 1929 was undoubtedly intended to take its place beside the Acts of 1888 and 1894 as one of the fundamental measures governing the status and functions of local authorities. Yet, ... it now appears to mark the end of an epoch rather than the beginning of a new period of stability, and it seems more like an administrative tidying up which left the main problems of the relations of area to function in local authorities unresolved.⁹

Perhaps because the 1929 Local Government Act was used as a vehicle for 'administrative tidying up', putting onto the statute long called for reform of boundaries and poor relief, that the 1929 Act has been largely overlooked by historians. The case

picture of hospital reform see A. Levene, M. Powell and J. Stewart, 'The Development of Municipal General Hospitals in English County Boroughs in the 1930s', *Medical History*, 50, (2006), 3-28. A. Levene, 'Between Less Eligibility and the NHS: The Changing Place of Poor Law Hospitals in England and Wales, 1929-39', *Twentieth Century British History*, (2009). For central-local government relations see B. Taylor, J. Stewart and M. Powell, 'Central and Local Government and the Provision of Municipal Medicine, 1919-1939', *English Historical Review*, 122, 496, 397-426, (2007).

⁸ J. Stewart 'For a Healthy London: The Socialist Medical Association and the London County Council in the 1930s.' *Medical History*, 42, (1997), 417-46.

⁹ M. Schulz, 'The Local Government Act of 1929 and Subsequent Legislation' in C.H. Wilson, (ed.), *Essays on Local Government* (Oxford, 1948), 67-112.

has been made for a re-examination of the Act and its outcomes. Levene, Powell and Stewart have noted that the 1929 Act 'was significant in terms of the development of health services generally, because it aimed to remove pauperism as a criterion for access to treatment.'¹⁰ The propensity of County Boroughs to take up the opportunities presented to local authorities via permissive legislation is viewed by this recent work as relative to the size of the County Borough, the preferences and attitudes of the Council, the relationship with the voluntary hospital sector and the influence of energetic Council members, medical officials and Medical Officers of Health.¹¹ The powers contained in the Act offered new opportunities for local authorities willing to use the new legislation. As an exercise in administrative tidying up, the Act was long overdue. Social reformers and health professionals from the turn of the twentieth century, (including Sheffield MOH Harold Scurfield in evidence to the Royal Commission on the Poor Laws in 1909), had called for root and branch modernisation in health and social policy administration with increased local authority powers.¹² Inter-war economic conditions provided the Government with the impetus to introduce the 1929 Local Government Act. The desire to address Britain's post-First World War problems included a response to ease the rate burden on industry. The 1929 Act was a modernising measure designed to tidy up the disparate elements of local government (including health care) into a more co-ordinated public service. The administrative status quo was criticised in 1927:

the hotchpotch system of public health administration now in vogue cannot go on. It is permeated with undesirable administrative complexity, and exists entangled in a veritable jungle of authorities, acts, bye-laws, regulations, orders, circulars, memoranda and reports. The complete re-organisation and revision of the public health service is a matter which will have to be definitely considered in the near future.¹³

¹⁰ A. Levene, M. Powell and J. Stewart, 'The Development of Municipal General Hospitals in English County Boroughs in the 1930s', *Medical History*, 50, (2006), 3-28.

¹¹ A. Levene, M. Powell and J. Stewart, 'The Development of Municipal General Hospitals in English County Boroughs in the 1930s', *Medical History*, 50, (2006), 6.

¹² *Royal Commission on the Poor Laws and the Relief of Distress*, Appendix Vol.4, (London, 1909), qu 41884-42046.

¹³ W.G. Kershaw, 'Presidential Address on Public Health Administration and Local Government', *Journal of*

The Act presented opportunities for policy reform that were well suited to the ethos of the Council in Sheffield in the 1930s. The intention of the Labour Party was to provide local authority health care as a valued municipal service, without the taint of the Poor Law. The Act was described by the Labour Council as ‘completely in accordance with our policy of limiting to the smallest possible extent the operation of the poor law in the city.’¹⁴ This wide-ranging legislation was steered through Parliament by the Minister of Health Neville Chamberlain.¹⁵ The Act extended the powers of county councils and introduced de-rating for industry. Local government was compensated by the introduction of block grant finance based on a formula of five indicators of need. The indicators included the total population, the rateable value of the area, the number of unemployed people and the number of children under five. It was the intention of the Act that local authorities would further develop their health services through non-poor law legislation such as the Maternity and Child Welfare Act of 1918 and the Public Health (Tuberculosis) Act of 1921 so that local authority health care would be the responsibility of public health committees (PHC) and the health departments not the PAC.¹⁶ The 1929 Local Government Act encouraged local authorities to ‘appropriate’ former workhouse hospitals and place them under the administration of the Council Health Committee rather than retain them as part of the relief of the poor under the PAC. The Act therefore allowed local authorities to develop former workhouse hospitals as municipal general hospitals for use by the whole population and not just the sick poor. The Act also explicitly encouraged greater partnership working and liaison

the Royal Sanitary Institute, XLVIII, 1927, 440-447, 440.

¹⁴ Sheffield Labour Party, *Six Years of Labour Rule* (Sheffield, 1932), 18.

¹⁵ The full title of the 1929 Local Government Act illustrates its broad scope : ‘An Act to amend the law relating to the administration of poor relief, registration of births and deaths, and marriages, highways, town planning and local government; to extend the application of the Rating and Valuation (Apportionment) Act, 1928 to hereditaments in which no persons are employed; to grant complete or partial relief from rates in the case of the hereditaments to which that Act applies; to discontinue certain grants from the Exchequer and provide other grants in lieu thereof; and for purposes consequential on the matters aforesaid.’ LGA 1929 19 & 20 Geo c. 17.

¹⁶ Along with the 1916 Public Health (Venereal Disease) Regulations, local authority personal health services were therefore focussed on a mix of statutory requirements and permissive legislation in the field of tuberculosis, maternity and child welfare and venereal disease.

between the two hospital sectors extant before the NHS, the charitable voluntary hospitals and the municipal hospitals, via Section 13 of the Act.

The Act was a potentially progressive development for local government administration in that it gave authorities freedom to run services, central government actively encouraged County Boroughs to take up the powers of hospital administration and engage in closer relations with the voluntary sector. The legislation had a redistributive intent in that it allowed central government to direct support to poorer areas at the expense of more affluent areas, without increasing overall government expenditure.¹⁷ The 1929 Act included punitive provisions which allowed the Minister of Health to reduce the amount of grant awarded to local authorities, depending on circumstances and as he saw fit. Under Section 104 of the Act if a local authority failed 'to achieve or maintain a reasonable standard of efficiency and progress in the discharge of their functions relating to public health services' the amount of block grant could be reduced.¹⁸

To assess the effectiveness of the Act the government launched a huge exercise of observation and information gathering by conducting public health surveys of County Boroughs in the early 1930s. The surveys were detailed appraisals designed to equip the Minister of Health with adequate data beyond that submitted in the annual reports of each borough's Medical Officer of Health. The potential of this Ministerial power was described by Wilson in 1946; 'a reduction in grant ... would arouse great resentment, and in the case of a large Local Authority, a considerable political storm.'¹⁹ Despite the potential punitive nature of the findings of the surveys no such powers of grant reduction were invoked. The Ministry of Health in the 1930s was in a weakened position. The Ministry was created as a forward looking development with the intention of reforming the health of the nation after the First World War. Able staff

¹⁷ M. Daunt, 'Payment and Participation: Welfare and State-Formation in Britain, 1900-1951', *Past and Present*, 150, (1996), 169-216, 199.

¹⁸ Local Government Act 1929, Section 104, quoted in W. Robson, *Local Government in Crisis*, (London, 1968), 51.

¹⁹ N. Wilson, *Municipal Health Services*, (London, 1946), 151.

were initially appointed such as the first Minister of Health Christopher Addison who commissioned radical plans for the reform of health administration such as Lord Dawson of Penn's Interim Report of 1920.²⁰ This optimism was short lived and the Ministry suffered under public expenditure cuts following the Geddes Axe that saw its personnel cut by a third to the point where it was staffed by junior civil servants who lacked authority.²¹ The Ministry in the 1930s could cajole local authorities to modernise services, but it was not in a position to enforce a centralised command and control regime. The Ministry's role was one of adviser and provider of expert opinion with the main real threat being not grant reduction, but further central government scrutiny through a re-survey.²² As William Asbury stated in 1938 'public representatives and public officials concerned need not worry. No Minister of Health would take such a drastic step'.²³ Determined local authorities therefore, had considerable scope to pursue their own agendas.

The data collected by the Ministry of Health surveys proves a useful and underused source to aid our understanding health care in the 1930s. The confidential, wide ranging and comprehensive reports made by the Ministry of Health provide a useful expression of Whitehall's opinion of local authority health care policy in the 79 English County Boroughs of the 1930s. The final survey report was intended for internal use by the Ministry of Health and was not seen by the local authority concerned. After the survey had been undertaken a 'survey letter' was sent from the Minister of Health to the relevant local authority pointing out areas of public health care which the

²⁰ Consultative Council on Allied and Medical Services, *Interim Report on the Future Provision of Medical and Allied Services*, Cmnd 693, London, (1920).

²¹ Charles Webster has noted how the Ministry of Health from the mid-1920s into the 1930s was 'a career back-water staffed by second rate minds suitable only to act as instruments of regulation'. Webster, C. 'Conflict and Consensus: Explaining the British Health Service', *Twentieth Century British History*, 1, 2, (1990), 115-51, 142.

²² Spending cuts in the early 1920s cut the number of Ministry of Health civil servants from 6,500 to 4000 leaving junior staff to administer the Department. B. Taylor, J. Stewart and M. Powell, 'Central and Local Government and the Provision of Municipal Medicine, 1919-1939', *English Historical Review*, 122, 496, 397-426, 403.

²³ W. Asbury, 'The Future of the Public Health Services', *Journal of the Royal Sanitary Institute*, 59, (1938), 733.

Minister expected the local authority to address through improvement schemes.²⁴ During the Second World War the Ministry of Health and Nuffield Provincial Hospital Trust conducted hospital surveys that were intended for publication. As the Ministry Surveys from the 1930s were compiled as confidential, internal Ministry of Health documents, the comments and assessments made by the surveyors relating to local authority health services, as well as their candid assessments of the politicians and officers responsible for the administration of health care in the localities, are not couched in the diplomatic language of official correspondence and provide a very revealing picture.

As such, the Surveys contained in the MH 66 series of files held at the National Archives, provide a unique insight into the internal workings of local authority health departments in the 1930s. The majority of locally generated sources such as Council committee minutes, contemporary newspapers, MOH Reports and party political material, both Labour Party material and anti-Labour publications were produced with the intention of disseminating information through the public sphere. They tend to portray the Health Department and public health work in Sheffield in a generally and favourable light. These sources tend to depict a relentless story of progress and improvement in health indicators and in the administration and provision of health services.

The primary purpose of the 1929 Act was to abolish the system of Poor Law Guardians and transfer the responsibility for the relief of the poor to the county and county borough councils who were then compelled to create Public Assistance Committees (PACs) by the appointed day in April 1930. As Poor Law Guardians were directly elected by the wider franchise in the 1920s and therefore accessible to the public, some contemporary voices saw the abolition of the Boards of Guardians as a reduction of local democracy.²⁵ Labour Poor Law Guardians in the London boroughs of

²⁴ See Survey Letter for Sheffield PRO MH 66/1076, Ministry of Health Survey Public Health Services of Sheffield County Borough, Survey Letter, (1935).

²⁵ W.A. Robson, 'The Central Domination of Local Government', *Political Quarterly*, 4, (1933), 95-96.

Poplar and West Ham had used the local autonomy in poor relief to set levels of benefit above those deemed acceptable by central government. The central state was therefore keen to transfer the responsibility of poor relief away from the more volatile Guardians elected on a wider franchise from 1918, into what was considered as the safer hands of County and County Borough councils.²⁶

As key elements of the Act were permissive the effectiveness of the provisions contained in the legislation were nationally uneven.²⁷ In many areas of Britain little changed and the Act meant little more than an administrative modification, with Poor Law infirmaries transferred from being the responsibility of one branch of public assistance, the now defunct Guardians, to being the responsibility of the new local authority Public Assistance Committees (PAC). How the 1929 Local Government Act impacted on hospital services in Sheffield is dealt with in the next chapter. The remainder of this chapter examines local authority health services in Sheffield in the 1930s other than hospitals. It uses the Ministry of Health Survey for Sheffield to examine the Ministry view of key personnel in public health in Sheffield as well as three main branches of the health department concerned with tuberculosis, maternity and child welfare and venereal disease services.

The Ministry of Health Public Health Survey for Sheffield, 1934.

The Ministry of Health Public Health Survey of Sheffield, was undertaken by C.J. Donelan from May to July 1934. Despite some strong criticism of the arrangement of health services in Sheffield, the health services of the city were not seen as being in need of re-survey or further close scrutiny by the Ministry.²⁸ The Ministry of Health survey letter for Sheffield pointed to the 'excellence of the hospital services in the city and the cordial co-operation between the Corporation and the voluntary hospitals.'²⁹

²⁶ D. Vincent, *Poor Citizens: The State and the Poor in Twentieth Century Britain* (London, 1991), 61.

²⁷ M. Powell, 'An Expanding Service: Municipal Acute Medicine in the 1930s', *Twentieth Century British History*, 8, (3), (1997), 334-357.

²⁸ PRO MH 55/16 Letters on Survey Reports and Subsequent Action and Correspondence. (1933-1934).

²⁹ PRO MH 66/1076, Ministry of Health Survey Public Health Services of Sheffield County Borough, Survey

The Minister of Health expressed his appreciation over the promptness with which the Council had re-organised its health services under the principles of the Local Government Act of 1929. Indicating appreciation that the Council had moved quickly to appropriate the former Poor Law hospitals at the earliest opportunity. However, the letter went on to state that 'it is disappointing to find that the former grant-aided services are not so satisfactory. The tuberculosis service is admittedly run on somewhat unorthodox lines, but Sheffield can claim that the results as shown by the death rate are good.'³⁰ Ministry criticism was also levelled at the city's venereal disease service which was characterised as 'defective'. A pencil comment on the margin of an early draft of the post-survey letter to Sheffield, made by an anonymous Ministry of Health official (initialled 'W.A.R.') noted that 'I confess to some surprise and disappointment that defects are relatively so numerous. From various visits I had expected to find a better result here.'³¹

The survey itself questioned the zeal of Sheffield GPs and the MOH to place patients on the register as suffering from tuberculosis, doubting whether all notifications of tuberculosis were accurate, especially for children. The long standing compulsory tuberculosis notification scheme, introduced in Sheffield in 1903, had established the practice of early diagnosis. Donelan on behalf of the Ministry questioned the adequacy of the organisational structure of the Health Department in Sheffield and recommended the appointment of more staff such as an Assistant Maternity and Child Welfare Officer and a Chief Sanitary Inspector. The Ministry also believed that greater co-ordination of health services could be achieved if the post of Medical Officer of Health and Schools Medical Officer were combined in one. In Sheffield the two posts had remained separate since the appointment of the first SMO, Ralph Williams, in 1908.

Letter, (1935).

³⁰ PRO MH 66/1076, Survey Letter.

³¹ PRO MH 66/1076, Draft Survey Letter.

The Official View of Public Health in Sheffield in the 1930s

A striking feature of the Ministry of Health local authority public health surveys of the 1930s, is the weight given to the competence of the Medical Officer of Health. The political make up of the Council or Council's financial acumen was rarely mentioned. As the chief officer responsible for the administration of local authority health care, the background of the MOH, his management competence, habits, personality, practices and medical philosophy were scrutinised and highlighted by the surveyors. In areas where local authority health services were found to be severely lacking, such as in Cornwall, the MOH was squarely given the blame.³² By the same token, in areas where local authority health services were unusually well developed, such as in Bradford where the MOH had introduced a scheme for a municipal general hospital as early as 1920, the Ministry saw the Medical Officer of Health, John Buchan as the crucial dynamic force.³³ Throughout the Sheffield survey report, the Ministry of Health surveyor C.J. Donelan found the organisation of the Health Department in Sheffield to be somewhat peculiar from other County Boroughs, but he had to admit that in most ways it was efficient. All of the 'peculiar' aspects of health care arrangements and any of the defects in Sheffield's public health service were seen as being entirely the responsibility of, John Rennie, the MOH for Sheffield. All the positive aspects were cited as being the responsibility of Rennie's supposed Deputy MOH, James Clark.

Rennie had been the city's Tuberculosis Officer from 1912 until he was promoted after the death of Frederick Wynne in 1930.³⁴ Donelan was not impressed

³² See PRO MH 66/30 Ministry of Health Public Health Survey for the Administrative County Council of Cornwall.

³³ For Bradford and John Buchan see PRO MH 66/477 Ministry of Health Public Health Survey for the County Borough of Bradford, 1932. Also T. Willis, 'The Bradford Municipal Hospital Experiment of 1920: The Emergence of the Mixed Economy in Hospital Provision in Inter-War Britain', in M. Gorsky and S. Sheard, *Financing Medicine: The British Experience Since 1750* (Routledge, 2006), 130-144.

³⁴ John Rennie was born in Aberdeen in 1883. He studied medicine at the University of Aberdeen where he was taught by James Clark. Rennie was a GP who became Assistant Medical Officer at Durham County Sanatorium, Stanhope. He was appointed Tuberculosis Officer for Sheffield in 1912. He became MOH in 1930 and retired in 1947. MOH Annual Reports for Sheffield, 1912-1948.

with the Sheffield MOH and felt that John Rennie, held 'unusual views in regard of Tuberculosis'.³⁵ For the Ministry inspector, the driving force behind all the positive aspects of the work of the Health Department was Dr James Clark, Poor Law Medical Superintendent of Fir Vale Infirmary from 1912 who had become the Deputy MOH and Medical Superintendent of the city's general hospitals in 1930.³⁶ The surveyor's report to the Minister noted that Clark had been John Rennie's tutor in anatomy at the University of Aberdeen and inferred that the tutor-pupil relationship had been maintained into their working lives in Sheffield.³⁷ The abilities of James Clark clearly impressed the Ministry surveyor, who described Clark as:

a man of very considerable clinical and administrative ability, who is keen on his work, and of a kindly disposition, yet he is intolerant of inefficient subordinates and is evidently possessed of boundless energy. He is an officer whom Sheffield is undoubtedly fortunate to possess and it appears to me largely due to his activities that the most commendable features of the Sheffield health work are due. Not only does he act as medical Superintendent of large institutions he is also an operating surgeon at Fir Vale [City General] hospital where he performs the majority of some 1700 operations a year and he sees personally every patient in that hospital on admission and discharge and frequently during the course of treatment. He is at work from very early in the morning until after midnight and it is his practice to conduct a tour of the hospital every night.³⁸

James Clark was given added responsibility (without an increased salary) in 1934 when he was made Medical Superintendent of the city's infectious disease

³⁵ PRO MH 66/1076.

³⁶ James Clark was born in 1880 in Ayrshire. He was awarded the MB ChB from the University of Aberdeen in 1905. Clark worked in the Anatomy Department at Aberdeen and then St Pancras North Hospital, he took an MD at Aberdeen and then an MRCP in 1908. In 1909 he took a DPH at University College London. After working in several fever hospitals in London Clark was appointed Deputy Medical Superintendent at Park Hospital for Children Hither Green and in 1911 he took a Primary Fellowship of the Royal College of Surgeons. In 1912 he was appointed as Medical Superintendent of Fir Vale Hospital. Clark was appointed Deputy MOH for Sheffield in 1930 when he became responsible for the municipal hospitals. He was a lecturer in public health at Sheffield University. Clark retired in 1950 at the age of 70 and served on two NHS Hospital Management Committees in Sheffield until the age of 85. In retirement he was also Vice-President of the Sheffield Hospitals Council. *Caledonian Society of Sheffield Newsletter*, 63, (May 1969).

³⁷ PRO MH 66/1076.

³⁸ PRO MH 66/1076, p26.

hospitals.³⁹ Donelan noted how Clark's seniority, authority and reputation enabled him to hold considerable influence over the City Council as he had previously done over the late Board of Guardians. Clark had been influential in the Council's choice of John Rennie as the successor to Frederick Wynne as MOH. As the post was not advertised and the salary offered was below the BMA scale, the surveyor noted that 'acrimonious correspondence' had been entered into with the BMA and the Society of Medical Officers.⁴⁰ Following Rennie's appointment as Medical Officer of Health, he had advised the Council that Clark should be appointed as Deputy MOH, again this was done without advertisement and led to acrimonious correspondence from the BMA particularly over the fact that the Deputy MOH position did not carry a salary.⁴¹ The Ministry was wary of local patronage and the use of connections in appointments. The position of Tuberculosis Officer to replace Rennie was offered to H. Midgely Turner, a former Junior Medical Officer of Sheffield Council and Tuberculosis Officer for Worcestershire. Again the post was not advertised and resulted in correspondence with the BMA. He was seen by the Ministry of Health inspector as being indoctrinated by Rennie and at 33 too young to be acting as not only Chief Clinical Tuberculosis Officer, but Medical Superintendent of the City's Tuberculosis Institutions and Lecturer in Tuberculosis at the University of Sheffield. Donelan stated that 'I think it is unfortunate that Sheffield should not have gone further afield for a tuberculosis clinician and imported some new ideas into their service. Where Clark was depicted as dedicated, hard working, efficient and up to speed with modern medical thinking, Donelan's portrayal of Rennie was much less favourable. John Rennie, recorded Donelan, was:

very conscientious, very honest and very plain spoken. Dr Rennie has considerable tenacity of purpose amounting at times to obstinacy. He has the sound Celtic perseverance of a northern Scotsman and has in twenty years in Sheffield added the immobility commonly attributed to the

³⁹ The practice of assigning responsibilities to Dr Clark rather than appoint another fully qualified member of staff was noted by the surveyor as one which 'appears to strike the dominant note in the health organisation of Sheffield'. PRO MH/1076 p34.

⁴⁰ PRO MH 66/1076 p27. Records of the Sheffield Division of the BMA show that the practice of advertising medical posts with Sheffield City Council which were below the BMA scale was a constant concern of the local medical profession throughout the 1920s. British Medical Association Sheffield Division Minutes, 1924-1930. SCA LD 2384 (5).

Yorkshireman. He is somewhat slow of cerebration and believes in the doctrine of personal supervision of all activities and is obviously reluctant to delegate authority or administrative control. He is essentially bred in the old style of public health and appears to have found it difficult to adapt his conceptions to modern developments and while he undoubtedly does his best on a system which he believes to be right, it appears to me that in certain directions he has failed to grasp the fundamental principles of the newer health services for example maternity and child welfare.⁴²

⁴¹ PRO MH 66/1079, p. 31.

⁴² PRO MH 66/1076, p. 28.

Donelan was so determined to stress the different qualities of the respective contributions made by Rennie and Clark to the efficiency of health services in Sheffield that the inspector drew a chart in his report outlining the responsibilities held by each respective officer. By commenting on his perception of the quality of the services provided under the Rennie and Clark, the Ministry of Health surveyor drove the point home that the MOH Rennie, was responsible for all the negative aspects of public health in Sheffield, and that Clark, the surgeon who acted as the unpaid Deputy MOH from 1930 who had been prominent in hospital history in Sheffield from 1912 and remained so into the 1960s, was responsible for all that was good in public health in Sheffield in the 1930s. The table is reproduced below:

Table 3.1 Public Health Services in Sheffield

Service	Dr Clark	Dr Rennie	Character of Service
General Hospitals	Dr Clark controls almost entirely.		In general the service is very good.
Maternity	Service largely Under Dr Clark's Influence.	Dr Rennie supervises midwives, maternity homes and VD.	Good in the main. Supervision of Midwives and maternity homes – indifferent. VD poor.
Infant Welfare	Dr Clark has no connection to this service.	Dr Rennie controls through the Superintendent Health Visitor	Service is indifferent in character.
Tuberculosis	Dr Clark has no relation to this service.	Dr Rennie is the dominant influence here.	The service presents a number of unsatisfactory features.
Venereal Disease	Dr Clark only responsible for cases at City General Hospital.	The work is performed by Voluntary Hospitals. Nominally under the supervision of Dr Rennie	Service provided by Voluntary hospitals is of a very poor quality. Co-ordination with other services is imperfect. Only cases at CGH dealt with satisfactorily.

Source PRO MH 66/1079 Ministry of Health Survey of Public Health Services in the County Borough of Sheffield, 1934.

Donelan pointed out that all of the services which were directly under Rennie's control could be characterised as 'poor' or 'indifferent', except for general sanitation work. Even here there was room for criticism. Donelan felt that too much of Rennie's time was spent acting as Chief Sanitary Inspector for the city, personally making house to house inspections over matters such as bed bug infestations and 'writing personally signed letters to various persons in the city' instructing people to remove defective ceiling plaster, rather than empowering his subordinates to dispatch printed notices.⁴³ The Ministry surveyor felt that a separate fully qualified full time Chief Sanitary Inspector should be employed as well as fully qualified subordinates, rather than rely on the services of an elderly former plumber, stone mason and the council clerks who the City engaged as the five Supervisory Sanitary Inspectors in Sheffield. He reported that Rennie was 'a very excellent exponent of the old style of public health and environmental hygiene but in regard to the newer public health and to personal hygiene he is helpless without the guiding influence of Clark'.⁴⁴ The surveyor believed that Rennie's ideas on public health had 'crystallised some 20 years ago' and:

in view of the fact that Clark was responsible for the appointment of Rennie as Medical Officer of Health I am driven to the conclusion that the real MOH in Sheffield is not Dr Rennie but Dr Clark. Sheffield is very fortunate that they possess such an officer as Dr Clark. He is a man who will not easily be replaced, he holds a key position regarding the health services and it is clear that when he retires the system which he has built up will disintegrate, for it is improbable that the City Council will find another man of so outstanding abilities who will be able to assume so many and so diverse responsibilities. The City Council is fortunate, from the economic point of view in only paying the salary of one Medical Superintendent for an officer who performs the duties of these numerous posts.⁴⁵

For the Ministry of Health surveyor then, the 'peculiar' nature of arrangements in the Sheffield City Council Health Department were due to a situation of skewed

⁴³ PRO MH 66/1076 p48.

⁴⁴ PRO MH 66/1076 p38.

⁴⁵ PRO MH 66/1076 p39.

professional power dynamics. The situation was one where authority, innovation and efficiency resided in the skills of James Clark, the Deputy MOH, who was effectively acting as the senior officer to the actual post holder of the office of MOH for the city, John Rennie. A decade earlier Frederick Wynne had characterised the job of MOH as being no longer about 'going around sniffing drains'⁴⁶ however the Ministry of Health surveyor feared that Rennie's preference to focus on environmental improvement was outdated compared to Clark's able and enthusiastic management of a fully functioning local authority health and hospital service. The irreplaceable nature of Clark, was recognised by the Health Committee and the Regional Health Board in 1948. Clark was due to retire in 1945, however he was persuaded to stay on as Medical Superintendent of the City General Hospital and oversee the transition to the NHS. He eventually retired in 1950 at the age of 70. In retirement he served on two of the Sheffield NHS Hospital Management Committees until the age of 85.⁴⁷ The local authority health care system built up by Clark, was never tested to disintegration in his absence, but was ultimately reconfigured by the nationalisation of the health service under the NHS Act of 1946.

The third member of the local authority health care triumvirate to be scrutinised by the Ministry of Health inspector was the Chairman of the Health Committee, William Asbury. Donelan went out of his way to record the contribution made by Asbury:

it would not be doing justice to the health organisation in Sheffield to omit some reference to the Chairman of the Health Committee Mr Asbury, who is also Chairman of the Public Assistance Committee. He has apparently risen from comparatively humble origin and he has an exceptional personality, he takes a keen interest all the health activities and he has a very keen desire to see that the Local Government Act of 1929 is brought into operation to the fullest possible extent. He has an exceedingly wide grasp of public health procedure and of public health sanitary law, he is able to rapidly sum up the essential features of a situation and evidently possess a very marked sway with members of the council. Such progress as has been made

⁴⁶ *Sheffield Independent*, 11 February 1927.

⁴⁷ I. Burnett, 'Interview with James Clark', *The Caledonian Society of Sheffield Newsletter*, No.63, (Sheffield,

in Sheffield in health matters in recent years has evidently been in no small measure due to his efforts.⁴⁸

Donelan's report gives an insight into the nature of power relations and the decision making process in local politics in Sheffield in the 1930s. Donelan observed that the real source of power in Sheffield lay outside the Council Chamber. Others have noted the high degree of party discipline in the Council Chamber among the pre-war Labour group. Helen Mathers has stated that the Leader of the Council, Ernest Rowlinson 'ensured that the Labour group never entered the council chamber divided on policy'.⁴⁹ Understanding the precise mechanics of this tight party discipline is difficult when using official records. Sources such as Council committee minutes, newspapers and Sheffield Labour Party archives reveal little of how the practicalities of local authority decision making were carried out. Donelan's observations for the Ministry of Health provide an insight into the unofficial, and therefore unrecorded political practices in the city. Donelan noted how Sheffield Borough Council was run:

by a sort of cabal. There is a body known as the "special section" which is an unofficial committee of the Council consisting of five chairmen of the principal committees comprising of the leaders of all the important political parties on the Council. Apparently, when some project is under discussion it is customary for the special section to meet, and around the luncheon table they discuss the pros and cons of the proposition and a decision whether or not to proceed is reached. After this decision it is for the individual members of this body to carry the point to their political parties outside the council. Hence when any proposition comes forward in the Council it comes as an agreed measure and has a smooth passage. This appears to have been the machinery employed in connection with the appointments of Dr Rennie as Medical Officer of Health, with the recent appointments of Dr Clark and Dr Midgely-Turner and with the appropriation of Fir Vale Hospital as the City General Hospital.⁵⁰

May, 1969).

⁴⁸ PRO MH 66/1076 p40.

⁴⁹ H. Mathers, 'Ernest Rowlinson' in J. Bellamy and J. Saville, (eds.) *Dictionary of Labour Biography*, vol. 6 (London, 1982), 236.

⁵⁰ PRO MH 66/1076 p41.

This comment by Donelan offers an insight into the practice of policy-making processes in local government in Sheffield in the 1930s. The *Sheffield Year Books* for the period reveal how entrenched the Labour Party had become. Labour lost control of the Council for only one year in the period under consideration, 1932, when the anti-Labour alliance - renamed the Municipal Progressive Party took control of the Council. In the municipal election of November 1933, the Labour Party had a majority of 14 Councillors and Aldermen, with a total of 49 to the Progressives 35 in a chamber of 96.⁵¹ All the important Council Committees were dominated by Labour Members. For example the Health Committee in 1934 consisted of 12 Labour members, seven Municipal Progressives and two Conservative members.⁵² At the time of the Ministry survey, in the Spring of 1934, principal areas of activity; Education, Health, Estates, Public Assistance, Finance, and the Parliamentary and General Purposes Committee were all under the stewardship of Labour Party chairmen – William Asbury chaired two Committees (Health and Public Assistance) and the Leader of the Council, Ernest Rowlinson also chaired two committees (Education and General Purposes) – therefore the secret ‘special section’ luncheons cited by Donelan, where allegedly the key decisions on the governance of Sheffield were taken, could easily have consisted of three Labour Councillors.⁵³

The previous sections have examined the views of the Ministry of Health on the health services of Sheffield in the 1930s and noted the favourable opinion of the Ministry to the contributions made by James Clark and William Asbury. The following sections examine the three principal areas of activity of local authority health care which were the responsibility of the Medical Officer of Health, Dr Rennie: the tuberculosis service, the maternity and child welfare services and the venereal disease service.

⁵¹ *Sheffield Year Book 1934*, (Sheffield, 1933).

⁵² *Sheffield Year Book 1934*, (Sheffield, 1933).

⁵³ In the mid-1930s Ernest Rowlinson was Chairman of two Committees: Education as well as the Parliamentary and General Purposes Committee, Asbury was also Chairman of two Committees Health and the Public Assistance Committee and T.H. Watkins was Chairman of the Finance Committee. *Sheffield Year Book 1934* (Sheffield, 1933).

Tuberculosis

We now know that tuberculosis is an infectious disease caused by the presence of a form of bacteria. Pulmonary tuberculosis (also previously known as consumption or phthisis) arises when the bacteria is breathed into the lungs and disease spreads to lymph nodes.⁵⁴ As seen in the last chapter, cow's milk can be a carrier of TB affecting the bones and joints particularly in children and this recognition was important in the move towards the pasteurisation of milk nationally introduced in 1949 and compulsory in Sheffield from 1962. Until well into the twentieth century, tuberculosis was a notoriously difficult disease to diagnose, treat and cure. A number of factors saw the disease come to prominence in the early twentieth century, despite the fact that tuberculosis death rates had been in decline since the middle of the nineteenth century. After the First World War the treatment and prevention of the disease became a requirement of local authority health care under the 1921 Public Health (Tuberculosis Act). In line with all infectious diseases tuberculosis was declining in both incidence and mortality rates, however as cholera and smallpox became much less of a concern, tuberculosis increasingly appeared to be a relatively high cause of death. Robert Koch had isolated the tubercle bacillus in 1882 and tuberculosis was declared compulsorily notifiable as an infectious disease nationally in 1912. It was some time before the disease was recognised as infectious and not, as was originally feared, hereditary, however, its incidence was greater in (but not exclusive to) lower socio-economic groups, generally thought to be due to the effects of overcrowding and poor diet. TB was therefore a disease that carried with it elements of social stigma and suspicion. In this way tuberculosis was part of a poverty complex and it is therefore difficult to say with any accuracy which particular policies or actions were responsible for the retreat of the disease up until the late 1940s.

What we can say with certainty is that tuberculosis was a disease that aroused a

⁵⁴ F.B. Smith, *The Retreat of Tuberculosis: 1850-1950* (London, 1988), 236-47. L. Bryder, *Below the Magic Mountain* (Oxford, 1988), 227-65.

great deal of fear and was seen as a danger to all society especially through particular kinds of social contact, with certain classes in certain environments. Michael Worboys has noted how policy was shaped by the notion of the urban poor being a susceptible 'soil' in which the 'seed' of tuberculosis could propagate. The National Association for the Prevention of Tuberculosis was established with royal patronage in 1898 and it was this organisation that heavily promoted the notion of sanatoria promoting fresh air, rest and later on in the twentieth century the use of drugs including vaccine therapy and tuberculin.⁵⁵

Other medical historians such as F.B. Smith and Linda Bryder have argued that tuberculosis policy in the inter-war period can be characterised by an emphasis on the use of tuberculosis sanatoria and little else.⁵⁶ The widespread use of TB institutions and some medical intervention had limited success in addressing the disease before the introduction of the effective antibiotic streptomycin in the late 1940s and the use of BCG vaccine in the 1950s.⁵⁷ The rates of tuberculosis notification and of tuberculosis mortality had shown a steady decline from the middle of the nineteenth century to the mid-1940s. As Smith states 'we do not know why this was so' and the reasons for this decline are still debated by historians.⁵⁸ The decline of TB debate relates to Thomas McKeown's general mortality decline thesis for the nineteenth century, in that McKeown argues improved standard of living - through better diet - was the key driver of reduced mortality and that doctors' medical curative and preventative efforts were of little consequence.⁵⁹ Building on this view F.B. Smith has argued that finance and medical expertise was wasted by the provision of expensive TB sanatoria, when (in retrospect) efforts should have been applied to seeking a medical cure for TB and prevention through improved living conditions. Smith declares that that 'public money

⁵⁵ M. Worboys, 'The Sanatorium Treatment for Consumption in Britain, 1880-1914' in J.V. Pickstone, (ed.), *Medical Innovations in Historical Perspective* (London, 1992), 48-73, 55.

⁵⁶ F.B. Smith, *The Retreat of Tuberculosis: 1850-1950*, (London, 1988). L. Bryder, *Below the Magic Mountain*, (Oxford, 1988).

⁵⁷ J. Welshman. *Municipal Medicine: Public Health in Twentieth Century Britain*, (Peter Lang, Oxford, 2000). 124.

⁵⁸ F.B. Smith, *The Retreat of Tuberculosis: 1850-1950*, (London, 1988), 1.

could and should have been diverted to trying preventive measures and to helping severe impoverished cases and their families.⁶⁰ Simon Szreter agrees with McKeown that direct medical intervention played little or no part in the decline of pulmonary tuberculosis death rates before 1948, however Szreter has argued for the recognition that social policy and state intervention did have an effect on mortality rates in the form of better sanitation and the reduction in overcrowding through better housing.⁶¹

Local authorities in the inter war years faced the challenge of dealing with a disease that was chronic, little understood, was difficult to diagnose and to treat and that carried with it a social stigma. The Ministry of Health promoted the use of the TB sanatorium system, yet the limited effectiveness of these institutions, offering only a temporary respite from ill-health was recognised at the time by some including in Sheffield Councillor William Asbury. In Asbury's view the public health work of local authorities would only ever be effective if people that had been temporarily treated in the hospitals and TB sanatoria were able to return to decent homes after leaving medical care.⁶² This approach resulted in a wide ranging TB policy in Sheffield in the 1930s that featured early diagnosis, sanatoria, some limited medical treatment, after care and a TB re-housing scheme. The latter was made possible by the Council's municipal housing programme.

The Tuberculosis Service in Sheffield in the 1930s

In Sheffield in the 1930s the Tuberculosis Section of the Health Department consisted of a Tuberculosis Officer, plus five Medical Officers who worked on a part time basis at the dispensary and at the residential institutions, there were also 27 part time Health Visitors equivalent to five full time health visitors. Donelan, the Ministry of Health inspector noted in 1934 that a considerable amount of time was spent by

⁵⁹ T. McKeown, *The Modern Rise of Population* (London, 1976).

⁶⁰ F.B. Smith, *The Retreat of Tuberculosis: 1850-1950* (London, 1988), 245.

⁶¹ S. Szreter, 'The Importance of Social Intervention in Britain's Mortality Decline c. 1850-1914: A Reinterpretation of the Role of Public Health', *Social History of Medicine*, 1, (1988), 1-37.

⁶² Sheffield MOH, Annual Report, 1928.

Health Visitors to initially assess and investigate patients and in subsequent follow up visits. Intervention had been a long term feature of the preventive tuberculosis service in Sheffield. By 1904 there were two Tuberculosis Inspectors in the city authorised to hand out written advice on reducing the risk of spreading the disease and to see that the houses of patients were disinfected with Formalin and spittoons were issued by the Corporation.⁶³ After care was seen through follow-up visits made by Health Visitors. This broad policy of early diagnosis, intervention, after care and prevention was a TB policy that continued to characterise the period under examination.

As tuberculosis was seen as a disease of the urban poor it seems unusual for Sheffield, the fourth largest city in the country to frequently have had the lowest tuberculosis mortality rate amongst all county boroughs with a population over 200,000 for the period of the 1920s and 1930s. The unemployment rate for Sheffield was never as high as the distressed areas of the North East and Wales however it was never less than 20,000 for the whole of the 1920s and Sheffield had the highest number of insured unemployed among the major cities in 1932 at 60,000 insured unemployed workers.⁶⁴ A social survey into unemployment in Sheffield published in 1932, estimated that when considering the number of dependants of the unemployed that 100,000 people, one fifth of the city's population, were directly affected by unemployment in the early 1930s.⁶⁵ Pollard has noted that underemployment was a chronic problem in Sheffield in the 1920s and 1930s with short time working common in the metal trades.⁶⁶ The transfer of responsibility to the council for poor relief was a major drain on city finances. Public Assistance Committee expenditure in 1933-1934 at the time of the Ministry Survey, was twice the amount spent on education, three times the amount spent on public health and four times the amount spent on highways.⁶⁷

⁶³ C.H. Shaw, 'A Review of Infectious Diseases in Sheffield', (typescript Sheffield Local Studies Library, 1992).

⁶⁴ A.D.K. Owen, *A Survey of Unemployment in Sheffield* (Sheffield Social Survey Committee, 1932).

⁶⁵ A.D.K. Owen, *A Survey of Unemployment in Sheffield* (Sheffield Social Survey Committee, 1932).

⁶⁶ S. Pollard, *A History of Labour in Sheffield*, Liverpool University Press (1959), 13.

⁶⁷ The rate contribution to the PAC budget in 1933-34 was £930,478. The Council faced a deficit in 1933 of £90,970 the previous year had seen a surplus of £52,400. The deficit continued in 1934 at £208,600 and £355,000 in 1935. PAC expenditure peaked in 1934 at £1,016,000. *Sheffield Independent*, 12 September 1934, 14 November 1934 and 13 February 1935.

As previously seen the city was the first to introduce compulsory notification for pulmonary tuberculosis through Section 45 of the Sheffield Corporation Act of 1903.⁶⁸ In 1907 the corporation opened its first sanatorium at Commonsides with accommodation for 20 patients with pulmonary tuberculosis. Crimicar Lane sanatorium opened in 1909 also with 20 beds. A further municipal tuberculosis sanatorium was opened a year later at Winter Street Hospital with 110 beds. The council pioneered municipal tuberculosis dispensaries, the first one being opened in 1911.⁶⁹

Linda Bryder has noted that the average number of TB hospital and sanatoria beds per 100 deaths from tuberculosis for England and Wales in 1929 was 69. Bryder's figures show that Sheffield had a higher than average number of hospital and sanatoria beds per 100 deaths from tuberculosis with a rate of 151, compared to an average for the large cities of Sheffield, Liverpool, Manchester, Glasgow, Birmingham, and the urban areas of Lancashire and the West Riding of 77.⁷⁰ The statistics offer an indication that Tuberculosis provision was more extensive in Sheffield than other places, however the statistics do not reveal the detail of the city's tuberculosis policy. Not all of the beds that were used for TB patients were sanatoria beds. After Labour took control of the Council in 1926, vacant wards in the Poor Law Infirmary at Nether Edge were used for tuberculosis patients. The policy was not popular with the well to do residents of Nether Edge who despatched a deputation to the Health Committee objecting to the night time sounds of 'coughing, retching and spitting' of the tuberculosis sufferers placed in the quiet suburb.⁷¹ A Mrs Turton complained that her cook had left her service 'purely on the grounds that the noise from the [TB] block had affected her health, she (the cook) being unable to sleep at night because of the coughing.'⁷² The Nether Edge residents

⁶⁸ *Memorandum on the Scheme of Sheffield City Council for the Prevention and Treatment of Tuberculosis*, Sheffield MOH Annual Report Appendix, 1944.

⁶⁹ *Memorandum on TB*, Sheffield MOH Annual Report Appendix, 1944.

⁷⁰ L. Bryder, *Below the Magic Mountain* (Oxford, 1988), 82.

⁷¹ Deputation of Nether Edge residents to Sheffield City Council Hospitals Committee, 23 March 1928. SCC Hospitals Sub-Committee Minutes, 23 March 1928, SCA 39 (49).

⁷² Deputation of Nether Edge residents to Sheffield City Council Hospitals Committee, 23 March 1928. SCC Hospitals Sub-Committee Minutes, 23 March 1928, SCA 39 (49).

also objected to the patients climbing up the wall of the infirmary to ask passing local children to post letters for them and raised objections to the patients spitting on the pavement around the Hospital. One of the Nether Edge residents, Mr C. Firth, was of the opinion that 'it was not right that a tuberculosis hospital should be placed where it was.'⁷³ The Hospitals Committee gave short shrift to the objections of the Nether Edge residents stating; 'Shortly - we think that there is nothing to complain of on these grounds.'⁷⁴ However the Nether Edge residents' group did not give up their campaign easily and with legal assistance took their campaign directly to the Minister of Health. The Council offered a compromise insisting that the Hospital permanently closed the windows of the TB wards in order to minimise the noise. The Council Committee did not however accept the Nether Edge resident's further request to erect giant hoardings all around the perimeter of the hospital.⁷⁵

Tuberculosis Notification

Tuberculosis death rates in Sheffield were lower than average and notification rates were higher than average – leading the Ministry to question whether those notified were actually sufferers of TB. In 1934, the year of the Ministry of Health Public Health Survey the figures for tuberculosis notification were twice as high in Sheffield than for the County Borough average for England and Wales. The trend continued through the decade, the TB notification rate for Birmingham in 1938 was 1.15 per 1000, in Sheffield it was 1.68 per 1000.⁷⁶ It was the practice for GPs to refer cases for notification to the dispensary.⁷⁷ Relatively few notifications therefore came from GPs themselves. For instance in 1932, 92.71 per cent of tuberculosis cases notified during life, were patients

⁷³ *Ibid.*

⁷⁴ *Ibid.*

⁷⁵ Hospitals Sub Committee Minutes, 21 March 1929, SCA 39 (50).

⁷⁶ The number of notifications of tuberculosis of the lung in 1938 was 876 and for other forms of tuberculosis was 208, giving an incidence rate per 1000 of the population of 1.68 for pulmonary TB and 0.40 for other forms of the disease. The notification rate for all forms of TB in Birmingham in 1938 was 1.15/1000 population. Sheffield MOH Annual Report, 1938, Birmingham Medical Officer of Health Annual Report, 1938.

⁷⁷ Of the 2, 519 new suspected cases of tuberculosis seen at the dispensary in 1928, 1, 941 were referred by GPs, 384 by the School Medical Service, 177 by the Voluntary Hospitals and 5 patients attended at their own request. Hospital Sub-Committee Minutes, 17 January 1929, SCA 39 (50).

that had been sent to the tuberculosis dispensary prior to notification.⁷⁸

The Ministry surveyor C.J. Donelan, noted that ‘undoubtedly the Sheffield Tuberculosis Officers and GPs notify far more freely than elsewhere. Since so many notified cases recover, notification appears to be regarded as an incident rather than as a disaster. Every patient on the register is carefully supervised and the Chief Tuberculosis Administrative Officer is the MOH [Rennie] who for many years was the Tuberculosis Officer, and he is responsible for the characteristics of the service.’⁷⁹ The dispensary took large numbers of x-rays and loaned beds and bedding. TB shelters were a small part of the TB service in Sheffield.⁸⁰

Doctor H. Midgely-Turner, the City Tuberculosis Officer outlined the thinking behind TB notification in Sheffield in 1934 stating that ‘the number of notifications received is not a criterion of our position as regards Tuberculosis. Our work ... is directed towards a decrease in the number of infectious cases amongst the primary notifications and establishing a diagnosis of Tuberculosis in the earliest stages of the disease’⁸¹ The intention was to notify cases as early as possible before they became infectious in order to administer treatment and to cure the disease, to nip ill-health in the bud. There were 65,697 attendances at the central dispensary in 1932, this high number was welcomed by the Tuberculosis Officer as evidence that ‘patients are anxious to seek the treatment provided by the municipality.’⁸² The Tuberculosis Officer recognised that poverty and poor diet were detrimental in the fight against disease, however Midgely-Turner cited the general economic situation rather than the behaviour of individuals: ‘the prolonged industrial depression has given rise to a widespread poverty which is affecting large numbers of working class homes in the city. One of the first effects of poverty is to cause deterioration in diet, food being selected for its bulk rather than its nutritive value. It follows that prolonged and widespread poverty must bring in its train

⁷⁸ Sheffield MOH Annual Report, 1932.

⁷⁹ PRO MH 66/872, App. L.

⁸⁰ Only one shelter was loaned in 1928. Sheffield MOH, Annual Report 1928.

⁸¹ Sheffield MOH, Annual Report, 1932.

⁸² Sheffield MOH, Annual Report, 1932.

some relative under-nutrition and diminution in resisting power. Under-nutrition is one of the factors which predispose to the development of tuberculosis disease.’⁸³

Tuberculosis Mortality

As Tuberculosis Officer from 1912 –1930, Rennie was responsible for the long-term direction of the Council’s tuberculosis policy. His level of control was seen by the Ministry of Health surveyor to be detrimental to the efficiency of the service citing Sheffield’s TB service as ‘atypical ... maximum attention is given to prevention of the spread of the disease and treatment of the individual is regarded as more or less incidental to the main object.’⁸⁴ Donelan noted that the local authority in Sheffield claimed that the fall in the death rate from tuberculosis which was greater than in other County Boroughs was due to their tuberculosis scheme.

In the early twentieth century Sheffield had seen a very high incidence of pulmonary tuberculosis, particularly among middle aged and old aged males. This was an unusual trait as the disease was most prevalent in young adults. Tuberculosis in Sheffield was notably a male disease rather than a female disease and it had long been recognised that there was a close correlation between incidence of tuberculosis and occupation in the metal trades.⁸⁵ Dark, damp, cramped and unventilated working conditions particularly in grinding workshops were linked to poor health in males. The MOH stated in 1929 ‘the black spot, as regards tuberculosis in Sheffield, is the grinding industry.’⁸⁶ The mortality rate for pulmonary tuberculosis amongst grinders in 1929 was six times that of all persons aged over 15 in Sheffield. In the 44 year period between 1886 and 1929 the percentage of deaths due to tuberculosis of the lung among all people in Sheffield over the age of 15 was halved from 14.4 per cent to 7.4 per cent. For the same period the percentage of deaths from pulmonary tuberculosis among grinders

⁸³ Sheffield MOH AR, 1932.

⁸⁴ PRO MH 66/872, Ministry of Health Public Health Survey, Sheffield County Borough, Appendix L, 1934.

⁸⁵ J.C. Hall, ‘The Effect of Certain Trades on Life and Health’, *Transactions of the National Association for the Promotion of Social Science*, (Sheffield Meeting, 1865), 382-402.

⁸⁶ Sheffield MOH AR, 1929.

actually increased from 35.6 per cent in 1886-90 and 38.8 per cent in 1926-1929.⁸⁷ In recognising the detrimental effects of a poor environment regarding tuberculosis incidence, the policy which was developed in Sheffield was one which recognised that both poor working conditions and poor housing conditions were a serious hurdle in reducing levels of tuberculosis. The council had little control over conditions in grinding workshops. Housing on the other hand was an area where the policy of the Labour Council could have a positive impact. A tuberculosis re-housing scheme was made possible by Labour's commitment to building low density, high quality housing on garden city lines. The scheme began as an experiment in 1928 and by 1932 was seen by the council as an 'officially recognised activity of the scheme for the prevention and treatment of tuberculosis.'⁸⁸

The Tuberculosis Re-housing Scheme

The distinctive trajectory of Public Health policy in the early twentieth century was to emphasise medical treatment and promote the personal responsibility of individuals in a bid to modify behaviour. While Tuberculosis policy in Sheffield covered this ground it was also concerned with the wider environment in which patients lived. To the Ministry of Health surveyor, this policy of environmental intervention was seen as an anachronism. William Asbury had signalled the Labour Party's environmental conception of public health in the late 1920s, citing the reason for the locus of the smallpox outbreak of 1926/27 in the industrial area of Attercliffe as being due to the poor health of the inhabitants, poor housing conditions and bad sanitation. TB policy was pursued along similar notions.

Close liaison between key Council Committees - the Estates Committee and the Health Committee made the TB re-housing policy a reality.⁸⁹ Large families where

⁸⁷ Sheffield MOH, Annual Report, 1929.

⁸⁸ Sheffield MOH, Annual Report, 1932.

⁸⁹ A conference was held between the Estates Committee and the Hospitals Sub-Committee in October 1927 and resolved to take 'steps to expedite the letting of houses on various estates to applicants on the register in respect of whom the Health Committee guarantee the payment of rent'. Hospitals Sub-Committee Minutes, 19

tuberculosis had occurred were targeted for re-housing away from poor living conditions into new homes on the council's housing estates.⁹⁰ The 'special conditions' of the re-housing scheme were that the TB patient was to have a separate bed and bedroom, there could be no lodgers in the house, the patient was to present for examination at the dispensary when required and carry out the requirements of the Tuberculosis Officer. Re-housed families were kept under close supervision by Tuberculosis Inspectors.⁹¹ Health Visitors and Male Inspectors were to have access to the house for the purposes of supervision and the other members of the family were to attend the dispensary when required and were to be examined for tuberculosis at least a year after notification.⁹²

The Health Committee recognised the importance of providing financial help in the re-housing of the poor by providing a subsidised rent for necessitous cases. In Glasgow, where a tuberculosis re-housing scheme had also been introduced, tenants were required to pay a standard economic rent and no subsidies were provided.⁹³ Smith has noted that in places where tuberculosis re-housing schemes were attempted they were generally unpopular as the intention was to keep the illness secret, however news that a 'consumptive family' had been placed on the estate soon spread and the tenants were often forced to leave, 'their reserved houses were dubbed 'consumptive's houses and were shunned by the tuberculous and the sound alike.'⁹⁴ As can be seen from Table 3.2 below, between 1928 and 1938 a total of 261 families in Sheffield were re-housed under this scheme.⁹⁵

April 1928, SCA 39 (49).

⁹⁰ A typical case before the Hospital Sub-Committee in the late 1920s was one where the patient, her husband and seven children were living in a house with two living rooms and two bedrooms. The husband and two of the children were sleeping in the same bed as the patient. The Committee recommended that the husband be given the tenancy of a three bedroom house on the Manor Estate and that the Health Committee guarantee 7/10 per week towards the rent. Hospitals Sub-Committee Minutes 17 May 1928, SCA 39 (49). The average rent of a three bedroom council house in 1930 was 12/2 per week, the average rent for a two bedroom Council house was 10/6. Hospitals Sub-Committee 16 January, 1930.

⁹¹ Sheffield MOH Annual Report, 1929.

⁹² PRO MH/1076 p98.

⁹³ N. McFarlane, 'Hospitals, Housing and Tuberculosis in Glasgow: 1911-1951, *Social History of Medicine*', (1989), 76.

⁹⁴ F. B. Smith, *The Retreat of Tuberculosis: 1850-1950* (London, 1988). L. Bryder, *Below the Magic Mountain* (Oxford, 1988), 171.

⁹⁵ Sheffield City Council Public Health Committee, *The Public Health Services of the Sheffield City Council*, (Sheffield, 1937), 16. Sheffield MOH, Annual Report 1938.

Table 3.2 Sheffield City Council Tuberculosis Re-housing Scheme 1928-1938

Year	Cases re-housed	Terminated tenancies	Still under scheme 1938	Still on estate after special conditions terminated
1928-1932	137	107	30	45
1933	34	25	9	14
1934	22	15	7	7
1935	18	12	6	7
1936	20	7	13	6
1937	14	4	10	2
1938	16	2	14	1
Totals	261	172	89	82

Source: Sheffield Medical Officer of Health Annual Report 1938.

The Chairman of the Hospitals Sub-Committee and the Tuberculosis Officer made tours of inspection of families that were re-housed under the scheme. From official sources it is difficult to assess whether stigmatisation occurred in these communities. However, the report of 1931 describes how; ‘on these tours one is struck by the keen appreciation of the improved environment shown by the families concerned. This appreciation is reflected in the pride taken both in the gardens and the homes. The improvement in the health of contacts, which frequently follows the improvement in environmental conditions, is frequently very noticeable.’⁹⁶ In medical terms the scheme was a leap of faith for the Council. H. Midgely-Turner stated that ‘while preventive results are difficult to assess, I feel sure that they are very real.’⁹⁷

⁹⁶ Hospitals Sub-Committee, 19 March 1931, SCA 39 (59).

⁹⁷ Hospitals Sub-Committee, 19 March 1931, SCA 39 (59).

As the scheme required the patient to seek treatment as a condition of the tenancy, it could be interpreted as a very intrusive example of local state intervention and observation. However its principal aim was the prevention of further cases of tuberculosis in the family and the community. The MOH felt that ‘the more permanent benefit of the scheme would be for the “contacts” i.e. the family of the infectious cases.’⁹⁸ The Tuberculosis Officer was reluctant to impose a time limit on the removal of the family from the housing scheme on the death of the patient as ‘from a medical point of view the whole value of the scheme is the protection of, and well being of the contacts, most of whom will be definitely infected with tuberculosis.’⁹⁹ The Council’s policy of building low density council housing was crucial to this philosophy, as the Tuberculosis Officer stated in 1931; ‘the source of infection is transferred from a densely populated area, to an area where the spacing of houses is such that the danger of infection to the inhabitants of neighbouring homes is negligible. Thus this special re-housing scheme is a benefit not only to the other members of the family of the infectious case, but also the community at large.’¹⁰⁰

The social responsibility of the local authority in the prevention of disease was stressed by H. Midgely-Turner who urged the Health Committee to deal with council tenants who were suffering tuberculosis and who could not afford to pay their full rent, in the same manner as those who were re-housed under the scheme.¹⁰¹ In 1933 Midgely-Turner stated that ‘tuberculosis schemes constitute a type of trench warfare in which positions are held and gains are made here and there by small advances. To make a big advance it is necessary to abolish slums and to raise the general standard of living, particularly for the poorest section of the community.’¹⁰² The total number of infectious

⁹⁸ Sheffield MOH, Annual Report, 1938.

⁹⁹ Report Regarding the Housing of Infectious Cases of Tuberculosis, Hospitals Sub-Committee, 19 March 1931, SCA 39 (59).

¹⁰⁰ Report Regarding the Housing of Infectious Cases of Tuberculosis, Hospitals Sub-Committee, 19 March 1931, SCA 39 (59).

¹⁰¹ Hospitals Sub-Committee Minutes, 16 January 1930, SCA 39 (50).

¹⁰² Hospitals Sub-Committee Minutes, 14 September 1933, SCA 39 (54).

cases and family members or 'contacts' re-housed in the decade from 1928-1938 was 1,487.¹⁰³ Although the majority of tenants re-housed under the scheme had their tenancies terminated on the death of the family member suffering from TB, a sizeable number, over a third of those re-housed under the scheme in the 1928-38 period, remained on the new estates as ordinary tenants after the rent rebate had been removed.¹⁰⁴

Tuberculosis in Children

As was seen above there was a tendency in Sheffield for high referral rates for TB. The whole question of the diagnosis of tuberculosis was fraught with uncertainty, largely because its onset was slow and because the disease remained a chronic condition. C.J. Donelan, the Ministry of Health surveyor, opposed the readiness of the Health Department in Sheffield to diagnose TB in children. Donelan felt that Rennie was keen to provide Sheffield with a 'thoroughly efficient health service ... but it is extremely difficult to convince him that his own ideas are not the best.'¹⁰⁵ Rennie was seen as 'tending towards obstinacy' in tuberculosis policy and particularly its incidence in children. In Donelan's opinion, Rennie had an 'idée fixe' that incidence of the disease was higher amongst children in Sheffield than elsewhere in the country. Where Sheffield recorded 0.57 per cent of children aged 5-15 with tuberculosis in 1931, the figure for England and Wales was 0.073 per cent.¹⁰⁶ For the Ministry inspector it was a 'remarkable state of affairs' that Sheffield constituted 1/70 of the country's population yet 1/4 of children treated for tuberculosis in the country were treated under the Sheffield scheme.¹⁰⁷ The death rate from the disease in this age group was low. Rennie on the other hand believed that only in Sheffield was tuberculosis in children being adequately diagnosed 'and if it is not being diagnosed in comparative amounts in other places that

¹⁰³ Sheffield MOH, Annual Report, 1938.

¹⁰⁴ Sheffield MOH, Annual Report, 1938.

¹⁰⁵ PRO MH 66/1076 p29.

¹⁰⁶ Sheffield MOH, Annual Report, 1931.

¹⁰⁷ PRO MH 66/1076 p92.

is due to the failure of clinicians in these other areas to detect tuberculosis lesions.’¹⁰⁸

It is clear that children with chest complaints that were not necessarily suffering from tuberculosis were given treatment under the remit of the anti-tuberculosis scheme. Rennie’s successor as Tuberculosis Officer, Dr H. Midgely –Turner, argued that because the commonest form of the disease in adults was localised in the lungs ‘it is too frequently forgotten that tuberculosis is a systemic disease due to infection by the Tubercle bacillus which first reaches and permeates the lymphatic system of the body.’¹⁰⁹ Midgely-Turner argued that the disease should be taken seriously in children for two reasons. Firstly, as the risk of serious tuberculosis developing in later life was great and the prognosis for the disease in the early stages of life was good. Secondly, he believed that childhood lymphatic tuberculosis coincided with the period of active growth and development, and that infection of the bronchial glands could lead to deformed chest and infection of the developing mesenteric mid-gut glands which could lead to a disturbance in digestion and nutrition, especially fat so that tuberculosis toxæmia could lead to excessive growth without a gain in weight.¹¹⁰

The Ministry inspector felt that Midgely-Turner was heavily influenced by Rennie in being ‘dogmatic’ in his ideas over tuberculosis and the inspector was not convinced that the diagnosis of large numbers of children with ‘minor tuberculosis’, ‘Nilus TB’ or ‘tuberculous bronchial glands’ was at all accurate. Donelan stated that ‘It does not appear to me to be very clear that these children are definitely tuberculous and I think to a considerable extent that Sheffield is providing a good deal of convalescent treatment for children under the title of anti-tuberculous work. In Sheffield the diagnosis of pulmonary tuberculosis is made for school children approximately nine times as frequently as elsewhere. Yet this is done on evidence, which in my opinion is slender.’¹¹¹ It was not customary for the corporation to charge for treatment at the tuberculosis institutions. The large numbers of children being treated under the banner

¹⁰⁸ PRO MH 66/1076 p30.

¹⁰⁹ Sheffield MOH, Annual Report, 1932.

¹¹⁰ Sheffield MOH, Annual Report, 1932.

of 'minor-tuberculosis' was at a cost the Health Department £1,800 per year in 1934 and Donelan felt that this expense was 'doubtful to justify at any rate under the heading of tuberculosis.'¹¹² The difference of opinion illustrates the difficulty of accurately diagnosing and treating TB at the time. The policy of readily assigning instances of ill health in children as forms of minor TB also illustrates the Council's propensity to place the TB service at the heart of local authority health care, to emphasise prevention and early diagnosis, and allowing the Council to treat children free of charge. The TB service was utilised to continue the operation of the open air schools programme providing rest, improved diet and fresh air for unhealthy and impoverished children.¹¹³

Tuberculosis Treatment and Hospitals

The Tuberculosis Officer Dr H. Midgely-Turner, was seen by Donelan as conservative as he was not an enthusiastic supporter of the contemporary medical treatments for TB being experimented with in the mid-1930s. These procedures included intrusive pneumo-thorax treatment with air pumped into a collapsed lung, which the TB Officer believed 'did more harm than good'.¹¹⁴ Restorative occupational therapy for recovering TB patients, such as furniture making, basket weaving and gardening was promoted by the Ministry of Health and attempted in areas such as Leicester.¹¹⁵ Midgely-Turner was again opposed to this form of therapy as he felt that it had a detrimental effect on a patient's progress. Donelan noted that rural recuperative village settlements were seen of little value in Sheffield, and that TB shelters were of little use in the city. Tuberculosis strategy in Sheffield as seen by the Ministry inspector was long periods of rest, the principal sanatorium treatment being prolonged rest and feeding. Yet some medical interventions were attempted as part of the

¹¹¹ PRO MH 66/1076 p95.

¹¹² PRO MH 66/1076 p.212.

¹¹³ When the Council took over the King Edward VII Hospital in 1927 it argued that fees for treating children with TB should cease as they were not required of other cases treated at the municipal TB hospitals. Sheffield Borough Council Hospitals Sub-Committee Minutes, 21 March 1929, SCA 39, (50).

¹¹⁴ PRO MH 66/1076 p212.

¹¹⁵ J. Welshman. *Municipal Medicine: Public Health in Twentieth Century Britain* (Peter Lang, Oxford, 2000), 136. L. Bryder, *Below the Magic Mountain* (1988), 157-98.

tuberculosis service in Sheffield. Tuberculin (an antigen skin test) treatment was used on 236 pulmonary and non-pulmonary cases between 1930 and 1938. Midgely-Turner was again sceptical and reserved judgement of the efficacy of this treatment, stating that 'in many cases the immediate response to this form of treatment is good but it is too early yet to give an opinion on the later results.'¹¹⁶ Treatment using gold salts - anti-inflammatory compounds - was also tried, however the Tuberculosis Officer stated that 'I could not satisfy myself that this form of treatment appreciably affected the course of the disease and it is now rarely used.'¹¹⁷

The inspector was unimpressed with Sheffield's domiciliary service for tuberculosis. The first municipal tuberculosis dispensary opened in Sheffield in 1911 in Corporation flats in Hawley Street. In 1918 the city transferred the dispensary and took over premises owned by the LMS Railway Company in Queens Road. The dispensary a former convent and railway goods warehouse, remained on these premises for the whole of the 1918-1948 period. There were no branch dispensaries. Donelan described the dispensary as 'gloomy and noisily situated, however it appears well equipped with x-ray and a whole-time qualified dispenser who issues considerable amounts of cod liver oil, malt and oil, Grimsby Emulsion and cough mixtures.'¹¹⁸

As well as the dispensary there were four tuberculosis sanatoria in the city, plus the accommodation at Nether Edge Hospital leased to the corporation by the Guardians from 1926.¹¹⁹ Three hospitals were provided by the local authority for the institutional treatment of pulmonary cases. Crimicar Lane Hospital had originally been built as a smallpox hospital. The Commonsides Hospital was a converted house, and Winter Street Hospital was a former infectious disease hospital.¹²⁰ In 1934 there were 507 beds in

¹¹⁶ Sheffield MOH, Annual Report, 1938.

¹¹⁷ Sheffield MOH, Annual Report, 1938.

¹¹⁸ PRO MH 66/1076 p99

¹¹⁹ 106 beds were available at Crimicar Lane Sanatoria for male patients, 42 beds and 5 shelters at Commonsides, 40 male beds and 60 female beds were available at Winter Street Hospital and 88 beds for male patients, 52 for female patients, and 120 beds for children at Nether Edge Hospital. PRO MH 66/1076 p101.

¹²⁰ L.G. Parsons, S. Clayton Fryers and G.E. Godber, *The Hospital Services of the Sheffield and East Midlands Area* (HMSO, 1945), 21.

municipal sanatoria and tuberculosis hospitals including 260 beds at Nether Edge Hospital, formerly a Poor Law Infirmary which was transferred to the Health Committee in 1930. Donelan felt that 'the whole of the tuberculosis accommodation in Sheffield is of a somewhat makeshift nature, but both Dr Rennie and Dr Midgely-Turner are very satisfied with it and do not consider that anything further is needed.'¹²¹ The surveyor criticised the lack of specific differentiation over which type of patient was sent to each of the four hospitals, although the majority of elderly and degenerative cases were sent to Nether Edge Hospital, while pulmonary and non-pulmonary cases were kept completely separate. He felt that the treatment offered was 'essentially conservative,' featuring rest, improved diet and fresh air and noticed that patients at Crimicar Lane were required to take their own temperature and patients dealt with their own sputum. Donelan stated that 'the amount of treatment on modern lines appears to be negligible'.¹²² None of the pulmonary tuberculosis hospitals had x-ray plant. King Edward VII hospital, for orthopaedic non-pulmonary cases was formerly a voluntary hospital, but had recently been taken over by the corporation. It was seen as 'an excellent example of elegance obtained at the expense of convenience with verandas, colonnades and a small operating theatre and x-ray. The work here is very good.'¹²³ Built in 1914, the buildings of the King Edward VII Hospital were described in 1945 as 'reasonably satisfactory', and the function of the hospital was questioned as it fell 'between two stools, being neither a sanatorium nor an orthopaedic hospital but something of each.'¹²⁴

Donelan recorded that 'Dr Rennie declares most emphatically that Sheffield will never provide any new beds for tuberculosis and is satisfied with the existing institutional accommodation and he has every reason to believe that under the present methods of dealing with tuberculosis in Sheffield it will not be many years before the disease disappears entirely from the city, more tuberculosis beds are therefore seen as

¹²¹ PRO MH 66/1076 p101.

¹²² PRO MH 66/1076 p101

¹²³ PRO MH 66/1076 p101.

¹²⁴ L.G. Parsons, S. Clayton Fryers and G.E. Godber, *The Hospital Services of the Sheffield and East Midlands Area* (HMSO, 1945), 21.

unnecessary. I think that he is unduly optimistic in his views on the probable disappearance of tuberculosis in Sheffield.¹²⁵

Eleven years after the Ministry of Health Public Health survey the tuberculosis hospitals in Sheffield were still being described as 'unsatisfactory'.¹²⁶ During the Second World War Rennie drew up proposals for a comprehensive tuberculosis service featuring 'provision for Mass Radiography, dispensary treatment, sanatorium treatment of tuberculosis of the lungs, hospital treatment of surgical tuberculosis amongst children and adults and hospital treatment of all surgical diseases of the chest.'¹²⁷ The ambitious scheme included plans for the building of a completely new sanatorium of 500 beds on a fifty acre site at the cost of £520,000. It also proposed the expansion of the King Edward VII Hospital by 40 beds at a cost of £30,000, and the construction of a completely new dispensary incorporating a mass radiography unit.¹²⁸

The number of tuberculosis beds in these wartime proposals exactly matched the existing number of beds for tuberculosis patients in the city, therefore this was not a plan to introduce additional institutional sanatoria provision, rather the ambitious scheme could be seen as an attempt by the MOH, who retired in 1947, to leave a lasting personal legacy for TB care in Sheffield. Rennie had begun his professional life in Sheffield as the city's Tuberculosis Officer in 1913 and continued to direct tuberculosis policy after his promotion to MOH in 1930. Though the plan was approved by the Council in 1945, the scheme did not see the light of day. The mass radiography unit was the only aspect of the plan to be realised opening on Ellin Street in June 1945. 12,793 people were examined in the first six months of the operation of the unit.¹²⁹ On the appointed day in July 1948 it was the old tuberculosis institutions of Crimicar Lane, Commonsides, Winter Street and the King Edward VII Hospital that were handed over to

¹²⁵ PRO MH 66/1076 p208.

¹²⁶ L.G. Parsons, S. Clayton Fryers and G.E. Godber, *The Hospital Services of the Sheffield and East Midlands Area* (HMSO, 1945), 21.

¹²⁷ Sheffield MOH, Annual Report, 1944.

¹²⁸ Sheffield MOH, Annual Report, 1944.

¹²⁹ Sheffield MOH, Annual Report, 1945.

the NHS.¹³⁰

The emphasis of the Health Department in Sheffield on matters of prevention, notification, after care, some medical treatment plus the subsidised re-housing scheme illustrate that TB policy in Sheffield went further than that characterised by Bryder and Smith as typical of the era – with an over-reliance on sanatorium treatment. Although it is very difficult to attribute specific factors in the decline in death rates of tuberculosis, the policy of prevention and early diagnosis was believed to be effective by health administrators in Sheffield. No other city had a better tuberculosis death rate than Sheffield in the period. The Ministry of Health's negative assessment of local authority tuberculosis policy in 1930s Sheffield can be challenged as it allowed effective local action in health policy. However the negative findings of the Ministry surveyor in relation to the City's maternity and child welfare services and to VD provision are more difficult to dispute.

Maternity and Child Welfare Services

Donelan felt that 'in common with other health services in Sheffield, the organisation for maternity and child welfare is peculiar'.¹³¹ The Council appointed its first Women's Sanitary Health Inspector (WSI) in 1899, which along with Leeds, Bradford and St Helens placed it in the vanguard of local authorities appointing women health inspectors.¹³² By 1913 there were 17 Women Sanitary Inspectors under a Chief Women's Sanitary Inspector all with the triple qualification of hospital nurse, midwife and sanitary inspector.¹³³ Tanya McIntosh has pointed out how the distinction between health visitors and qualified Sanitary Inspectors in Sheffield was important as the latter carried higher salary and greater responsibilities in contrast to other cities such as

¹³⁰ Sheffield MOH, Annual Report, 1948.

¹³¹ PRO MH 66/1076 p66.

¹³² C. Davies, 'The Health Visitor as Mother's Friend: A Woman's Place in Public Health 1900-1914', *Social History of Medicine*, 1, 1, (1988), 39-59, 47.

¹³³ Sheffield MOH, Annual Report, 1913.

Birmingham who advertised only for 'lady health visitors.'¹³⁴ WSIs retained this role in Sheffield until redesignated as health visitors in 1934.¹³⁵ The Ministry of Health survey of that year reported that the MOH Rennie, was attempting to run the Maternity and Child Welfare service without delegating appropriate responsibility to the Chief Woman Inspector. Under the MOH in the 1920s, Frederick Wynne, the Chief WSI, Mrs Franks had been largely responsible for the administration of the service, Donelan felt that 'Dr Rennie is intolerant of any authority other than his own and has considerably curbed her activities.'¹³⁶ Nonetheless, Mrs Franks was still seen by Donelan, as having a considerable influence over the work of the department, although this was said to be 'an unfortunate feature since she appears to be possessed of a doctrine that the duty of a health visitor is not to act as a sympathetic adviser but as a detective and she evidently believes that mothers should be drilled rather than educated.'¹³⁷

Mrs Franks had been a Women's Sanitary Inspector since 1903, she retired in November 1934 at the age of 65.¹³⁸ Donelan noted the preference in Sheffield for 'Women Sanitary Inspectors' rather than health visitors and stated that neither Rennie nor Franks 'consider the title "Inspector" has any disturbing effect upon the somewhat stubborn mind of Sheffield people.'¹³⁹ Rennie and Franks were both of the opinion that the Health Visitors Certificate introduced by the Ministry of Health in 1919 was of no value. Mrs Franks was 'very proud that Health Visitors have warrants as Sanitary Inspectors and have right of access to houses.'¹⁴⁰

The Assistant Medical Officer responsible for child welfare, Dr Black was responsible to Dr Clark the Medical Superintendent of the City General Hospital. Donelan felt that the salary of £350 paid to Dr Black was low and was an indication of the low priority given to maternity and child welfare in the city. Expenditure on the

¹³⁴ T. McIntosh. 'A Price Must Be Paid For Motherhood: The Experience of Maternity In Sheffield, 1879-1939' (University of Sheffield PhD. thesis, 1997), 122.

¹³⁵ *Ibid*, 119.

¹³⁶ PRO MH 66/1076 p34.

¹³⁷ PRO MH 66/1076 p35.

¹³⁸ Sheffield City Council Minutes of the Health Committee, 28 August 1934, SCA 112/30.

¹³⁹ PRO MH 66/1076 p69.

Maternity and Child Welfare work in Sheffield compared to other towns also appeared low. The figures for 1930 were presented in the Ministry Report and are reproduced below in table 3.2:

Table 3.2

**Expenditure on Local Authority Maternity and Child Welfare Service
per 1000 population 1930**

County Borough Council	Expenditure per 1000 population on Maternity and Child Welfare
Sheffield	£8 5s 7d
Birmingham	£30 15s 6d
Leeds	£44 7s 11d
Manchester	£46 3s 7d
Liverpool	£47 13s 9d

Source: PRO MH 66/1076 p. 208.

Donelan noted that this apparent low cost of the service was ‘spurious due to the fact that as far as possible all the costs of confinements in institutions are recovered through the Public Assistance Committee as women who are unable to pay the full cost of maintenance in the maternity wards at Fir Vale (City General) and Nether Edge Hospital are sent in as public assistance cases through the machinery of the poor law.’¹⁴¹ This contradicts Labour’s public assertion that their policy for health was not to use the machinery of the poor law. Sheffield in general had a comparatively low number of maternity beds in both the voluntary and the municipal sector. Table 3.3 below shows the position of Sheffield in relation to maternity and ante-natal beds in comparison to other towns:

¹⁴⁰ PRO MH 66/1076 p69.

¹⁴¹ PRO MH 66.1076 p210.

Table 3.3 Maternity Bed Provision 1934

City	Births 1932	Municipal Beds	Voluntary Beds	Total No of Beds	Beds/1000 po
Glasgow	22,732	111	191	302	0.29
Birmingham	16,431	132	90	222	0.22
Liverpool	18,149	309	117	426	0.48
Manchester	11,825	227	105	332	0.43
Sheffield	7,390	90	43	132	0.24

Source: PRO MH 66/1076 p 79.

A civil service memo accompanying the Ministry of Health Survey letter to Sheffield, expressed doubt that maternity bed accommodation in Sheffield would be adequate even with the addition of a planned maternity block at the City General Hospital. The memo also expressed concern that infant welfare was centralised to one clinic at Orchard Place, 'this is an unusual arrangement in so large a city and the council should satisfy themselves that the attendance of mothers with infants and young children is not prejudiced by the concentration of welfare work in one centre, four or five miles from some parts of the city.'¹⁴² Donelan's report stated that 'Dr Rennie does not believe in the establishment of branch centres and is strongly opposed to them.' Donelan pointed out that Sheffield was expanding and that it appeared inconvenient to have one centre in the middle of the city and have women travel up to 5 miles. Rennie's response was that 'mothers quite looked forward to pushing a perambulator to the centre or going on a tramcar, the maximum fare being one and a half pence'.¹⁴³ The maternity and child welfare centre issued milk and two Medical Officers and two Women Inspectors attended baby consultancy sessions. Donelan described the arrangements for these sessions as 'perfunctory,' there were no arrangements for the medical examination and treatment of pre-school children who were referred to the voluntary hospitals or private

¹⁴² Ministry of Health Memo re: Survey Letter. Dudley C.L. Ward to Sheffield Town Clerk., 7 March 1935. SCA 640/42.

¹⁴³ PRO MH 66/1076 p71.

practitioners. There were no arrangements for the home nursing of measles, whooping cough, or polio. There was also no municipal nursery school.

A second maternity and child welfare centre was opened before the War by the Minister of Health Mr Walter Elliot in 1938, on the Firth Park housing estate. Asbury stated that 'the opening of the new centre begins a new chapter in the evolution of preventive medicine in Sheffield. Only after a complete survey of the city and acknowledgement of the housing developments likely to take place over a number of years could the Health Committee with any degree of accuracy decide on the location of suburban centres. Firth Park is the natural choice for the first centre.'¹⁴⁴ The centre was an innovative step in the provision of one stop shops for social services with the lower ground floor of the building being used as a Public Assistance Centre. Asbury stated 'there is neither reason nor justification for differing standards in our various social services, at least so far as premises are concerned. For those who are compelled through circumstances over which they have no control, to seek assistance, this cheery part of the building may even provide a ray of hope in otherwise dark days.'¹⁴⁵ The Firth Park centre was further developed as a health centre under the NHS.

The council introduced an assisted scheme for midwives in 1932 to relieve the pressure on maternity beds, which guaranteed a fee for the midwife, while the corporation recovered a contribution from the patient. Donelan noted the close supervision of midwives by the Health Department's 26 Women Inspectors. McIntosh has interpreted this as close supervision as a general suspicion of the activities of midwives, particularly in the light of the very high rate of Maternal Mortality in Sheffield in the 1930s. There was an open suspicion in Sheffield that high levels of MMR were linked to abortion and that midwives knew more about abortion than they let on.¹⁴⁶ The trajectory of the Infant Mortality Rate in Sheffield had declined in line

¹⁴⁴ *Public Assistance Journal and Health and Hospital Review incorporating The Poor Law Officers Journal*, 20 September 1935, 955.

¹⁴⁵ *Public Assistance Journal and Health and Hospital Review incorporating The Poor Law Officers Journal*, 20 September 1935, 955.

¹⁴⁶ T. McIntosh, 'An Abortionist City: Maternal Mortality, Abortion and Birth Control in Sheffield, 1920-

with national trends, it reduced from 85/1000 live births in 1925 to 55/1000 live births in 1934.¹⁴⁷ Sheffield experienced very high levels in the same period regarding Maternal Mortality Rates. MMR peaked in 1927 at 7.27 per thousand births, the figure for 1934 was lower at 6.11 however it was above the national average for 1934 of 4.60.¹⁴⁸ The situation was described by the *Sheffield Independent* as a 'blot upon civilisation'.¹⁴⁹

The MOH Annual Report noted in 1934 that 337 abortion cases were admitted to the City General Hospital compared to 280 the previous year. Asbury contributed a foreword to the 1934 Annual Report noting the high rates of abortion and Maternal Mortality for Sheffield and obliquely commented that 'it is obvious that the existing organisation in its present form cannot be expected to continue to cope with the work much longer if as is the wish of the Committee progressive development is to proceed without restriction.'¹⁵⁰ The whole issue of MMR, birth control and abortion was a delicate one with little support from central government for the provision of birth control clinics. The Ministry issued a Memorandum in 1931 allowing Councils to supply contraceptive advice on the restrictive basis of medical grounds to married women.¹⁵¹ The Ministry suspected that the rules were being stretched in Sheffield doubting that cases dealt with at the clinic 'were entirely suitable for contraceptive measures. Some vague diagnosis of pneumonia, malnutrition or albuminuria [kidney disease] is not in itself sufficient.'¹⁵²

Outside of the MOH Annual Report, Asbury signalled a more direct support for contraception stating in that 'he had heard no evidence that women died as a consequence of the use of contraceptives, but he did know that the numbers who died from abortions was going up each year.'¹⁵³ In opposition Asbury had introduced a

1940', *Medical History*, 44, (2000), 75-96, 91.

¹⁴⁷ MOH, for Sheffield Annual Report 1934.

¹⁴⁸ MOH, for Sheffield Annual Reports, 1927, 1934.

¹⁴⁹ *Sheffield Independent*, 12 November 1936,

¹⁵⁰ W. Asbury, Foreword to 1934 MOH for Sheffield Annual Report.

¹⁵¹ Ministry of Health Memorandum 153 MCW. Cited in McIntosh, (1997), 194.

¹⁵² PRO MH 66/1076 p79.

¹⁵³ *Birth Control News*, April 1930, 183, Quoted in T. McIntosh, 'An Abortionist City: Maternal Mortality,

motion to the Council in May 1926 calling for municipal clinics to be set up to give birth control advice. The motion was defeated.¹⁵⁴ When Labour were in control of the Council support was given to a Shoreditch Borough Council resolution to the Ministry of Health calling for the Ministry to allow local authorities the power to provide birth control clinics for working class women.¹⁵⁵ Further support for birth control provision was channelled through the voluntary sector. The Sheffield Women's Welfare Clinic was established in 1933 in Attercliffe, as a branch of the Family Planning Association supplying advice and Dutch caps. The City Council provided rent free premises in the Vestry Hall and a grant of £50 per year, a move which was opposed by the anti-Labour alliance.¹⁵⁶ Subscribers to the clinic included Labour party ward branches the two Sheffield co-operative societies and individuals including William Asbury.¹⁵⁷ None of the Sheffield trades unions nor the Trades Council were listed as subscribers, suggesting that the issue, though important to leading Labour politicians was not equally prioritised by the wider Labour movement.

Venereal Disease Services

At the start of the twentieth century VD treatment was provided by the state for the treatment of military personnel only. VD treatment for civilians had been introduced in the late nineteenth century under the harsh application of the Contagious Disease Acts. This legislation was used to address the dual problem of prostitution and venereal disease, through the coercive power of removing a woman suspected of being a prostitute in sea ports and garrison towns, to hospital to be examined for VD and to undergo a regime of education and moral reform.¹⁵⁸ Between 1864 and 1884 this legislation was increasingly seen as an infringement on personal liberty and was repealed under the Contagious Disease Acts in 1884. In the years before the First World

Abortion and Birth Control in Sheffield, 1920-1940', *Medical History*, 44, (2000), 92.

¹⁵⁴ Sheffield Council Minutes 5 May 1926, cited in McIntosh, *Ibid*, 193.

¹⁵⁵ Sheffield City Council Health Committee Minutes, 25 February 1930, SCA 112 29.

¹⁵⁶ *Sheffield Independent*, 3 January 1931.

¹⁵⁷ Sheffield Women's Welfare Clinic Annual Reports, 1933-39, Contemporary Medical Archive Centre, Wellcome Institute for the History of Medicine, FPA A4/A 14.

¹⁵⁸ L. Bland, 'Cleansing the Portals of Life: the Venereal Disease Campaign in the Early Twentieth Century', in M. Langan and B. Schwarz, (eds.) *Crises in the British State 1880-1930* (London, 1985), 192-208.

War there was a growing call for measures to control venereal disease without recourse to repression.¹⁵⁹ Medical developments had also boosted interest in VD such as the diagnostic ability of the Wasserman Test and the discovery of Salvarsan for the treatment of syphilis.

State involvement in VD provision for the general population followed The Report of the Royal Commission on Venereal Diseases (1916).¹⁶⁰ The subsequent Venereal Diseases Act of 1917 required local authorities to provide a free, confidential VD service. It introduced an arrangement where the central state provided 75 per cent of the cost of VD clinics which were run mainly through arrangements with the voluntary hospitals. Councils were encouraged to undertake educational activities, although this aspect was not compulsory. A voluntary society, the National Council for Combating Venereal Disease, (later to become the British Social Hygiene Council in 1925) promoted self regulation and chaste lives, while emphasising the need to protect the race and the nation.¹⁶¹ The British Social Hygiene Council undertook propaganda lecture tours and made use of documentary films and posters for both civilians and the services. Offers made by the British Social Hygiene Council to provide illustrative talks and film shows on VD in Sheffield were turned down. Although admitting that he had not personally seen the films or heard the lectures, the MOH believed that they 'did more harm than good' and advised the Council to refuse the offers from the BSHC.¹⁶²

In the 1934 Ministry of Health Public Health Survey of Sheffield, Donelan severely criticised the VD service in the city, stating that 'arrangements for VD work in Sheffield present the least satisfactory feature of the various health activities.'¹⁶³ He saw the problem as a lack of interest from the MOH and the fact that VD work was provided

¹⁵⁹ L. Bland, 'Cleansing the Portals of Life: the Venereal Disease Campaign in the Early Twentieth Century', in M. Langan and B. Schwarz, (eds.) *Crises in the British State 1880-1930* (London, 1985), 192-208.

¹⁶⁰ D. Evans, 'Tackling the Hideous Scourge: The Creation of the Venereal Disease Treatment Centres in Early Twentieth Century Britain', *Social History of Medicine*, (1992), 413-433.

¹⁶¹ B.A. Towers, 'Health Education Policy 1916-1926: Venereal Disease and the Prophylaxis Dilemma' *Medical History*, 24, (1980), 70-87.

¹⁶² Sheffield City Council Education Committee Minutes, Schools Medical Service Sub Committee, 1 October 1928, SCA 293 Minute Book No 6.

by arrangements with three separate voluntary hospitals with no coordination. Donelan informed the Ministry that educational and propaganda relating to VD was not used in Sheffield and that the 'Council have no use for the British Social Hygiene Council.'¹⁶⁴ Donelan was of the opinion that the VD service in Sheffield was 'of a distinctly second-rate nature and that considerable improvement is desirable.'¹⁶⁵

The MOH Rennie was responsible for the service himself as there was no separate Medical Officer for VD. His was seen to have limited influence over clinical work undertaken by specialists the three voluntary hospitals and the university as the consultants were 'important persons in the medical world locally and to some extent in the country, therefore it is not easy for the MOH to suggest reforms and improvements.'¹⁶⁶ Donelan characterised Rennie's attitude to VD as 'sluggish' as 'he holds the theory that there is very little VD prevalent in Sheffield. His main argument in support of this is the absence of apparent night life in the town.'¹⁶⁷ Rennie also argued that the small amount of work carried out at the VD centres was evidence that there was little VD in the city. Donelan argued that 'this is merely evidence that the centres do not attract cases.' Rennie was supported in his view by Dr Clark who recorded fewer cases of 'active or communicable' cases at the City General Hospital than previously.

VD centres were located at the two voluntary general hospitals, the Royal Infirmary and The Royal Hospital and at the Jessops Hospital for Women. The VD centre at the Royal Infirmary ran separate clinics for syphilis and gonorrhoea. In 1934 the clinic was in temporary accommodation awaiting the building of new premises for which the city council had contributed £100.¹⁶⁸ However Rennie did not appear to be concerned with the progress of the scheme and had not viewed any plans. The VD work was conducted in an 'ill lit, ill ventilated basement of the casualty department'. Dr

¹⁶³ PRO MH 66/1079 p107.

¹⁶⁴ PRO MH 66/1079 p122.

¹⁶⁵ PRO MH 66/1079 p122.

¹⁶⁶ PRO MH 66/1079 p107.

¹⁶⁷ PRO MH 66/1079 p107.

¹⁶⁸ Sheffield City Council Health Committee Minutes, 27 November 1934, SCA 112 30.

Skinner the VD officer at the Royal Hospital had introduced the taking of Wasserman reactions as routine for all out patients.¹⁶⁹ With 11.9 per cent of tests as positive in 1934, Donelan recorded that 'there is an appreciable proportion of syphilis in the community.'¹⁷⁰ MOH Reports were keen to point out the numbers of those treated at the clinics from Sheffield and those from outside the City as well as highlight the fact that most of the cost of treatment was reclaimed from the Ministry of Health.¹⁷¹

Donelan recorded that only at Jessops Hospital for Women which saw all female cases was there a high standard of diagnosis and treatment for VD. The hospital was however reluctant to treat syphilis and had only recently begun doing so. Low numbers of women compared to men in Sheffield were recorded as attending gonorrhoea clinics. The national average in 1934 was 3.67 male cases attending gonorrhoea clinics to 1 woman. The figures for Sheffield were 11.61 men to 1 woman. Again, Donelan interpreted this as a reluctance of the population to attend rather than as the MOH believed an indication of the low incidence of VD in Sheffield.

None returns and defaulting patients were noted at all of the clinics. Donelan noted that the Medical Officers were failing to stress the necessity of regular attendance until the course of treatment was ended. The general hospitals sent out reminder notices however the Jessop Hospital did not. The specialists at Jessops were said to 'have taken fright at sending reminders' in case they were opened by someone other than the addressee. He felt that there was a general air of vagueness about the method of dealing with patients and that the centres were more interested with matters of therapy than of prevention.¹⁷² The VD education and propaganda work of the Council was described as 'negligible'. Donelan also described how it was the practice to appoint junior assistant surgeons to the VD clinics. A Dr Chisholm at the Jessops Hospital was described as 'a hesitant type who does not seem to be able to make his mind up as to whether a woman

¹⁶⁹ August Wasserman developed a successful diagnostic blood test for syphilis in 1905. Evans, 'Tackling the Hideous Scourge', 413.

¹⁷⁰ PRO MH 66/1079 p108.

¹⁷¹ E.g. MOH Annual Report for Sheffield 1929.

¹⁷² PRO MH 66/1079 p113.

is or is not suffering from gonorrhoea.’ The nature of the VD work in Sheffield was seen as ‘mediocre’ and Donelan suggested that the appointment of a VD Officer by the council could help to improve the service. None of the specialists employed to conduct the work at any of the three hospitals were primarily VD specialists.¹⁷³

Conclusion

The chapter has examined public health policy in Sheffield in the 1930s. It has added local detail to Charles Webster’s contention that health was important to Labour politics before the NHS debates of the 1940s. The examination of local sources and Ministry of Health records suggests that the contention of Bryder and Smith that tuberculosis policy in the first half of the twentieth century was overly reliant on institutional treatment and sanatoria does not hold for Sheffield. Tuberculosis policy in Sheffield was firmly based on early diagnosis, prevention and after care. The low tuberculosis death rate in Sheffield in the 1930s was attributed, by Sheffield policy makers at least, as being a direct result of the city’s long standing preventative and environmental approach to the disease. The effectiveness of actions taken by local authorities to combat TB in the era before the availability of streptomycin and BCG treatments will remain difficult to prove. The wide ranging approach however did lead to the introduction of innovative social policy including the introduction of the TB re-housing programme and the belief in the benefits of environmental improvement spurred the Council to instigate large scale municipal housing schemes.

Criticisms levelled at other services such as the Maternity and Child Welfare service are more difficult to refute. TB was characterised as a male disease in Sheffield with older grinders and metal workers suffering disproportionately. As a very patriarchal city with low levels of married female employment, tuberculosis was tackled with much effort, interest and resources by the Corporation whereas women’s health issues were not given such a priority. However the Council did recognise the city’s

¹⁷³ Dr Skinner at the Royal Hospital was a general physician, Dr Ferguson Wilson at the Royal Infirmary was a

reputation as a place of high maternal mortality rates and abortion, and using the limited machinery open to them in the 1930s attempted to address the problem through the promotion of family planning in the city by providing practical and financial support for the voluntary sector Sheffield Women's Welfare Clinic.

As was seen in the 1920s the abilities and interests of the Medical Officer of Health remained central to the direction of the work of the Health Department. The question of whether the Council developed an effective public health philosophy in the 1930s is more complex. Jane Lewis has stated that 'by confining themselves to clinic work and hospital administration most public health doctors managed to avoid controversy.'¹⁷⁴ In Sheffield the powers made available through the 1929 Local Government Act were enthusiastically taken up and former Poor Law hospitals became part of the expanded remit of the Health Department. The next chapter examines the development of the municipal hospital service within a wider hospital service for Sheffield.

surgeon and Dr Chisholm at Jessops was a gynaecologist. PRO MH 66/1079 p118.

¹⁷⁴ J. Lewis, *What Price Community Medicine?: The Philosophy, Practice and Politics of Public Health since 1919* (Brighton, 1986), 33.

Chapter 4

Hospitals in Sheffield 1918-1948

Introduction

Previous chapters have described how Sheffield is unusual for a large city as it is not a regional, financial or administrative centre. In one important aspect however, Sheffield did become the centre of a region in terms of its role at the centre of The Sheffield Regional Hospital Board under the NHS from 1948.¹ Several factors in the inter-war years enabled this development. The presence of its University medical school, consultants at the voluntary teaching hospitals - united through a Joint Hospitals Council and the development of the municipal hospital service. In Sheffield there were two specialist voluntary hospitals, the Children's Hospital founded in 1876, and the Jessop Hospital for Women founded in 1864, and two general hospitals the Sheffield Royal Infirmary founded in 1797 and the Sheffield Royal Hospital founded in 1832.² Voluntary hospitals originated as charitable institutions for the reception of the sick 'deserving' non-pauperised poor, the development of the mass contributory scheme raised questions about the status of the voluntary hospitals with the scheme increasingly seen by contributors as a form of insurance. As well as the infectious disease hospitals, the public hospitals under the Board of Guardians to 1930 and the Council Hospitals Committee from 1930-48 were the Firvale Union Hospital (City General from 1930) and the Ecclesall Union Hospital, which became Nether Edge Hospital from 1930.

Hospital policy in Britain in the first half of the twentieth century has been part of the analysis of social policy since the 1950s.³ Early lines of debate set the tone for later historical work, in particular concerns over the degree to which a political consensus led to

¹ The Sheffield Regional Hospital Board was one of the largest in England and Wales covering the West Riding of Yorkshire, Leicestershire, Lincolnshire, Rutland, parts of Derbyshire and Nottinghamshire. Sheffield Regional Hospital Board, *Report Upon the Work of the Sheffield Regional Hospital Board 1947-1952* (Sheffield, 1952). The Board was replaced by the Trent Regional Health Authority in the NHS re-organisation of 1974.

² *The Sheffield Hospitals*, (Sheffield City Libraries Department of Local History and Archives, Sheffield, 1959); Shaw, C. 'Aspects of Public Health', in Binfield, (ed.), *History of the City of Sheffield* (Sheffield Academic Press), vol. 2, 100-117.

³ R.M. Titmuss, *Problems of Social Policy* (Longman, 1950).

the introduction of health service reforms in the 1940s. Factors examined included the importance of regional policy, the impact of the Second World War and the influence of key political actors in shaping reform, notably the role played by the Minister of Health in the post war Labour government Aneurin Bevan.⁴ The early view of hospital policy-making was analysed and described at an elite level through the production of biographies of key players as well as the history of the national picture through histories of the Ministry of Health.⁵ The overall notion put forward in these accounts was that British hospitals between the wars were financially struggling, morally bankrupt, disconnected from the people and in general a malfunctioning non-system with voluntary hospitals reliant on charity and flag days and public sector hospitals being little improved from their origins as poor law infirmaries.⁶

Recently a more nuanced history of hospitals in the first half of the twentieth century has begun to be developed. Stephen Cherry has suggested that voluntary hospital finance in the years to 1939 was not as stagnant as previously thought as hospitals sought new sources of income through workers contributory hospital schemes.⁷ Building on Cherry's work, Gorsky, Mohan and Willis have evaluated the advances made by voluntary hospitals between the wars and have illustrated that income from contributory schemes, while substantial, could be problematic, raising important policy questions over rights of access.⁸ On local authority hospitals, Martin Powell and Alys Levene have provided an examination of the aggregate performance of the municipal hospital sector in the inter-war

⁴ D.M. Fox, *Health Policies, Health Politics: The British and American Experience* (Princeton University Press, 1986); C. Webster, 'Conflict and Consensus: Explaining the British Health Service', *Twentieth Century British History*, 1, 2, (1990), 115-151. C. Webster, 'Health, Wealth and Welfare During the Depression', *Past and Present*, 109, (1985), 204-230.

⁵ Campbell, J. *Nye Bevan: A Biography* (Hodder and Stoughton, London, 1987).

F. Honigsbaum, *Health Happiness and Security* (London, 1989), J.E. Pater, *The Making of the National Health Service* (London, 1981), R. Klein, *The New Politics of the National Health Service* (Harlow, 1995), C. Webster, *The NHS A Political History* (1998).

⁶ V. Berridge, 'Health and Medicine' in F.M.L. Thompson, (ed.), *The Cambridge Social History of Britain: 1750-1920* (Cambridge, 1990), N. Timmins, *The Five Giants: A Biography of the Welfare State* (Fontana, 1995), H. Jones, *Health and Society in Twentieth Century Britain* (Longman, 1994). C. Webster, (ed.) *Caring For Health: History and Diversity* (Milton Keynes, 1993).

⁷ S. Cherry, 'Beyond National Health Insurance: The Voluntary Hospitals and Hospital Contributory Schemes: A Regional Study', *Social History of Medicine*, 5, 3, (1992), 455-482. S. Cherry, 'Before the National Health Service, Financing the Voluntary Hospitals', *Economic History Review*, L, 2, (1997), 305-326. S. Cherry, *Medical Services and Hospitals in Britain 1860-1939* (Cambridge, 1996).

⁸ M. Gorsky, J. Mohan and T. Willis, 'Hospital Contributory Schemes and the NHS debates, 1937-46: The rejection of Social Insurance in the British Welfare State?', *Twentieth Century British History*, (2005), 16, 170-92. M. Gorsky & J. Mohan with T. Willis, *Mutualism and Health Care: British Hospital Contributory Schemes in the Twentieth Century* (Manchester University Press, 2006).

years following reforms made possible by the 1929 Local Government Act.⁹ Powell has suggested that the prevailing pessimistic view of municipal hospital care before the NHS should be reassessed.¹⁰ And John Stewart has provided an analysis of the development of inter-war municipal hospital policy in London noting the links between the Socialist Medical Association and the LCC.¹¹ Through this work a more dynamic picture of hospital policy in the pre-1948 era has begun to emerge. This chapter adds to this developing body of work through an examination of hospital policy in Sheffield in the decades before the NHS.

The guiding principles of the post war Labour government's NHS were to provide a health service that was tax-funded, universal, comprehensive and free at the point of use. The wartime Coalition's White Paper of 1944 proposed a national health service based on local government. However, to secure the support of the BMA for the new service, Bevan made a fundamental concession to the doctors and the leadership of voluntary hospitals in the 1946 NHS White Paper that hospital administration would be separate from local government.¹² The Sheffield example illustrates how local actors sought to address problems of finance and access using the policy instruments available at the time. Attempts were also made to incorporate grassroots democracy into hospital policy. Labour leaders in Sheffield in the 1930s recognised that the nation's hospital policy was problematic, that the service was inadequate, and believed that a service based on local government was the most sensible way forward. Events in the Second World War with the introduction of the Emergency Hospital Service (EHS) demanded joint working and better co-ordination of hospitals nationwide. This central government pressure during the emergency for the operation of hospitals as a system is seen as critical in accelerating the plans for a national health service.¹³ In Sheffield local co-ordination arrangements predated the EHS. Joint

⁹ M. Powell, 'An Expanding Service: Municipal Acute Medicine in the 1930s', *Twentieth Century British History*, 8, (3), (1997), 334-357. M. A. Powell, *Evaluating the National Health Service* (Buckingham, 1997). See A. Levene, M. Powell, and J. Stewart, 'The Development of Municipal General Hospitals in English County Boroughs in the 1930s', *Medical History*, 50, (2006), 3-28.

¹⁰ M. Powell, 'An Expanding Service: Municipal Acute Medicine in the 1930s', *Twentieth Century British History*, 8, (3), (1997), 334-357.

¹¹ J. Stewart, 'The Finest Municipal Hospital Service in the World? Contemporary Perceptions of the London County Council's Hospital Provision, 1929-39', *Urban History*, 32, 2, (2005), 327-344. J. Stewart, 'For a healthy London: The Socialist Medical Association and the London County Council in the 1930s', *Medical History*, 42, (1997), 417-436.

¹² C. Webster, *The Health Services Since the War, Volume 2: Government and Health Care* (HMSO, London, 1996), 274-6.

¹³ C. Webster, *The NHS: A Political History* (Oxford University Press, 1998), 6-7.

working between the two hospital sectors began in the 1920s and the Council developed the municipal hospital service extending agreements with the voluntary sector to operate a health service for Sheffield in the 1930s.

Certain features of hospital development in Sheffield in the period were unusual. Local authority hospital reform was driven by the belief of local politicians and local government officers that they had a mandate that pre-dated the Local Government Act of 1929, seeking justification for their actions in the provision of acute hospital care by citing the hospital clauses of the 1875 Public Health Act and the Sheffield Corporation Act 1918. The management of the voluntary hospitals in Sheffield was unusual in that the four hospitals came together under a Joint Hospitals Council, which oversaw a workers contributory scheme, and had a popular representative contributors' association - in itself this was not unusual, other large centres such as Liverpool and Birmingham had workers contributory hospital schemes. What was unusual was that the Sheffield scheme was graduated and featured a pro rata contribution from employers. The scheme also secured the backing of the local Labour movement. These features are examined below.

Hospitals 1918-1948

For the better off medical treatment in the early twentieth century was purchased through private practice, home nursing and in private nursing homes. For the rest of the population there were three main sources of hospital provision. Voluntary hospitals, municipal hospitals and Poor Law hospitals. The non-profit making charitable voluntary sector provided both specialist and general medical hospitals which were also teaching hospitals that were responsible for the training of doctors in association with universities. Voluntary hospitals were so called for three reasons: due to the honorary unpaid services provided by consultants, who built their reputations and client base through the prestige of being associated with hospitals; the hospitals were managed by volunteer Boards of Management who were generally drawn from wealthier subscribers, as Abel-Smith states 'hospitals were founded by persons of high standing in their local communities and governed by persons at the top or keen to approach the top of their social pyramid';¹⁴ although treatment was free the hospitals accepted voluntary gifts. Admission to voluntary hospitals was originally organised on a paternalistic basis through the use of 'subscriber's letters of recommendation', where those in need of treatment who were of good standing (i.e. the deserving poor) could obtain a ticket to be treated at a voluntary hospital from local worthies or employers who had paid a subscription towards the funds of the hospital.¹⁵

A local study of voluntary and municipal hospitals

Regional variations in hospital provision before the NHS have been noted as an important factor leading to the decision to nationalise the health service.¹⁶ In fact, Powell has noted that one of the few generalisations that may be made about the pre-war hospital system, is that it was difficult to generalise about.¹⁷ The importance of undertaking local case studies to contextualise and explain such regional variations in health provision has been recognised in John Pickstone's work on hospital developments before 1948 in

¹⁴ B. Abel-Smith, *The Hospitals: 1800-1948* (Massachusetts, 1964), 4-6.

¹⁵ J. Woodward, *To Do The Sick No Harm. A study of the British Voluntary Hospital System to 1875* (Routledge and Kegan Paul, London, 1974), 36-74.

¹⁶ M. Gorsky, J. Mohan, M. Powell, 'British Voluntary Hospitals, 1871-1938: The Geography of Provision and Utilization', *Journal of Historical Geography*, 25, (4), (1999), 463-482.

¹⁷ M. Powell, 'Hospital Provision Before the NHS: A Geographical Study of the 1945 Hospital Surveys', *Social History of Medicine*, 5, (1992), 483-505, 503.

Manchester and John Welshman's work on public health in Leicester.¹⁸ In Sheffield the key players involved in health and hospital administration included the local authority, the Labour movement, employers, the voluntary hospitals and the University. Steve Sturdy's work on the development of scientific medicine at the University of Sheffield, has described how medical teachers, in particular Professor Arthur Hall, made a conscious effort to ensure that developments in teaching and research between 1890 and 1922 were linked to wider social and political processes in the city including the analytical laboratory work of the local authority and the governance of voluntary hospitals.¹⁹ All of the Council Public Health Department's laboratory work was carried out by the University until 1947, Medical Officers of Health were made honorary Professors of Public Health until 1949 and the syllabus of both metallurgy and medicine, as well as research and consultancy, reflected the special circumstances of health and industry in a city reliant on metal trades.²⁰

This engagement of key players in health care with wider elements of social policy in Sheffield continued into the 1920s and 1930s. The University was actively involved in the events surrounding the formation of the workers contributory hospital scheme after the First World War - the 'Penny in the Pound Scheme.' The Vice Chancellor of the University of Sheffield, Sir Henry Hadow, was the Chairman of the Sheffield and District Joint Hospitals Council from its inception in 1919 until 1930.²¹ Sturdy has argued that the unusually high degree of involvement in civic affairs by the University of Sheffield in the early 1920s was a consequence of the fears of academics and medical practitioners, that the increasing Labour representation on the City Council would lead to political interference in health policy, namely the municipalization of hospitals and could therefore threaten their livelihoods.²² Research shows that these tensions continued into the 1920s and 1930s. An accommodation was made with Labour representatives that secured the development of one of the most successful contributory hospital schemes in the country and the management of relations between the local authority and the voluntary hospitals enabled the development

¹⁸ J.V. Pickstone, *Medicine and Industrial Society* (Manchester, 1985). Welshman, J. *Municipal Medicine: Public Health in Twentieth Century Britain* (Peter Lang, Oxford, 2000).

¹⁹ S. Sturdy, 'The Political Economy of Scientific Medicine: Science Education and the Transformation of Medical Practice in Sheffield, 1890-1922', *Medical History*, 36, (1992), 125-159.

²⁰ S. Sturdy, 'The Political Economy of Scientific Medicine: Science Education and the Transformation of Medical Practice in Sheffield, 1890-1922', *Medical History*, 36, (1992), 132.

²¹ Sheffield Joint Hospitals Council Minutes, 1919-1930, held at Westfield Health Scheme Sheffield.

²² S. Sturdy, 'The Political Economy of Scientific Medicine: Science Education and the Transformation of Medical Practice in Sheffield, 1890-1922', *Medical History*, 36, (1992), 145.

of a hospital service for Sheffield, one that fostered the development of a municipal hospital service. However, the Labour leadership throughout remained committed to the goal of a national health service based on local government.

Labour and Hospital Reform

In theory, the Labour movement was against the development of workers' hospital contributory schemes and in places such as Bradford, the trades council specifically refused to co-operate with the establishment of a contributory scheme.²³ Sommerville Hastings, the founding President of the Socialist Medical Association, MP for Reading, LCC Councillor and an influential figure on Labour Party policy for the municipalisation of health services, crystallised the Labour movement's view of voluntary hospital contributory schemes.²⁴ In the 1920s Hastings regularly condemned voluntary hospitals in the Labour press as undemocratic and cited workers contributory schemes as 'objectionable'.²⁵ This attitude was initially extant in Sheffield. In 1912 the Sheffield Trades and Labour Council called for the municipalisation of hospitals and passed a resolution condemning workers contributions to hospitals.²⁶ Yet, the Labour movement in Sheffield supported the voluntary hospital contributory scheme to an unusual degree. Asbury was briefly a member of the Sheffield Joint Hospitals Council in 1925 and 1926.²⁷ The Sheffield Trades and Labour Council held seats on the Joint Hospitals Council and Councillor Moses Humberstone, the Assistant Secretary of the Sheffield Trades and Labour Council, was President of the contributors' representative organisation the Sheffield and District Association of Hospital Contributors from 1920 until 1939.²⁸ This apparent ideological contradiction was not lost on the chief executive officer of the city council. In 1933 the Town Clerk Sir William Hart noted that:

²³ T. Willis. 'The Bradford Municipal Hospital Experiment of 1920: The Emergence of the Mixed Economy in Hospital Provision in Inter-War Britain', in M. Gorsky and S. Sheard, *Financing Medicine: The British Experience Since 1750* (Routledge, 2006), 130-144.

²⁴ J. Stewart. 'For a Healthy London: The Socialist Medical Association and the London County Council in the 1930s', *Medical History*, 42, (1997), 417-436.

²⁵ S. Hastings, 'Labour and the Hospitals', *Labour Magazine*, 3, 2, (1924), 54-56. S. Hastings, 'Nationalisation of the Hospitals', *Labour Magazine*, 4, 1926, 489-500.

²⁶ *Sheffield Telegraph*, 10 January 1912.

²⁷ *Annual Report of the Sheffield Joint Hospitals Council*, 1926.

²⁸ Minutes of the Sheffield Joint Hospitals Council (JHC), 1925-1926. Minutes of the Sheffield and District Association of Hospital Contributors, 1921-1948. Held at Westfield Health Scheme Sheffield..

... the interest of the workers has been aroused in the respect of voluntary hospitals, which in many cases would have had to be partially or wholly closed but for the efforts of the working classes to raise by individual weekly contributions among themselves the funds necessary for the support of the voluntary hospitals. Many of these helpers are strong party men and might naturally be expected to favour the transfer to the State or municipality of the voluntary hospitals, but so keen is their interest in the welfare of the hospitals that they are more than anxious to preserve their voluntary character and to render them whatever services they can.²⁹

Hart's reading of the situation reflected his involvement as a leading light in the British Hospitals Association, the national representative body of the voluntary hospitals. Hart's view acknowledged the large membership of the scheme, the involvement of Labour leaders in its administration and the vital role played by rank and file trade unionists in the operation of the scheme through wage deductions, collections and in workplace recruitment.³⁰ However, the involvement of the wider Labour movement in hospital contributory schemes, though significant, (estimated at ten million members at its peak), should not necessarily be read as whole-hearted support for the principles of the voluntary hospital sector.³¹ Labour leaders nationally and locally remained committed to a future health service based on local government. And on the nationalisation of the hospitals the Sheffield Trades Council was vehemently opposed to the continuation of the Hospitals Council under the NHS in the 1950s.³² In the 1930s William Asbury frequently cited his view that the municipalisation of all hospitals was the only sensible policy.³³ Writing in

²⁹ Sir W. Hart, 'A General Medical Service for the Nation', *Journal of the Royal Sanitary Institute*, LIV, 2, (1933), 61.57-63.

³⁰ Sir William Hart Sheffield Town Clerk, 1913-1931 was an expert on local government law. With W.O. Hart, he co-authored the contemporary standard textbook on the topic, *An Introduction to the Law of Local Government and Administration* (London, 1934). Hart was a leading light in the national organisation the voluntary hospitals, the British Hospitals Association, sitting on its Council until 1938 as well as its Legal and General Purposes Committees. In 1935 Hart moved the resolution for the BHA to establish the Committee of Enquiry 1935-1937, into the Position of the Voluntary Hospitals of the Country. The resulting Sankey Report recommended that contributory schemes be organised on a regional basis. Hart drafted the evidence of the Sheffield Hospitals Council to the Sankey Commission. Sheffield and District Regional Committee of the BHA, Minutes, 9 May 1935, 15 July 1935. Held at Westfield, Sheffield. British Hospitals Association, *Report of the Voluntary Hospitals Commission* (London, 1937).

³¹ A.T. Page. *Pennies for Health: The Story of the British Hospitals Contributory Schemes Association* (British Hospital Contributory Schemes Association, Birmingham, 1949).

³² See footnote 164.

³³ William Asbury stated in 1939, 'The only satisfactory approach to the [hospital] problem is for all hospitals intended for the acute sick to pass into the control of local authorities.' *Public Assistance*

1938 Asbury noted that despite recent developments, the hospital system was not perfect and suggested that; ‘the only satisfactory approach to the problem, is for all hospitals intended for the acute sick to pass into the control of local authorities. The arguments used by those who oppose local authority management of our hospitals today are very similar to those advanced in the past with regard to education, tuberculosis, maternity and child welfare and the care of the blind’.³⁴ The support of the Labour movement should therefore be read as expedient, pragmatic and temporary.

Voluntary hospital co-ordination

After the First World War there was a severe crisis in voluntary hospital funding. Both the Dawson (1920) and Cave (1921) Reports, recognised that the development of closer working arrangements between health care providers was essential.³⁵ The goal of co-operative working and co-ordinated hospital policy between the voluntary hospitals was a common theme of debates in health and hospital circles throughout the inter-war years.³⁶ Yet, in most places the tradition was for individual voluntary hospitals to compete for funds and act independently of each other. Part of the ‘hospital problem’ was that voluntary hospitals acted as single units in terms of finance, purchasing and training, which mitigated against the development of a system of meaningful co-operation and potential reductions in the overall burden of administrative costs through economies of scale.

In Sheffield this issue was dealt with swiftly after the First World War. Representatives of the medical staffs and the governing bodies of the city’s four voluntary hospitals, approached local industrialists, trade unionists, local government officers and City Councillors and formed the Sheffield Joint Consultative and Advisory Hospital

Journal and Health and Hospital Review incorporating the Poor Law Officers Journal, 17 March 1939, 297.

³⁴ W. Asbury, ‘The Future of the Public Health Services’, *Journal of the Royal Sanitary Institute*, 59, (1938), 727-740, 734.

³⁵ Consultative Council on Allied and Medical Services, *Interim Report on the Future Provision of Medical and Allied Services*, Cmnd 693, London, (1920). [Dawson Report]. Voluntary Hospitals Committee, *Final Report* (London, 1921). [Cave Report].

³⁶ See ‘Co-operation Among Voluntary Hospitals’, *BMJ*, 16 June 1923. ‘The Co-ordination of Hospital Services’, *Medical Officer*, 20 June 1931. ‘Hospital Co-ordination’, *Public Assistance Journal and Health and Hospital Review incorporating Poor Law Officers Journal*, Vol. XLIII, 14 September 1934, 895-896. D.C. Lamont, ‘The Hospital Services’, *Journal of the Royal Sanitary Institute*, LVI,

Council in 1919 (Sheffield Joint Hospitals Council from 1924) closely co-ordinating the operation of the four voluntary hospitals and establishing a workers contributory hospital scheme based on the pro rata contribution of 1d from each £ earned by members and securing the contribution of the employers of one third of the contribution of the employees.³⁷ From then on the voluntary hospitals no longer needed to make individual appeals to the public for funds. The formation of the Joint Hospitals Council removed the need for competition for hospital funds between the voluntary hospitals of the city. It also set the ground for greater inter-sector co-operation and the use of spare capacity in municipal hospitals through joint working arrangements.³⁸ The 'Penny in the Pound Scheme' operated from 1921-1948 and collected a total of five million pounds from workers and employers for the Sheffield hospitals.³⁹ Cherry's work on voluntary hospital finance in the years to 1939 has illustrated the importance of workers hospital contributory schemes in rescuing the fortunes of voluntary hospitals. Regional variations are also important here. Cherry has shown that for the 1930-36 period workers hospital contributory schemes were responsible for 12 per cent of voluntary hospital income in Bristol, 14 per cent in London, 40 per cent in Birmingham, 44 per cent of voluntary hospital income in Liverpool, and that in Sheffield the voluntary hospitals were reliant on the contributory scheme for 70 per cent of their income in the 1930s.⁴⁰

Early Years of the Sheffield Joint Hospitals Council

Before the First World War the four voluntary hospitals in Sheffield acted as independent entities. During the war the medical staffs worked together and a series of common problems came to light, such as mounting debts, bed shortages, the need to modernise the hospitals and the inadequacy of the existing hospital sites. The effect of the wartime co-operation prompted the joint honorary medical staffs in March 1919 to sign a letter addressed to the lay Boards of Management suggesting

No I, July 1935, 9-17.

³⁷ Sheffield Hospitals Council Incorporated, *Record of the Penny in the Pound Scheme* (Sheffield 1949).

³⁸ Minutes of Sheffield Joint Consultative and Advisory Hospitals Council, 14 June 1922 and Sheffield and District Association of Hospital Contributors, Quarterly Delegates Meeting 23 September 1925.

³⁹ Sheffield Hospitals Council Incorporated, *Record of the Penny in the Pound Scheme* (Sheffield 1949), 7.

⁴⁰ S. Cherry, 'Accountability, Entitlement And Control Issues and Voluntary Hospital Funding, 1860-1939', *Social History of Medicine*, 9, 2, (1996), 215-233.

that a joint hospitals council should be established for Sheffield, to address the problems facing the voluntary hospitals and particularly their respective sites which were 'dirty, noisy, insalubrious and lacking in the three most important requirements of wards for sick patients, viz; fresh air, sunshine and quiet'.⁴¹ At a meeting of the lay members of the Boards of the four voluntary hospitals on 3 July 1919 a resolution was passed stating that the Council should consist of 36 members and have five representatives from each of the hospitals (The Chairman of each hospital Board plus two medical and two lay members) five from the University of Sheffield, five from the Edgar Allen Institute (a physiotherapy institute) and five members representing the employers and workpeople of the city.⁴² The Lord Mayor was to be President of the Council. The Sheffield Consultative and Advisory Hospitals Council first met in the Lord Mayor's Parlour of Sheffield City Council on the 30 July 1919.⁴³ From then on the Council met at the Royal Hospital.

Sir Henry Hadow, the Vice Chancellor of the University of Sheffield was elected Chairman, a position he held until 1930. The Council decided on two objectives, to put the finances of the Sheffield voluntary hospitals on a sound financial footing and to make the people of Sheffield 'hospital conscious'. The Joint Hospitals Council was to be an advisory and consultative body in that executive authority remained with the four voluntary hospital boards. A range of sub-committees were set up to examine finance, beds, nursing and sites. A Publicity Committee and a General Purposes Committee were established in 1921. Even a collation sub-committee was established to collate the information from the other sub-committees.⁴⁴ The Joint Hospitals Council decided that consolidating all the voluntary hospitals onto one site with a single administrative board and staff would be a beneficial policy as it would 'develop team work, working in groups and specialization and would prevent economic waste.'⁴⁵ The objectives of the Joint Hospitals Council were set out in detail by distributing a questionnaire to the boards of the voluntary hospitals. The

⁴¹ Resolution Adopted at a meeting of the lay member of the Boards of the four Voluntary Hospitals, 3 July 1919. Sheffield Hospitals Council minute book held at Westfield Health, Sheffield.

⁴² Resolution Adopted at a meeting of the lay member of the Boards of the four Voluntary Hospitals, 3 July 1919. Sheffield Hospitals Council minute book held at Westfield Health, Sheffield.

⁴³ Sheffield Hospitals Council Incorporated, *Record of the Penny in the Pound Scheme* (Sheffield 1949), 7.

⁴⁴ Sheffield Hospital Council Committee Minute Books, held at Westfield Health Scheme, Sheffield.

questionnaire carefully established the aims and objectives of the Council, whilst reassuring the Boards that they should not be alarmed at the extent of the proposed reforms. It asked whether ‘the endowed funds of the voluntary hospitals should be placed under the Charity Commissioners’ to which the answer was ‘No’. It asked ‘should the government take over the hospitals or hand them over to Sheffield City Council’ to which the answer was also ‘No’. It also asked ‘would the public welcome a consolidation of funds, so that one contribution from an individual or firm could be made instead of several and would such a consolidation facilitate and increase the collection of contributions from workmen’s societies?’ To which the answer was ‘yes, if properly organised.’⁴⁶

A greenfield site at Norton was purchased with the intention of amalgamating the hospitals. The two general hospitals merged into one governing body in 1938, however the Norton site remained under developed and was only used as an auxiliary maternity centre. A Million Pound Appeal Fund was launched in 1938 for the purpose of building a new combined general hospital near the university. The intention was to raise a third from employers, third from employees and a third from subscribers to the League of hospital builders. A site was purchased in 1940, and architects appointed, however what became the Royal Hallamshire Hospital did not open until 1961 under the NHS. Half of the target was reached by 1948.⁴⁷

The Creation of the Penny in the Pound Scheme – Securing Labour Support

In the consultation exercise with the voluntary hospitals, the Joint Hospitals Council noted that the system where each of the voluntary hospitals made appeals for funds was ‘irritating to the public’ Fred Osborn (industrialist, Deputy Chairman of the Joint Hospitals Council from 1922-29 and Chairman of The Royal Hospital) as Chairman of the Finance Committee put forward the proposal for what became the ‘Penny in the Pound’ scheme. Osborn’s plan envisaged a scheme where contributions of a penny in each pound earned by workers in Sheffield industries should be

⁴⁵ Sheffield Joint Hospitals Council Minutes, 27 February 1920.

⁴⁶ Sheffield Joint Hospitals Council Minutes, 20 March 1920.

⁴⁷ Sheffield Hospitals Council Incorporated, *Record of the Penny in the Pound Scheme 1919-1948*

collected through payrolls to secure the financial position of the voluntary hospitals. The Osborn plan suggested that an employer contribution should be included of 3 shillings per employee per annum. It also called on trades unions, friendly societies, and co-operative societies to contribute 2d per member per annum. The circular initially stated that it was the policy of the Council to commend as an ultimate ideal the amalgamation [of the hospitals] on one site'.⁴⁸ However this clause was later dropped. The document noted the poor financial state of the hospitals, the burden of increased prices and the rise in nurses' wages. The proposed plan was issued to 100 leading firms in Sheffield and its district in the hope that they would 'give a frank expression of their opinions of the scheme as drafted'.⁴⁹ The Osborn document pointed out that the Chancellor of the Exchequer had recently stated that deductions of income tax were to be allowed for employers making charitable donations, this included donations to hospitals where the trader's employees received free treatment.⁵⁰

The Joint Hospitals Council sought the support of a wide range of civic representatives. This inclusive element was not merely a rational response to the problems facing voluntary hospital finance after 1918 or an exercise in camaraderie, it was essential if the scheme was to succeed. The scheme initially received a cool response from organised Labour. Eighteen months after the scheme was proposed the Hospitals Council met a deputation from the Sheffield Trades Council in the Winter of 1920. The trades council had been suspicious of the Joint Hospitals Council from its inception believing that any offers of worker representation on a body dominated by local businessmen and medical leaders was likely to be little more than tokenism. In its stance the trades council mirrored the general line of national figures in the Labour Party in the 1920s such as Somerville Hastings.⁵¹ Overtures were made to the

(Sheffield, 1949).

⁴⁸ Sheffield Voluntary Hospitals, Scheme for Raising Additional Income, 1920. Westfield Health Scheme Archives.

⁴⁹ Sheffield Voluntary Hospitals, Scheme for Raising Additional Income, 1920. Westfield Health Scheme Archives.

⁵⁰ In June 1921 the Secretary of the Chamber of Commerce wrote to the Chairman of the Hospitals Council explaining that the Income Tax exemption would be given regarding employers subscriptions to the scheme providing that the money was used for revenue and not capital expenditure. SHC Minutes June 1921.

⁵¹ See footnote 25.

trades council for support and a sub-committee was established by the trades council to consider the scheme. The sub committee was instructed to meet with the Hospitals Council and 'explain why we are opposed to their principles'.⁵² The three members of this trades council sub-committee, Mrs Wilkinson, Councillor Cecil Wilson and Councillor Alf Barton met the Hospitals Council in secret to give the Hospitals Council an opportunity to present its plan which had not been put before the full trades council. Any expression of support for the Hospitals Council by the trades council was therefore a highly sensitive issue. The sub committee reported that it was in full agreement with the Hospitals Council over the need to put the finances of the hospitals on a firmer footing. It proved its socialist credentials by pointing out that the voluntary hospitals did not provide the whole hospital service in the city, that the hospitals should receive aid from the Exchequer in the same way as the police and education services, it argued that the proposed scheme was weighted too heavily towards the subscriptions of the workers and that 'the general conclusion which the sub-committee had come to was that it would be an advantage for the hospitals to be Municipally controlled.'⁵³

The meeting with the representatives of the trades council appears to have developed into a socialist theoretical objection to voluntary hospital contributory schemes. The Hospitals Council record of the meeting states that 'it was found that it was not possible to deal with the somewhat abstruse questions of capital and income, introduced by the deputation, it was thought better to be dealt with by the Finance Committee.'⁵⁴ The main result of the meeting was that the Hospitals Council had opened a dialogue with the trades council, paving the way for an agreed solution and gaining the support of the Labour movement. When the two sides met again in November 1920, the trades council proposed changes to the plan. The delegation suggested that the STLC would be prepared to support the penny in the pound contribution from wages on the condition that three more trades council representatives were allowed onto the Hospitals Council, and crucially, on the

⁵² Sheffield Trades and Labour Council Minutes of the Executive Committee, 29 November 1920. Sheffield City Archives, LD 1638 MF A.159.

⁵³ Report of Sheffield Federated Trades and Labour Council on the Proposed Hospitals Scheme, Sheffield Hospitals Council Minutes, 13 October 1920.

⁵⁴ Sheffield Joint Hospitals Council, 24 November 1920. Held at Westfield Health Scheme.

condition that the scheme be altered so that the proposed 3s per annum per employee contribution paid by employers was replaced by a system where 'the employers would be willing to contribute one third of the amount raised by the workers'.⁵⁵ This was highly significant as no other contributory scheme adopted this system. The Birmingham Contributory scheme had a 25% employers contribution, which was not widely paid and a 2d per week flat rate workers contribution.⁵⁶ The Sheffield contributory scheme was organised on a pro-rata basis and the majority of Sheffield firms paid the one-third contribution. The trades council also persuaded the Hospitals Council to drop its call for trades unions, co-operatives and friendly societies to contribute to the scheme from their funds on the grounds that workers would be paying for the scheme twice.⁵⁷ The trades council recommendations were accepted without alteration and the circular sent to firms for consultation was revised and the scheme launched in April 1921. Securing the support of the Sheffield Trades Council was seen as crucial to the success of the contributory scheme, and the trades council had used its bargaining position to secure a major change to the design of the scheme.

The Hospitals Council was increased to 46 members in November 1920, when the three representatives of the Sheffield Trades and Labour Council were invited to join along with the Master Cutler and 6 others.⁵⁸ The signatures of the three Trades Council representatives were added to the new circular sent to firms and the scheme was successfully launched.⁵⁹ The support of the Labour movement was secured and the STLC printed an Annual Report on the progress of the Penny in the Pound Scheme in the Trades Council Annual Report for the 1920s and 1930s.⁶⁰ In 1921 the Assistant Secretary of the Trades Council, Moses Humberstone, requested a further three seats on the Hospitals Council.⁶¹ The Hospitals Council passed a resolution in

⁵⁵Minutes of the Hospitals Council, 20 December 1920. Minutes of the Sheffield Trades and Labour Council, 29 November 1920. Sheffield Trades and Labour Council Minutes of the Executive Committee, Sheffield City Archives, LD 1633-1642.

⁵⁶ *Birmingham News*, 31 December 1927.

⁵⁷ Minutes of the Sheffield Trades and Labour Council, 29 November 1920. Sheffield Trades and Labour Council Minutes of the Executive Committee, Sheffield City Archives, LD 1633-1642.

⁵⁸ Sheffield Joint Hospitals Council, Minutes, 24 November 1920.

⁵⁹ Minutes of the Hospitals Council, 20 December 1920.

⁶⁰ Sheffield Trades and Labour Council Minutes of the Executive Committee, Annual Reports, 1921-1929. Sheffield City Archives, LD 1633-1650.

⁶¹ This request was turned down as it would have required an alteration to the Constitution of the Hospitals Council. Sheffield Joint Hospitals Council Minutes 23 March 1921.

April 1921 stating that 'it is essential for the success of the voluntary scheme that in some form there should be direct representation of the works contributors on the Joint Hospitals Council and also on individual hospital boards.'⁶² The Hospitals Council reported that the Chamber of Commerce had agreed to publicise the scheme in its monthly journal and the trades council had consulted all branch secretaries of the Sheffield trades unions all replies had been positive except that of the A.E.U. which declined to recommend the scheme to its members.⁶³ By June the voluntary hospitals had agreed to increased representation on their governing boards for works contributors.⁶⁴

The organisation of the scheme was the responsibility of Sidney Lamb. He was employed as Organising Secretary of the Scheme in 1920 (a position he held until 1925 when he became the Secretary of the Merseyside Penny in the Pound Scheme). He also advised the Birmingham scheme in the mid-1920s when the Birmingham Hospitals established their contributory scheme.⁶⁵ Lamb was charged with the responsibility of organising the scheme suggested by Fred Osborn and revised by the Sheffield Trades and Labour Council representatives. Lamb's plans included the point that 'the penny in the pound contributed by employees would be a form of insurance, and would entitle them to institutional treatment, if admitted into hospital.'⁶⁶ This issue of the contributory schemes being a form of insurance with a robust notion of payment for entitlement was controversial. The new system replaced the system of recommendations where patients sought free treatment at the voluntary hospitals by presenting a letter of recommendation from a subscriber to the hospital. The system in 1921 was said to be 'out of date and largely ignored.'⁶⁷ Books of certificates were issued to firms whose employees contributed to the scheme, and the dependents of the contributor were also covered. The scheme therefore filled the gap in National Health Insurance arrangements which covered the contributor only, and generally did not include hospital benefit.

⁶² Sheffield Joint Hospitals Council Minutes, 23 March 1921.

⁶³ Sheffield Voluntary Hospitals Chairmen's Sub-Committee, 4 April 1921.

⁶⁴ Sheffield Joint Hospitals Council Minutes, n.d. June 1921.

⁶⁵ 'Voluntary Hospital Contributory Schemes', *The Hospital*, 33,1, (1927), 16-19.

⁶⁶ Sheffield Joint Hospitals Council, Minutes, 4 February 1921.

In 1929 the consultant medical staff of the hospitals recognised the importance of the scheme to the survival of the voluntary hospitals in Sheffield, however there were reservations regarding an over-reliance of the voluntary hospitals on the workers contributory scheme. In a memo to the Board of the Royal Infirmary, the medical staff stated:

From the point of view of the staff, the Penny in the Pound scheme has not been altogether satisfactory, though they fully recognise its immense importance to the hospitals. It has affected the income of the consultants adversely, by not being a purely charitable scheme, and having been exploited by people who are in no way objects of charity. It was and is perhaps presented to potential contributors as an insurance scheme and it was never meant to be the case. These abuses could be met by a proper and efficient system of almoning must be instituted if the consultant staff are to continue to exist ... perhaps make the Penny in Pound Scheme an insurance scheme on the lines of an approved society.⁶⁸

The staff of the Royal Infirmary believed that revenue from the scheme would decline over time as people began to pay for municipal hospital treatment through the rates. In fact the opposite happened and the hospitals came to rely on the scheme for their income. The medical profession was greatly concerned at the time over 'hospital abuse' i.e. that people who could afford to pay privately for treatment were using the contributory schemes. The Sheffield BMA had initially refused to support the scheme until an income limit had been fixed.⁶⁹ The Sheffield scheme was unusual in that it did not operate an income limit. The Association urged the medical profession not to press for an income limit for membership of the Penny in the Pound scheme, 'to avoid class distinction a policy of trust in the honour and good faith of the contributors should be encouraged.' O.B. Steward stated to Delegates that 'the scheme was launched for all classes of contributors without any question of an income limit. It is not fair to fix an income limit at this stage'.⁷⁰ The Royal Infirmary staff

⁶⁷ Sheffield Joint Hospitals Council, Minutes, 10 February 1921

⁶⁸ Memo from the staff of the Royal Infirmary to the Board of the Hospital 24 May 1929. In Town Clerks Department Correspondence, SCA 640/48.

⁶⁹ Sheffield and District Association of Hospital Contributors, Delegates Meetings, 15 February 1922. British Medical Association, Sheffield Division, Minutes 23 September 1923, SCA LD 2384 (5).

⁷⁰ O.B. Steward, Sheffield and District Association of Hospital Contributors, Delegates Meetings, 15 February 1922.

memo to the Board in 1929, pointed out that contrast between hospital income in the capital and Sheffield;

London draws on the charity of the whole country through the Kings Fund. The financial position of London cannot be applied to the rest of the country. The income of all the extra metropolis hospitals is little over double that of the London Hospitals. It is obvious from these facts that the voluntary element in London is infinitely stronger financially than in Sheffield. In Sheffield the financial strength of the voluntary system is dependent on the Penny in the Pound Scheme. If this fails the voluntary system must fail to support the Hospitals.⁷¹

The staff had no option than to recognise that the Penny in the Pound Scheme provided the finances of the voluntary hospitals, however the degree that the Hospitals relied on a workers' contributory scheme was a major concern. From the local government perspective, Asbury agreed that the scheme was considered as a form of insurance by its members and pointed out how its popularity had brought pressure on both sides of the hospital divide:

It was only to be expected that contributors on the workers' side would regard this as a form of insurance, and in increasing numbers they have asserted what they consider the rights of themselves and their families to be admitted to hospital without question when the necessity has arisen. The effect of this, particularly since 1930, has been that the services of the local authorities have been used to an ever increasing extent to supplement those of the voluntary hospitals.⁷²

The ambiguous nature of the schemes as quasi-insurance/charitable bodies was maintained until after the introduction of the NHS. Before the NHS the schemes avoided becoming insurance companies in order to maintain the charitable status of hospitals and benefit from philanthropic donations. The contributory scheme saw a transformation in the finances of the voluntary hospitals, so that by the mid-1930s the hospitals were able to

⁷¹ Memo from the staff of the Royal Infirmary to the Board of the Hospital, 24 May 1929. In Town Clerks Department Correspondence, SCA 640/48

⁷² W. Asbury, 'The Future of the Public Health Services', *Journal of the Royal Sanitary Institute*, 59, (1938), 733.

balance their budgets for the first time in 20 years.⁷³ For Moses Humberstone, the President of the Contributors Association there was 'no doubt that the Penny in the Pound Scheme has saved the voluntary hospitals of this city.'⁷⁴ The annual income from employees and employers was £112,021 in 1928, £193,902 in 1938 and £327,921 at the close of the scheme in 1948.⁷⁵ The amounts raised by individual establishments were not published, nor were the employers contributions published separately from employees. However, the employer's one third contribution was maintained throughout the lifetime of the Sheffield scheme. Minutes show that in 1924 employees contributed £60,000 to the scheme and employers £25,909.⁷⁶ The Annual Report for 1926 included lists of contributing firms who paid the 'full' one third employer's contribution and listed the small minority of firms where employers did not contribute.⁷⁷

⁷³ *Sheffield Telegraph*, 24 April 1935.

⁷⁴ *Sheffield Telegraph*, 24 April 1935.

⁷⁵ Sheffield Hospitals Council Incorporated, *Record of the Penny in the Pound Scheme 1919-1948* (Sheffield, 1949), 28.

⁷⁶ Sheffield and District Association of Hospital Contributors, Minutes of the Quarterly Delegates Meetings, 23 September 1925.

⁷⁷ Sheffield Joint Hospitals Council, Annual Report, 1926.

In its first 13 years the scheme raised £1,607,500 distributed as follows:

Table 5.1 Distribution of Penny in the Pound Scheme Income 1921-34⁷⁸

Destination of funds	Amount in £
Sheffield Voluntary Hospitals	1,095,900
Voluntary Hospitals in other districts	78,000
Public Authority Hospitals	12,700
Convalescent Service	99,250
Ambulance Service	52,450
Necessitous Patients Travel Expenses	13,000

The existence of the scheme allowed for greater co-operation between the two hospital sectors in the city. In June 1921 the Joint Hospitals Council illustrated that it was more than just a collection mechanism for the voluntary hospitals as it negotiated with the Poor Law Guardians to establish a scheme where vacant accommodation in Poor Law Infirmaries could be used by contributors. Under this early example of inter-sector hospital co-ordination a flat rate of 10s per patient week was paid by the Hospitals Council to the two Sheffield Boards of Guardians and no inquiries were made into the means of the patients. The issue of whether patients sent to the Poor Law Infirmaries were eligible to stand as election to the Boards of Guardians elections had to be settled. The Guardians requested that the cases received at the Infirmaries should not consist of an undue amount of chronic cases.⁷⁹

Following the voluntary hospitals financial crisis after the First World War the government established a special committee chaired by Viscount Cave. His Report of 1921, the Voluntary Hospitals Commission was charged with the distribution of a one off government grant of half a million pounds to all the country's voluntary hospitals.⁸⁰ In most places new local Voluntary Hospitals Committees had to be established to oversee the reception and distribution of each area's share of the grant. In Sheffield, as the Joint Hospitals Council had existed since 1919, a sub committee

⁷⁸ *Sheffield Telegraph*, 24 April 1935.

⁷⁹ Sheffield Joint Hospitals Council Minutes, 30 October 1921.

⁸⁰ Ministry of Health, *Voluntary Hospitals Committee, Final Report*, Cmd 1335, (London, 1921).

of the Hospitals Council was allowed to act as the local Voluntary Hospitals Committee under the Voluntary Hospitals Commission for the distribution of the Sheffield hospitals £22,050 share of the government grant.⁸¹ From 1924 the Joint Hospitals Council operated the ambulance service on behalf of the voluntary hospitals.⁸² In 1930 the service was merged with the municipal ambulances of the Watch Committee and St John's Ambulance so that until 1948 the Joint Hospitals Council operated the Central Ambulance Service for all hospitals, municipal and voluntary in a 20 mile radius of Sheffield.⁸³ The scheme successfully raised finance for hospitals from workers and employers, it encouraged joint working, acted as a distribution committee for the Cave Committee grant and ran the ambulance service for the city. Another aspect worthy of attention is its attempts at boosting the involvement of grassroots democracy in health care, Sheffield workers in large numbers were keen to get involved with a practical means of contributing to the social services of the city.

The Contributors' Association - 'Humanity not Democracy'.

The Joint Hospitals Council tapped into the strong working class associational life in Sheffield to ensure sustained support for the scheme and established The Sheffield and District Association of Hospital Contributors in 1921. The Sheffield Trades and Labour Council was instrumental in the establishment of the contributors' association. The S&DAHC acted as a pressure group within the hospital system, ensuring that workers were represented on voluntary hospital boards and that contributors had direct democratic involvement in the policy of the Joint Hospitals Council. Trades Council representatives requested that each of the contributing firms should send a delegate to a meeting at Victoria Hall on the 16 November 1921. Representatives from 264 contributing firms attended the first meeting.⁸⁴ It was decided that quarterly meetings of the delegates should be held. These meetings of the Sheffield and District Hospitals Contributors Council, (later the Sheffield and District Association of Hospital Contributors) were regularly attended by

⁸¹ Sheffield Joint Hospitals Council Minutes, 19 September 1921.

⁸² Sheffield Joint Hospitals Council, Annual Report 1924.

⁸³ Central Ambulance Service, Report and Statement of Accounts, 1938, Held at Westfield Health Scheme.

⁸⁴ Sheffield and District Association of Hospital Contributors, Delegates Meetings, 16 November 1921.

400-600 delegates in the 1920s.⁸⁵ Colonel Connell a Senior Surgeon at the Sheffield Royal Infirmary expressed the 'delight of himself and his colleagues on the valuable co-operation which the employees of the city were now giving in the reconstruction of the activities of the Voluntary Hospitals'.⁸⁶ However, in a telling sign that the medical elite wished to limit the potential increased workers involvement in hospitals, Connell urged 'that they would think of the work of the hospitals more as Humanity than of Democracy.'⁸⁷ The Association on the other hand, felt that the huge interest expressed by the contributors should indeed lead to greater degree of democracy and 5 contributor nominees were elected to serve on the voluntary hospital boards. This was increased to 10 in 1922 and 19 by 1926.⁸⁸

The Association was based on workplaces with its committees organising payroll collections or deductions as well as running fundraising events and fetes. Each section of 500 or fewer contributors was allowed to send one delegate to the quarterly delegates meetings. Councillor Moses Humberstone Assistant Secretary of the Sheffield Trades and Labour Council was elected President and O.B. Steward the Company Solicitor of the Derwent Water Board, was elected Vice-Chairman. Steward was influential in the wider contributory schemes movement and became Vice President of the British Hospitals Contributory Schemes Association from 1942-1947.⁸⁹ The mass meetings of the Association elected an Executive Committee with 17 members, 5 of whom sat on the Hospitals Council. The objectives of the Sheffield and District Association of Hospital Contributors as set out in its constitution were to:

conduct active propaganda work in support of the Scheme; to
enlist regular subscribers to the scheme; to voice the views of the
contributors, members of the Association and their dependents; to

Records at Westfield Health Scheme.

⁸⁵ In 1922 600 people attended the Association's fourth Quarterly Delegates meeting, 350 people attended its AGM in 1924, 300 delegates attended the 100th Quarterly meeting in 1946. Sheffield and District Association of Hospital Contributors, Delegates Meetings, 26 July 1922, 5 March 1924, 3 December 1946, Records at Westfield Health Scheme.

⁸⁶ Sheffield and District Association of Hospital Contributors, Delegates Meetings, 16 November 1921. Records at Westfield Health Scheme.

⁸⁷ Sheffield and District Association of Hospital Contributors, Delegates Meetings, 16 November 1921. Records at Westfield Health Scheme.

⁸⁸ Sheffield Hospitals Council Annual Report, 1922 and 1926. Records at Westfield Health Scheme

⁸⁹ A.T. Page. *Pennies for Health: The Story of the British Hospitals Contributory Schemes Association* (British Hospital Contributory Schemes Association, Birmingham, 1949), 11.

watch over the interests of these contributors and their dependents; to secure efficient adequate and prompt treatment, so far as the accommodation of the hospitals will allow of contributors and dependents, as a means of carrying out the work of the association effectively to secure adequate representation of the Association and its members on the Sheffield Joint Hospitals Council and on the Boards of the Hospitals. As an Association actively interested in Hospital work – to assist in every way possible to work in conjunction with the Sheffield Joint Hospitals Council on behalf of the Sheffield and District Voluntary Hospitals; and in particular (and having specially in mind necessary extensions of hospital accommodation and the provision of convalescent treatment) to provide means for meeting the needs of those members of the community who, suffering in any way from sickness or ill-health, may by reason of poor circumstances due to unemployment or any other cause, be in need of help.⁹⁰

In 1922 the Association secured the payment of travel and loss of earnings expenses to ensure that working people could attend meetings of hospital business. It pressed the Hospitals Council to urge the hospitals to accept OAPs, the unemployed and children under 12 for free treatment at the Sheffield hospitals. By 1922 the Chairman announced that the meetings had grown so large that it was necessary to decentralise. The Association passed a resolution to annually elect area-based Ward and District Committees. The number of contributors at the time was given as a conservative estimate of 100,000. By 1922 there were 132,000 contributors 28,000 of those were from outside Sheffield.⁹¹

In 1935 the Sheffield Hospitals Council became an Incorporated Company Limited by guarantee, and was administered by a Committee of Management that reflected the regional operation of the scheme. This consisted of 59 members: 9 from Local Authorities (3 from Sheffield 1 from Rotherham, Barnsley, Doncaster, West Riding, Derbyshire, Nottinghamshire), 5 from employers, 12 from trades councils (7 from Sheffield 1 from Rotherham, Barnsley, Doncaster, Worksop, Chesterfield) and 9 others (including the BMA, the press and the university). By far the largest group

⁹⁰ Sheffield Hospitals Council Incorporated, *Record of the Penny in the Pound Scheme 1919-1948* (Sheffield, 1949), 21.

⁹¹ Sheffield Hospitals Council Minutes, 26 July 1922.

represented on the Council was the Association of Hospital Contributors with 24 seats on the Council.⁹² By 1935 the Voluntary Hospital board representatives on the Committee of Management of the Hospitals Council were all members of the Contributors' Association.

The degree of grassroots democracy employed by the Association was challenged in 1939. In a story headlined 'Ruled from the top', The *Sheffield Telegraph and Independent* reported on the quarterly Delegates meeting of Contributors' Association. A delegate argued that the decision being discussed at the meeting - to excuse contributors serving in the armed forces from payments to the scheme for the duration, should be referred to the individual works hospitals committees. Mr L. Hinchcliffe said that he was in agreement with the resolution but he that argued a greater principle was at stake. Hinchcliffe stated 'may I suggest that we are fighting for democracy to be maintained in this organisation.' O.B. Steward, President of Association, said that it had never been agreed that 'delegates should attend as robots'. He argued that the 'Association was democracy in action as the government of the Association was in the hands of the delegates. When are you going to get anything done' he added 'At a critical time like this it is beyond thought that you should take back everything of importance to get instructions from a works committee.'⁹³ The Hinchcliffe resolution was defeated. However it illustrated the degree to which some contributors in Sheffield wished to exercise control.

At the close of the Penny in the Pound Scheme in 1948, it had 350,000 contributors.⁹⁴ As dependents were included it is safe to assume that close to a million people were covered for hospital treatment in Sheffield and its surrounding district. The success of the scheme made it central to supporting the voluntary hospitals in Sheffield and its popularity as a mass movement fostered a spirit of partnership in which municipal and voluntary hospital relations could operate as a functioning interdependent hospital system in the years before the NHS.

⁹² Memorandum and Articles of Association of the Sheffield and District Convalescent and Hospitals Services Council (Incorporated), (1935), 11. Held at Westfield.

⁹³ *Sheffield Telegraph and Independent*, 30 October 1939.

⁹⁴ Sheffield Hospitals Council Incorporated, *Record of the Penny in the Pound Scheme* (Sheffield 1949).

Local Authority Hospitals

Local authority involvement in the provision of hospitals developed from a service which consisted initially of hospitals which were a legal requirement for the treatment of infectious diseases and tuberculosis, to become a fully fledged municipal general hospital service offering specialist treatment, resident medical officers and a casualty department. The 1875 Public Health Act empowered local authorities to provide hospitals for infectious disease cases. The 1911 National Insurance Act allowed local authorities to establish sanatoria for tuberculosis patients.⁹⁵ These hospitals in Sheffield were Lodge Moor Infectious Disease Hospital, The Winter Street Hospital, Commonsides Sanatorium, and Crimicar Lane Sanatorium. The Council also ran a hospital for non-pulmonary TB cases, King Edward VII Hospital.⁹⁶

As voluntary hospitals were primarily for the non-infectious 'interesting' cases that were useful for teaching, hospitals for the elderly, infirm chronic sick and destitute were provided under statutory arrangements through the poor rate in association with workhouse arrangements and were overseen by Poor Law Boards of Guardians prior to 1930. As Powell has pointed out it was this sector that held the majority of hospital beds.⁹⁷ Under the Local Government Act of 1930 Poor Law functions were transferred to the Public Assistance Committees of local authorities. The Ministry of Health encouraged local authorities to administer hospitals through Health Committees rather than the administrative machinery of poor relief, although the reality in many places was that former poor law infirmaries remained under the control of the Public Assistance Committees until the introduction of the NHS. In Sheffield the Poor Law hospitals were attached (although physically separate from 1906) to workhouse institutions at Nether Edge and Fir Vale.⁹⁸ It is well known that, like other large cities, the municipal hospitals of Sheffield were

⁹⁵ L. Bryder, *The Magic Mountain: A Social History of Tuberculosis in the Twentieth Century* (Oxford, 1988).

⁹⁶ Sheffield City Libraries Department of Local History and Archives, *The Sheffield Hospitals* (Sheffield, 1959).

⁹⁷ M. Powell, 'An Expanding Service: Municipal Acute Medicine in the 1930s', *Twentieth Century British History*, 8, (3), (1997), 334-357.

⁹⁸ Sheffield City Libraries Department of Local History and Archives, *The Sheffield Hospitals*, (1959).

appropriated quickly under the Health Committee in 1930.⁹⁹ What is less known is that that Council had a different view of the legitimacy of this process. The important principle of independent local government action was stressed by the Chairman of Health Committee and the chief executive officer of the Council, as Sheffield Council claimed that it was transferring the responsibility for the hospitals to its Health Committee under pre-existing Sheffield local government legislation and nineteenth century Public Health legislation and not under new national legislation. The Council claimed that in taking action to develop its hospitals, it was informing the Ministry of Health of its intentions almost as a matter of courtesy. The Chairman of the Health William Asbury and The Town Clerk Sir William Hart visited the Ministry of Health in March 1930. They informed the Ministry that the appropriation of the former workhouse hospitals was to take place under Section 249 of the Sheffield Corporation (Consolidation) Act 1918 and Section 131 of the Public Health Act 1875. Quoting this earlier legislation - while being mindful that the Ministry of Health had the legislative power to reduce block grant finance - the Town Clerk and the Chairman of the Health Committee stated that 'it was not necessary therefore to obtain the approval of the Ministry. At the same time we thought that the Ministry should be informed of our action.'¹⁰⁰

Prior to the 1929 Local Government Act, there were signs of how the Labour Council would approach hospital policy. As part of the reform of the Health Committee introduced by Labour immediately after their election in 1926, the Hospitals Sub-Committee of the Health Committee and the Tuberculosis Committee were merged into one body which first met in April 1927.¹⁰¹ Prior to 1930 the main work of the Hospitals Sub-committee was to deal with infectious disease arrangements such as the agreement with the Poor Law Guardians for the use of Nether Edge Poor Law Infirmary for tuberculosis patients. The Committee was also concerned with issues arising from the dispute between the residents of Nether Edge who objected to the presence of patients in the suburb and with the establishment and administration of the tuberculosis re-housing policy.¹⁰²

⁹⁹ A. Levene, M. Powell and J. Stewart, 'The Development of Municipal General Hospitals in English County Boroughs in the 1930s', *Medical History*, 50, (2006), p27 Appendix, County Borough General Hospital Accommodation and Appropriation Dates.

¹⁰⁰ W.E. Hart memo 19 March 1930, SCA/640/46, Sheffield Council Town Clerk's Department Correspondence with Ministry of Health Relating to Local Government Act 1929.

¹⁰¹ Sheffield City Council Hospitals Sub-Committee, Minutes, 21 April 1927, SCA 39 (49).

¹⁰² See Chapter 3.

In April 1927 the Hospitals Sub-committee instructed the City Treasurer to cease to collect payments from parents for maintenance costs of children with tuberculosis treated at King Edward VII Hospital. From the time of the opening of the hospital in 1916 until April 1927 parents had been asked to contribute on a sliding scale under Section 132 of the Public Health Act 1875.¹⁰³ Payments were not sought from pauperised parents, however the Hospitals Sub-Committee believed that the hospital fees should cease to be collected for all patients due to 'the small amount obtained from this source towards the maintenance of patients ... due to the difficulty of collecting, but largely due to the fact that the position of so many parents was so financially poor that it was impossible to ask them to contribute anything'.¹⁰⁴ The Ministry of Health initially disagreed with the policy of free treatment, yet when the Council pointed out that King Edward VII Hospital was not the only local authority hospital in Sheffield where children were treated for tuberculosis without charge, the Ministry stated that it had no further objection. The Medical Superintendent of the Hospital urged the Hospitals Sub-committee to consider the fact that since payments had ceased parents had been encouraged to let their children remain in the hospital, whereas in the 1920-1922 period 20 patients had been removed against the advice of the Medical Superintendent, once charges had been abolished no patients had been removed in this way.¹⁰⁵

In the appropriation plans for the Sheffield Poor Law hospitals the Hospitals Sub-committee of the City Council went to lengths to ensure that all traces of Poor Law administration were obliterated.¹⁰⁶ The preparations included instructions that the patient case papers and bed cards used at Nether Edge Hospital and the City General Hospital should be the same for all classes of patient in an effort to emphasise that local authority hospital care was distinct from the Poor Law.¹⁰⁷ The Committee went on to state that 'the name of the Sheffield Union on notice boards, stationary, linen etc. be obliterated where reasonably practicable and the Sheffield City General Hospital be substituted therefore.'¹⁰⁸ Despite calling for a more positive interpretation of local authority hospitals, Powell has

¹⁰³ Sheffield Borough Council Hospitals Sub-Committee Minutes, 21 March 1929, SCA 39, (50).

¹⁰⁴ SCC Hospitals Sub-Committee Minutes, 21 March 1929, SCA 39, (50).

¹⁰⁵ SCC Hospitals Sub-Committee Minutes, 21 March 1929, SCA 39, (50).

¹⁰⁶ The records of the two Poor Law Unions for Sheffield are no longer in existence. Archivists have suggested various reasons for their conspicuous absence from the Sheffield city archives including that they were destroyed by a flood, lost in the Blitz or deliberately destroyed by the Labour Council.

¹⁰⁷ SCC Hospitals Sub-Committee Minutes, 20 February 1930, SCA 39, (51).

pointed out how in some places hospital appropriation could mean little more than a change in the name over the door. Using the Wartime Hospital Surveys Powell has noted that the former workhouse infirmary in Sheffield, Nether Edge Hospital, had by 1945, still 'neither an operating theatre nor X-ray facilities and still primarily housed the chronic sick'.¹⁰⁹ However, analysis of local sources from the 1920s and 1930s illustrates how the local authority in Sheffield went to lengths to develop Fir Vale Poor Law Hospital as the City General Hospital – which became a fully functioning general teaching hospital integrated in to the acute hospital services of the city.

Joint Working and the Notorious Section 13

In 1945 the Ministry of Health Hospital Survey for the Yorkshire Region noted that 'apart from the natural desire to retain powers and activities which have developed in individual hospitals, there is often a suspicion of the aims of the "other side" which has tended in many districts to make an approach on a basis of mutual confidence difficult.'¹¹⁰ The Wartime Survey for Sheffield and the East Midlands was more blunt, stating that co-operation between the voluntary and municipal hospitals had 'been infrequent and ineffective.'¹¹¹ Charles Webster has noted that it was 'only in isolated instances such as Liverpool, Manchester and Oxford that extensive co-operation took place.'¹¹² Sheffield has been overlooked as a place where good working relationships between individuals and institutions led to a high degree of hospital co-ordination.

The formation of the Sheffield Municipal and Voluntary Joint Hospital Consultative Committee in 1930 illustrated the manner in which the two sectors were capable of joint consultation and joint action in the city. The formation and functioning of this committee was a practical realisation of advice suggested by central Government, which called for the closer co-ordination of health services. This was an era of central government financial retrenchment and health reform at arms length, where the Ministry of Health encouraged

¹⁰⁸ SCC Hospitals Sub-Committee Minutes, 20 February 1930, SCA 39, (51).

¹⁰⁹ M. Powell, 'An Expanding Service: Municipal Acute Medicine in the 1930s', *Twentieth Century British History*, 8, (3), (1997), 345.

¹¹⁰ H. Eason, R. Veitch-Clark, W.H. Harper, *Ministry of Health Hospital Survey: The Hospital Services of the Yorkshire Region*, (London, 1945), 19.

¹¹¹ L.G. Parsons, S. Clayton Fryers and G.E. Godber, *Ministry of Health Hospital Survey: The Hospital Services of the Sheffield and East Midlands Area* (HMSO, 1945), 8.

and suggested local action without the introduction of a state medical service or the initiation of large scale health care reform. The Minister of Health had called on voluntary hospitals and local authorities in the late 1920s to pursue a policy of greater co-ordination in the provision of hospital services.¹¹³ Legislation to promote closer co-operation between both sides of the hospital divide was introduced through Section 13 of the Local Government Act 1929.¹¹⁴

Section 13 was a late addition to the Act included as a House of Lords amendment inserted at the insistence of the voluntary hospital leadership and the medical profession. Webster has argued that Section 13 was a mere afterthought and that 'apart from isolated instances where local circumstances were favourable to co-operation, section 13 remained a dead letter.'¹¹⁵ The clause caused some consternation among the developing municipal hospital sector as it called for the municipal authorities to consult with the voluntary hospitals, but not vice versa. Asbury noted in 1938:

I am aware that under the Local Government Act, 1929, local authorities were compelled to consult with voluntary hospitals in their respective areas with regard to future extensions and development. I do not remember any obligation being imposed on the voluntary hospitals to consult with the local authorities, and this seems to me a one sided arrangement.¹¹⁶

¹¹² Webster, *Health Services Since the War*, (1988), 20.

¹¹³ In a number of public speeches in the late 1920s, the Minister of Health Neville Chamberlain repeatedly urged closer co-operation between the voluntary hospitals which often stood as independent units that were competing for patients and funds, and closer working relations between the voluntary and public health hospitals. The BHA asked for clarification on this matter. In a letter to the BHA in 1927, Sir Arthur Robinson of the Ministry of Health, set out a series of questions for hospital committees to consider. Robinson to BHA, 15 February 1927, Sheffield and District Regional Committee of the BHA, Minutes, 27 May 1927. Held at Westfield Health Scheme, Sheffield.

¹¹⁴ Section 13 of the Local Government Act 1929 stated: 'The Council, of every County and County Borough Council shall when making provision for hospital accommodation in the discharge of their functions transferred to them under this part of the Act, consult such committee or other body as they consider to represent the governing body and the medical and surgical staffs of the voluntary hospitals providing services in order of benefit to the County or County Borough as to the accommodation to be provided and as to the purposes for which it is to be used.' Local Government Act 1929 19 & 20 Geo c. 17.

¹¹⁵ Webster, 'Conflict and Consensus', 126.

¹¹⁶ W. Asbury, 'The Future of the Public Health Services', *Journal of the Royal Sanitary Institute*, 59,

In many places Section 13 was nothing more than a dead letter. Articles appeared in the public health press on 'The Notorious Clause 13'.¹¹⁷ By 1934 29 County Councils and 46 of the 79 County Boroughs in England had been recorded as making 'reasonably satisfactory' arrangements for joint working, 16 County Councils and 21 County Boroughs had taken 'preliminary steps' towards the establishment of joint committees, and 14 County Councils (14%) and 14 County Boroughs (17%) had done nothing towards the development of joint working between the municipal and voluntary hospital sectors under Section 13.¹¹⁸ In Manchester a Joint Committee was not established until 1934.¹¹⁹ In Leeds the municipal hospitals were still under the control of the Public Assistance Committee in 1934 with initial meetings held in 1936 to discuss the possibilities of joint working arrangements between the two hospital sectors.¹²⁰ However, in Sheffield the attitude was 'why stop at consultation'.¹²¹ This obscure clause became a significant catalyst in the effort to develop a hospital service in the city. The Parliamentary and General Purposes Committee of Sheffield City Council invited representatives from the governing bodies and the medical and surgical staffs of the four voluntary hospitals to a preliminary conference at the Town Hall on the 6 June 1929 to discuss the implications of Section 13 of the Local Government Act 1929.¹²² The Sheffield Municipal and Voluntary Hospitals Joint Advisory Committee was established with 14 representatives of the City Council and 14 representatives of the voluntary hospitals.¹²³ The first meeting of the new committee was held on 14 June 1930, however unlike other places, the various elements of the hospital authorities in Sheffield were preparing for these aspects of the new legislation throughout 1929.

(1938), 734.

¹¹⁷ The clause was seen as badly drafted and ineffectual in legislating for co-operation between the voluntary and municipal sectors. 'The Notorious Clause 13,' *The Hospital*, XXXII, 6, (June 1936).

¹¹⁸ PRO MH 58 209 Local Government Act 1929, Hospital Accommodation and Services: Co-operation Between Local Authorities and Voluntary Hospitals, 1934.

¹¹⁹ J.V. Pickstone, *Medicine and Industrial Society: A History of Hospital Development in Manchester and its Region, 1752-1946* (Manchester University Press, 1985), 279-93.

¹²⁰ Notes on Proceedings of a Conference Between the Health Committee of Leeds City Council and Representatives of the Voluntary Hospitals Council, 3 December 1934. Meeting to Discuss the Co-ordination of Hospital Services held at Leeds Civic Hall 19 October 1936. Leeds Local Studies Library LQP 362.11 L517.

¹²¹ Sir W. Hart, 'Hospitals as Affected by the Local Government Act, 1929', *Journal of the Royal Sanitary Institute*, L, 7, (1930), 49.

¹²² Sir Wm. Hart to J. Barnes, 7 May 1929. SCA 640/48, City of Sheffield Town Clerk's Department Correspondence.

¹²³ Minutes of the Sheffield Municipal and Voluntary Hospitals Joint Advisory Committee. 14 January 1930, SCA 201 (2).

The Sheffield Municipal and Voluntary Hospitals Joint Advisory Committee was set up in January 1930 with annually alternating chairmen from the City Council and from the voluntary hospital boards with Ernest Rowlinson and William Asbury acting as Chairman and Deputy Chairman for the first year of operation.¹²⁴ Where the establishment of co-operative working practices between the voluntary and municipal hospital sectors remained nothing more than a goal in many places in the 1930s, in Sheffield agreements reached between the Boards of Guardians and the voluntary hospitals in the early 1920s for the treatment of subscribers to the Penny in the Pound Scheme at Poor Law Infirmaries when there were no spare beds at the voluntary hospitals were developed in the 1930s as the municipal and voluntary sectors became increasingly interdependent.

The municipalisation and co-ordination plans for Sheffield were discussed by the Town Clerk, William Hart and the Ministry of Health. The Ministry felt that a new entrance should be provided at the City General and that any agreements reached with the voluntary hospitals 'should be of a simple nature so that if it is desired they can be extended.'¹²⁵ The City General was described as well equipped, staffed by a full medical officers and nurses 'extra surgical and medical assistance being afforded by two consultants each of whom receives a fixed annual retaining fee.'¹²⁶ The Council recognised the sensitivities involved in opening a municipal general hospital and went to lengths to call for a spirit of co-operation with the voluntary hospitals. The over-riding aims of joint working were to reduce waiting lists, make the best use of consultant and specialist services and open a useful dialogue between the two sectors.

As well as the drive to 'obliterate' the name of the Poor Law Union from municipal hospitals, the issue of managing relations between the public sector and voluntary sector hospitals had to be settled. The joint staffs of the Voluntary Hospitals made their position clear to the Town Clerk William Hart in 1929, stating that:

¹²⁴ Minutes of the Sheffield Municipal and Voluntary Hospitals Joint Advisory Committee. 1930-1948, SCA 201 (2).

¹²⁵ Memo by Hart Re: meeting at Ministry of health with H.W.S. Francis, 12 June 1929.

¹²⁶ Memo on Hospital Policy under LGA 1929, 20 June 1929, Town Clerks Department Correspondence, SCA 640/48.

The possibility of the admission of all and sundry to a Municipal Hospital whatever their means, would be a serious matter for the consultants of the city and would ultimately render it impossible to attach men of such high attainments as is essential for the well being of all sections of the community should be encouraged to take up work in Sheffield. There is no desire on the part of the Boards and staffs of the Voluntary Hospitals to check the development of the Municipal Hospitals, or to use them as a dumping ground for routine and uninteresting cases. They are actuated only by the desire to secure for Sheffield and its neighbourhood a health service of the highest efficiency and to ensure that all the partners in such a service should pull their weight to the full.¹²⁷

As with their fears over the reliance of the hospitals on the Contributory Hospital Scheme, the consultants were concerned that a developed Municipal Hospital service was a possible threat to their livelihoods. But, both sides of the hospital divide had something to offer in a joined up relationship. The voluntary hospitals had the expertise and consultants while the municipal sector had a municipal cash injection to develop new facilities at the City General and provided potential access to the medical profession of useful 'teaching material'.¹²⁸ Despite the reservations of the staff and the views of Asbury a pragmatic arrangement was brokered. Where joint working arrangements in other cities stalled, in Sheffield the agreement for the two hospital sectors to co-operate seems to have been straightforward. In June 1929 John Barnes the General Superintendent and Secretary of the Royal Infirmary passed on to the Town Clerk a confidential memo by the honorary staffs of the four voluntary hospitals relating to the 1929 Local Government Act. The staff pledged their wholehearted support for a scheme administered by voluntary and municipal hospital representatives to provide a hospital service for the city that could act as an exemplar to the country for future reform:

... the scheme should not present any great insuperable difficulties. In fact the staffs would even go further than this – they think that the opportunity now presents itself for Sheffield to give a lead to the country as regards providing an ideal scheme of hospital

¹²⁷ Report of Voluntary Hospitals Re: Co-ordination of Voluntary and Municipal Hospitals, n.d. circa. 1929, Town Clerks Department Correspondence, SCA 640/48.

¹²⁸ Memorandum by the Honorary Staffs of the Sheffield Voluntary Hospitals for Presentation to the Sheffield Municipal and Voluntary Advisory Committee, 5 April 1938. PRO MH 58/319.

service to bring together under one control all existing hospitals of the city together with the allied medical services and by so doing to provide a scheme which would probably not be excelled in the whole country.¹²⁹

The attitude of the medical staff of the hospitals in Sheffield was that as long as they were not directly controlled by the local authority and if an equally weighted, arms length body could be set up, they were more than happy to engage in joint working. In reply to the voluntary hospitals proposals the Town Clerk pointed out that the Council was in agreement with the medical community that the situation offered an opportunity to develop a hospital service for the city. In his role as mediator, Hart reassured the staff of the Voluntary Hospital that the Council was not proposing the municipalisation of all the city's hospitals, at the same time he made it plain that the Council did not intend to allow the voluntary sector a say in the management of the municipal hospitals;

the Corporation do not wish in any way to control the administration of the voluntary hospitals nor do they wish at all to surrender or share the control of municipal hospitals. Here it may be said that the Corporation do not wish to co-opt non-Council members on any Committee entrusted with the management of the hospitals.¹³⁰

The realisation of the plan required skilful diplomacy to reassure the medical staff of the voluntary hospitals that the two sides of the hospital divide in Sheffield could co-exist without one side swamping the other. As a result municipal and voluntary hospitals in Sheffield became increasingly inter-dependent in the 1930s and 1940s. The influence of key players; the Town Clerk, the Chairman of the Health Committee, the Contributory Scheme, the leading consultant at the Royal Hospital, the medical staff and the Medical Superintendent of the municipal hospitals all played a part in organising the available resources at their disposal into a functioning health service for Sheffield. Operationally there were two key elements to making the joined up system work, through the contributory scheme and direct liaison between the two sides of the hospital divide.

¹²⁹ John Barnes (Secretary of Sheffield Royal Infirmary to William Hart Sheffield City Council Town Clerk) 4 June 1929, in Town Clerks Department Correspondence, SCA 640/48.

¹³⁰ Notes on the memorandum of the Boards and staffs of the four Sheffield voluntary hospitals on hospital policy under the Local Government Act 1929, 20 June 1929, Town Clerks Department

The Sheffield Municipal and Voluntary Hospital System

In April 1930, representatives of the City Council including the Chairman of the Health Committee William Asbury, and the Chairman of the Hospitals Sub-Committee J.A. Longden, met members of the Sheffield Hospitals Council including the Chairman of the Joint Hospitals Council, Fred Osborn, Miss Gillott of the Association of Hospital Contributors and C.R.C Crabtree the Secretary of the Joint Hospitals Council. The meeting was to establish whether it was possible to set up a working arrangement between the City Council and the Joint Hospitals Council whereby contributors to the Penny in the Pound Scheme would be accepted free of charge at the City General Hospital now that the hospital; was under the control of the Health Committee and no longer part of the Poor Law.

The problem was that patients could be repeatedly paying for hospital treatment through the rates, through the contributory scheme and through charges. The meeting was to seek the views of the Joint Hospitals Council regarding the admission of scheme members in relation to Section 16 of the Local Government Act 1929 which stated that local authorities had to seek payment from patients in local authority hospitals towards maintenance costs where the patient was being treated for illness other than infectious disease. Asbury was keen to establish a new agreement under Section 16 of the Act, and not rely on agreements previously made between the Guardians and the Hospital Council where liable relatives had been charged for the maintenance of patients who were members of the Penny in the Pound Scheme. The Hospitals Council representatives stated that they were not in a position to make an arrangement whereby payments went to the City Council. The Joint Hospitals Council preferred to retain the former practice under the Guardians where the Joint Hospitals Council had reimbursed the contributor for the sum that had been assessed on him or his relatives who were treated in the Fir Vale Infirmary/City General Hospital.¹³¹

Correspondence, SCA 640/48.

¹³¹ Sheffield Borough Council Hospitals Sub-Committee Minutes, 16 April 1930, SCA 39, (51).

By 1932 the *Medical Officer*, reported that 'An agreement between Sheffield Health Committee and Sheffield Hospitals Council will enable any resident within the scope of the Penny in the Pound Scheme to obtain admission to Sheffield city general hospitals as a patient, subject to certain conditions. The resident must be in urgent need of treatment and unable to obtain it a voluntary institution.'¹³² The arrangement was for the Hospitals Council to pay twenty five shillings per patient provided that the total amount did not exceed £1000 per year. The number of patients treated under the arrangement was not to exceed 800 per year, another provision declared that the arrangement could be ended at the end of six months, with either party giving one months notice. Join up of the two systems was therefore possible. The two sides were able to complement each other and the development of the City General allowed the waiting lists of the voluntary hospitals to be reduced. The initial agreement for 800 contributory scheme members per year to be treated at the municipal hospital was extended and 3,500 members were treated at the City General in 1939.¹³³ The mutual benefits were that the waiting lists at the voluntary hospitals were reduced by using spare capacity at the municipal hospital and access to 'teaching material' was provided. The support of the voluntary hospital leadership was necessary for the City General to become a fully functioning general hospital with specialists, teaching and consultants.

The Hall/Clark Plan

The plan for joint (municipal and voluntary) hospital working in Sheffield was designed by two eminent medical practitioners from either side of the hospital divide in the City. From the voluntary hospitals, Professor Arthur J. Hall of the Royal Hospital and from the public hospitals James Clark.¹³⁴ They produced a private and confidential report in

¹³² *Medical Officer*, 23 April 1932.

¹³³ Sheffield Joint Hospitals Council Annual Report, 1939.

¹³⁴ Arthur Hall was the son of a Sheffield GP educated at Sheffield, Cambridge and St Barts. Described as a 'skilful physician and medical politician,' Hall was instrumental in transforming the syllabus of the University of Sheffield Medical School, moving it on from a traditional focus on anatomy to modern laboratory science ensuring that the viability of the Department and the University was secured through greater involvement with the local authority and the research and consultancy needs of industry. S. Sturdy, 'The Political Economy of Scientific Medicine: Science Education and the Transformation of Medical Practice in Sheffield, 1890-1922', *Medical History*, 36, (1992), 125-159. Born in 1880 in Ayrshire and educated at the University of Aberdeen, Dr James Clark was Medical Superintendent of the Sheffield Poor Law Hospitals from 1911 and the Municipal Hospitals from 1930 to 1948. Hall was Chairman of the Sheffield Joint Hospitals Council 1950-1959. He represented the Joint Hospitals

1930 which stated that the waiting lists at the voluntary hospitals were mainly for general or gynaecological surgery and could be met without adding to the existing number of beds. The Hall/Clark plan was to maintain the voluntary hospitals on their present sites and utilise the space at the City General Hospital at Firvale such that the voluntary and municipal hospitals of the city 'are placed on the same plane of service in all respects as separate units in a combined whole'.¹³⁵ The plan recognised that the two sectors had differing statutory foundations, however Hall stated 'the object, it is to secure an equality of the quality of medical service throughout the hospital units so that each corresponds in relation to medical assistance, laboratory facilities, nursing, diet, housing etc.'¹³⁶ The Hall/Clark plan to retain the voluntary hospitals on their existing sites and to develop the Firvale Hospital as the City General, was the blueprint for hospital developments in Sheffield from 1930 - 1948. The Hall/Clark plan integrated the co-operation of the voluntary hospitals into the development of the municipal hospital service in Sheffield. It was decided that to fulfil all the requirements of a general hospital the City General would require an outpatient department as well as specialists in all departments.¹³⁷ The report recommended that a casualty block be built at the City General Hospital, to be the accident and emergency centre for the north of the city and to relieve the pressure on beds caused by the surgical treatment of street accidents at the voluntary hospitals. Such a move called for the appointment of a Senior Resident Medical Officer. The Hall/Clark plan suggested that two more operating theatres be added to the existing theatre at the Firvale site and that three additional visiting staff should be appointed. They suggested that specialists should not be on an annual retainer but on a rota from the voluntary hospitals using a pay scale and that the hospital should apply to the University and the General Medical Council for teaching status. They recognised that the maternity services of the city were inadequate and that some system of unification between the Jessop Hospital and the Nether Edge and City

Council on the Regional Committee of the BHA, Sheffield and District Regional Committee of the BHA, Minutes, 9 May 1935, 15 July 1935. Held at Westfield, Sheffield. R. Rouse, 'Appreciation', *Caledonian Society of Sheffield Newsletter*, 63, (May 1969), 3.

¹³⁵ Professor Hall, Meeting of the Joint Committee of the Four Sheffield Voluntary Hospitals and the City Council Parliamentary and General Purposes Committee, 2 July 1929. Town Clerks Department Correspondence, SCA 640/48.

¹³⁶ Professor Hall, Meeting of the Joint Committee of the Four Voluntary Hospitals and the City Council Parliamentary and General Purposes Committee, 2 July 1929. Town Clerk's Department Correspondence, SCA 640/48.

¹³⁷ James Clark and Arthur J Hall, 24 January 1930, Private and Confidential Report on the Medical Requirements in Connection with the Joint Hospital Service for Sheffield, SCA 640/48, City of Sheffield Town Clerk's Department Correspondence.

General Hospital maternity services was necessary. The total cost of these improvements was estimated in 1930 at £40,000.¹³⁸

For Professor Arthur Hall the first task of the united scheme was to address the waiting lists at the voluntary hospitals. In November 1929 Hall sent a letter to the Town Clerk marked 'not for publication' that expressed some scepticism over the waiting list figures given by the voluntary hospital administrators;

There is a great need for in-patient beds, this is greater than it appears from the so-called waiting lists given by hospital secretaries. In some instances the names of all who ought to be admitted are put down – whether it is likely that accommodation will be available or not. In other cases it is the names of only urgent cases and many names are not put down because of the impossibility of admitting them.¹³⁹

Hall believed that the number of beds allotted to individual visiting staff was 'below what could be effectively worked if beds were available at the Royal Hospital.'¹⁴⁰ He therefore urged the consideration that Firvale hospital be extended as there was no further space available at the site of the Royal Hospital. In January 1930 there were 840 beds at Firvale Hospital, 251 of which were empty, at Nether Edge 224 out of 672 beds were empty.¹⁴¹ The problem was that under Section 16 of the Local Government Act local authorities were obliged to charge patients treated at municipal hospitals. An arrangement was reached where 500 patients per year from the voluntary hospitals lists would be treated at the municipal hospitals at 25s per case. A special sub-committee of the Joint Municipal and Voluntary Hospitals Advisory Committee recommended that 'Section 16 of the Local Government Act not be applied.'¹⁴² The requirements were met by the voluntary hospitals paying 25s per waiting list case treated at the City General Hospital to the City Council to

¹³⁸ Note by James Clark, January 1929 to Town Clerk. Town Clerk's Department Correspondence, SCA 640/48. Town Clerk's Department Correspondence, SCA 640/48.

¹³⁹ Arthur Hall to William Hart, 12 November 1929 Town Clerks Department Correspondence, SCA 640/48.

¹⁴⁰ Arthur Hall to William Hart, 12 November 1929 Town Clerk's Department Correspondence, SCA 640/48.

¹⁴¹ James Clark to William Hart, 1 January 1930, Town Clerk's Department Correspondence, SCA 640/48.

¹⁴² Sheffield Municipal and Voluntary Hospitals Joint Advisory Committee Minutes, April 1931, SCA 201/1.

avoid patient charges. The voluntary hospitals then applied for a grant from the City Council under Section 64 of the Public Health Act 1925 which allowed local authorities to make grants to voluntary hospitals. This arrangement was made in addition to the arrangements made to treat patients at the City General Hospital under the Penny in the Pound Scheme.¹⁴³ The arrangement operated from 16 May 1931, in its first 7 months 385 patients from the waiting lists of the Royal Infirmary and Royal Hospital were treated at the City General Hospital.¹⁴⁴ The waiting lists by January 1932 were reported as being 'down to normal proportions' as James Clark stated in a memo to the Town Clerk 'it looks as if the voluntary hospitals made a great deal more of their waiting lists than they need have done.'¹⁴⁵ By January 1933, the waiting lists at the voluntary hospitals had been reduced and 1,070 cases had been dealt with at the City General Hospital under the scheme.¹⁴⁶

In 1931 the City Council allocated £60,000 for the new facilities at the City General Hospital.¹⁴⁷ The Minister of Health, Sir Hilton Young opened the City General Hospital extensions in October 1934 including the new outpatient block, operating theatre, maternity block and nurses home. The Minister praised the wisdom of the Council for its commitment to develop the municipal hospital sector in the city.¹⁴⁸ Teaching arrangements in obstetrics began in 1936 and by 1946 the City General had Professorial teaching wards used by the University of Sheffield Medical School, Resident Physicians, an out-patient unit, a psychiatric unit, children's wards, a Maternity Department, a Genito-Urinary Department, a Radiological Department, a casualty Department and a Public Health Laboratory.¹⁴⁹

¹⁴³ Sheffield Municipal and Voluntary Hospitals Joint Advisory Committee Minutes, 31 March 1937, SCA 201/2.

¹⁴⁴ The majority of conditions treated from the waiting lists were surgical cases for hernia, haemorrhoids, tonsils and adenoids. Sheffield Borough Council Minutes of the Hospitals Sub Committee, 21 April 1932, SCA 39 (53).

¹⁴⁵ James Clark to Town Clerk, 25 January 1932. Town Clerk's Department Correspondence, SCA 640/48.

¹⁴⁶ Minutes of Sheffield Municipal and Voluntary Hospitals Joint Advisory Committee, 14 August 1933, SCA 201/(1).

¹⁴⁷ Sheffield Borough Council, Minutes of the Hospitals Sub Committee, 19 November 1931, SCA 39 (52).

¹⁴⁸ *Public Assistance Journal and Health and Hospital Review incorporating Poor Law Officers Journal*, 19 October 1934. Sheffield Medical Officer of Health Annual Report, 1934.

¹⁴⁹ Sheffield MOH, Annual Report, 1946.

Sir George Godber, one of the wartime Ministry of Health Surveyors of Sheffield and the East Midlands (and later the Chief Medical Officer from 1960-1973) recognised James Clark, the Medical Superintendent of the Sheffield Municipal Hospitals from 1911 and Deputy MOH from 1930, as the driving force behind the development of the City General Hospital. Godber noted how Clark 'patiently built up a supporting specialist staff and ran the hospital in a way that drew the best from all who worked with him.'¹⁵⁰ This chapter has shown that Asbury, Hart, Hall and Clark should all be credited with the design and operation of a viable hospital plan for Sheffield in the 1930s. The Town Clerk, William Hart claimed at the Annual Conference of the Royal Sanitary Institute in 1931 that 'In religion we are unhappily unable to agree and in politics divided, but in the service of the sick and suffering, creeds and politics are forgotten and all classes unite in assisting the work of the Hospitals.'¹⁵¹ The behind the scenes machinations and careful diplomacy that was required to get to that 'united' point, suggests that both party politics and professional politics were more relevant here than Hart was prepared to publicly admit. C.J. Donelan, recognised the role of both James Clark and William Asbury in making joint working in the Sheffield hospital service possible. Concluding his confidential Ministry of Health report on the Public Health Services of Sheffield, Donelan stated that:

... more progress appears to have been made here, than in any other area which I have visited. Here we have the combined effect of the clear vision of Dr Clark and the vigorous activity of an extremely able Chairman of the Public Health and Public Assistance Committees. Very big steps have been taken in the break up of the Poor Law by the appropriation of the Fir Vale and Nether Edge Hospitals. The closest possible co-operation with the Voluntary Hospitals appears to have been attained.¹⁵²

¹⁵⁰ Sir G. Godber, 'The Doomsday Book of British Hospitals,' *Bulletin of the Society for the Social History of Medicine*, (1983), 9.

¹⁵¹ Sir W. Hart, 'Hospitals as Affected by the Local Government Act, 1929,' *Journal of the Royal Sanitary Institute*, L, 7, (1930), 472.

¹⁵² PRO MH 66/1079, Ministry of Health Survey of Public Health Services in the County Borough of Sheffield, 1934, 218.

Humanising the Hospital Experience

Despite the efforts to provide free at the point of use hospital care in Sheffield, some patients were expected to pay for treatment at municipal hospitals. Those falling outside of Public Assistance, outside of the arrangements for treating patients from the waiting lists at the voluntary hospitals and those outside the arrangement with the Contributory Scheme, were required to pay for treatment at the municipal hospitals. An Almoner was employed by the City Council from April 1930 to organise the collection of payments for maintenance from patients treated at the City General Hospital and to seek appropriate referrals to supporting agencies. The role of almoner was not simply one of collecting payment but was essentially one of a proto-social worker. Employed from April 1930, Miss H.E. Rees suggested that the work of her Department should be to liaise with the Sister or Doctor involved and report any specific difficulties in the home conditions of the patient which might have an effect on their illness. The Almoner helped with arranging convalescence through a range of agencies including municipal departments such as the PAC, The Hospitals Council and employers. The Almoner also noted that that Doctors frequently recommended periods of convalescence for patients which involved a great deal of work for the almoner as many were not entitled to convalescence benefit under the Penny in the Pound Scheme and that the periods of convalescence arranged through the Joint Hospitals Council were too short.¹⁵³ The Almoner suggested that a fund should be established if the City Council wished patients to receive the kind of after care recommended by doctors. Miss Rees stated that 'a certain amount of expense will be involved, but such expenditure if carefully regulated, should on a long view effect an economy by preventing the recurrence of disease and further periods of treatment in hospital.'¹⁵⁴ In 1932 the Almoner assisted 'unmarried girls' attending the antenatal clinic 'talking over plans for the future' and making referrals to the Maternity and Child Welfare Clinic, the House of Help and the Catholic Babies Home.¹⁵⁵ The early work of the Almoner's Department was hindered by difficulties in the collection of patient payments before the 1932 agreement with the Joint

¹⁵³ Sheffield City General Hospital Almoner's Report, Hospitals Sub-Committee Minutes, June 1930, SCA 39, (51).

¹⁵⁴ Sheffield City General Hospital Almoner's Report, Hospitals Sub-Committee Minutes, June 1930, SCA 39, (51).

¹⁵⁵ Sheffield Borough Council, Minutes of the Hospitals Sub Committee, 16 June 1932, SCA 39 (53).

Hospitals Council. Patients/contributors were wary of seeking treatment if there was the possibility that they were going to be charged, such that the 'present lack of co-operation with the Penny in the Pound Scheme, appears to be having very serious consequences, not only in causing unwillingness to pay, but in discouraging its contributors from seeking early treatment.'¹⁵⁶ By 1933 the Almoner reported that patients were no longer wary of seeking hospital treatment; 'the arrangement with the Sheffield Hospitals Council is working smoothly - on the whole, its outstanding advantage being the great satisfaction given to contributors to the scheme and the consequent gain in good feeling among those who have been admitted as patients to the hospital.'¹⁵⁷

In order to perform the work of the department, the Almoner requested that a clerk be appointed to deal with the high rate of arrears and that a second Almoner be appointed with a 'definite training in social science and practical experience in hospital social work.'¹⁵⁸ Miss Rees was keen to establish a modern professional service with a staff that had qualified through the 2-3 years training offered by the Institute of Hospital Almoners. The new Almoner wished to avoid the parochialism in appointments to her department that had previously been the case in the Public Health Department and Miss Reese proposed that professionally qualified appointments were made rather than see the work of the department carried out by local people who had been employed for their 'knowledge of the city and the characteristics of its inhabitants.'¹⁵⁹ In November 1930, the Hospitals Sub-Committee recommended that a Clerk and an Assistant Almoner be appointed, and that the lines of development outlined by the Almoner in her report be approved.¹⁶⁰

The City Council made further attempts to humanise the experience of patients in the municipal hospitals through the introduction of a Hospital Library Service. The Chairman of the Libraries Committee, was Alf Barton a former anarchist, former member of the ILP and former Vice-President of the Sheffield Branch of the British Socialist Movement, and a member of the Communist Party of Great Britain for one month in its inaugural year in

¹⁵⁶ Sheffield City General Hospital Almoner's Report, Hospitals Sub-Committee Minutes, June 1930, SCA 39, (51).

¹⁵⁷ Sheffield Borough Council, Minutes of the Hospitals Sub Committee, 16 February 1933, SCA 39 (54).

¹⁵⁸ Sheffield City General Hospital Almoners Report, Hospitals Sub-Committee Minutes, June 1930, SCA 39, (51).

¹⁵⁹ SCC Hospitals Sub-Committee Minutes, 20 November 1930, SCA 39 (51).

1920. Barton, described as one of 'the leading Socialists of the city'¹⁶¹ explained that 'a person still retains his rights as a citizen although he is in hospital. Consequently a library service for the hospitals is a right of all citizens who when well have access to public libraries.'¹⁶²

Conclusion

This chapter has examined hospital policy in Sheffield in the decades before the NHS. The Sheffield example illustrates how local actors sought to address problems of finance and access using the available policy instruments at the time. Certain features specific to Sheffield have been highlighted including the operation of a graduated hospital contributory scheme with a mass membership and pro rata payment from employers. The role of the Joint Hospitals Council has been examined in fostering a spirit of co-operation and collaborative working. Professional politics and party politics were also important factors that shaped the development of hospital services in Sheffield before the NHS. In order to succeed the contributory scheme required the support of the Labour movement and made significant changes in order to win the support of the trades council. The Labour leadership remained committed to a health service based on local government. However, the dedication of the individuals who ran the contributory scheme was plain. On his retirement, Moses Humberstone the President of the Sheffield and District Association of Hospital Contributors and Assistant Secretary of the Sheffield Trades and Labour Council declared himself 'in love with the movement' in 20 years he had attended over 2000 meetings representing the interests of working people in the contributory scheme movement.¹⁶³ In Sheffield local hospital co-ordination predated the war time requirements of the Emergency Hospital Service. Joint working between the two hospital sectors began in the 1920s and the City Council developed the municipal hospitals by extending agreements with the voluntary sector to operate a health service for Sheffield in the 1930s. In this way Sheffield should be considered as one of the few places where productive joint

¹⁶⁰ SCC Hospitals Sub-Committee Minutes, 20 November 1930, SCA 39, (51).

¹⁶¹ H. Mathers, 'Alfred Barton', in J. Saville, (ed.), *Dictionary of Labour Biography*, vol. vi, (1982), 21-24.

¹⁶² Report of the Chairman of the Libraries Committee Regarding a Proposed Hospital Library Service, SCC Hospitals Sub-Committee Minutes, 18 December 1930, SCA 39, (51).

¹⁶³ Sheffield and District Association of Hospital Contributors, Minutes of the 17th Annual Meeting of Delegates, 7 March 1939. Held at Westfield Health Scheme.

working was possible. Opportunities provided under permissive legislation were embraced and both sides of the hospital divide entered into mutually beneficial arrangements.

This examination of events in the history of hospitals in Sheffield from 1918-1948, has shown that far from being a picture of a stagnating and struggling service the hospitals of the city underwent a massive process of change incorporating elements of democratisation, expansion and dynamism. Considering the economic conditions of the 1920s and 1930s, this was no mean feat. Effective liaison between the two sides of the hospital divide was made possible and Section 13 of the 1929 Local Government Act was a useful catalyst for reform in Sheffield. Good relations between the city's individual voluntary hospitals was a factor as well as the common aim of politicians and senior figures in the city including the Town Clerk William Hart, the Medical Superintendent/Deputy MOH James Clark, the Chairman of the Health Committee William Asbury and the leading physician Arthur Hall. Despite deep rooted ideological differences over the future direction of health services, pragmatism prevailed and positive steps were taken to reduce the waiting lists at the voluntary general hospitals and develop the municipal hospital sector. In 1948 Sheffield was selected as the centre of a Regional Hospital Board and a fully functioning hospital service provided by the voluntary and municipal sectors in Sheffield, financed by the rates and by the contributions of workers and employers was handed over to the NHS.

The contributory scheme continued under the NHS eventually becoming the Westfield Contributory Health Scheme providing cash grants for optical and dental charges introduced in 1951 as well as benefits for in-patients and convalescence also retaining its charitable work for the Sheffield hospitals. The relationship between the Hospitals Council and the Sheffield Trades and Labour Council deteriorated. In 1957 The trades council objected to the new scheme, arguing that it was 'contrary to the spirit of the NHS'.¹⁶⁴ The Sheffield Labour movement was surprisingly quiet on the loss of the municipal hospitals and the abandonment of the Labour Party policy of a health service based on local government. The following chapter follows up developments in health and hospital policy

¹⁶⁴ Secretary of the Sheffield Trades and Labour Council, V.M. Thornes, quoted in *The Times*, 27 September 1957. When the Trades Council announced their opposition to the scheme Bessie Braddock (MP for Liverpool Exchange) was drafted in to address a public meeting at the City Hall stating that 'The Sheffield Trades Council are cutting off their noses to spite the people they are supposed to represent.' *Sheffield Telegraph*, 6 December 1956.

in Sheffield in the period by examining municipal housing in the inter-war years and in particular the association of health and housing in policy.

Chapter 5

Local Authority Housing in Sheffield

Introduction

Unlike the history of health policy and the history of hospital policy in Sheffield, the record of the local authority in the provision of housing between the wars has previously received attention from Historians.¹ In evaluations of housing policy developments in the first half of twentieth century Britain, Sheffield has been recognised as one of the more progressive local authorities building more Council houses than the private sector in the period.² In opposition in the early 1920s, the Labour Party in Sheffield attacked the housing record of the Liberal/Conservative alliance and campaigned for a large scale municipal housing programme built by local authority employees through 'direct labour'.³ The Council delivered this in the 1920s and 1930s, taking full advantage of government subsidies introduced through a range of Housing Acts and defended its policy of building good quality suburban housing against calls to build more cheaply by the opposition and the Ministry. Health policy and Housing policy were explicitly linked by the Labour Council, both in their attacks on the opposition before 1926 and in defence of their large scale building programme in the years that followed. This chapter offers a brief examination the salient points in the development of housing policy in the period.

Inter-war housing policy was built on a foundation of legal requirements and permissive legislation.⁴ Government subsidies were introduced through the various

¹A.M. Craven. 'Housing Before the First World War' in C. Binfield (ed.), *History of the City of Sheffield* (Sheffield Academic Press, 1993), 65-75. A.D. H. Crook. 'Needs, Standards and Affordability: Housing Policy After 1914' in Binfield (ed.), *History of the City of Sheffield, vol. 2 Society* (Sheffield Academic Press, 1993), 76-99.

²P. Dickens, S. Duncan, M. Goodwin, M. and F. Gray. *Housing States and Localities* (Methuen, London, 1985), 165. M. Bowley, *Housing and the State* (Allen and Unwin, 1945). J. Burnett. *A Social History of Housing* (Routledge, London, 2nd Ed. 1986).

³In 1926 the leader of the Trades Council and Labour Group on the Borough Council Ernest Rowlinson stated 'we have done all a minority can do to accelerate building – the best and cheapest way is by direct labour.' Sheffield Trades and Labour Council, Annual Report, (1926), 14.

⁴The Housing Acts of the era were:

Housing of the Working Classes Act, (1890) allowed local authorities to promote the removal of unhealthy areas, permissive with no obligation to re-house displaced tenants. Local Authorities were not permitted to undertake building work except at the express consent of the LGB.

Housing Acts, in an attempt to address the ‘housing problem’ after the First World War with the aim of delivering the promised ‘homes fit for heroes’.⁵ However, as we have seen previously for health and hospital policy, permissive legislation in housing policy also resulted in regional variations in provision where dynamism depended on the will of local authorities. Housing legislation via subsidy was also problematic in terms of unseen consequences such as issues of affordability and displacement.

As with hospital and health policy, there were distinctive features to housing policy in Sheffield. Before the Second World War Sheffield Council policy was to build suburban estates consisting of houses of a decent size and standard – along ‘Garden City’ lines as opposed to the inner city flats seen in other cities. Andrew Thorpe has interpreted this aspect as key to explaining the dominance of the Labour party in Sheffield in the latter 75 years of the twentieth century, where the Labour Council created a ‘clientage’ of Labour voters housed in decent corporation houses and many working for the Council.⁶ Whether housing provision is linked to voting behaviour is debatable, however from an analysis of policy statements and the actions of the Council it is clear that a belief in the health benefits of decent living standards was the driving force behind Labour’s housing policy in Sheffield between the wars.

Housing and Town Planning Act, (1919) (Addison Act): duty on local authorities to survey their area and carry out plans for the provision of houses. Introduced subsidy for local authorities. Withdrawn 1921. Housing Act, (1923) known as the (Chamberlain Act): introduced exchequer subsidies to both private and public schemes for houses built before 1 October 1925. Local authorities allowed to carry out building work if private enterprise unable to fulfil the work. Withdrawn in 1929. Housing (Financial Provisions) Act, (1924) (Wheatley Act), Chamberlain subsidies continued for houses completed before 1939. Houses built under the 1924 Act received a higher subsidy of £9 per dwelling per year for 40 years conditional on the municipality’s contribution of 50% from the rates. No requirement to prove that private enterprise could not perform the work. Average rents were to be fixed. Withdrawn in 1933. Housing Act (1930) (Greenwood Act) redefined the criteria for slum clearance areas and placed an obligation on Councils to re-house all those displaced. Housing Act, (1935) every local authority to survey overcrowding. P. Malpass and A. Murrie, *Housing Policy and the State* (London, 1999), 41. S. Merret, *State Housing in Britain* (London, 1979), 308-312.

⁵ M. Swenarton, *Homes fit for Heroes: The Architecture and Planning of Early State Housing in Britain* (London, 1981).

⁶ A. Thorpe, ‘The Consolidation of a Labour Stronghold 1926-1951’, in C. Binfield (ed.), *History of the City of Sheffield* (Sheffield, 1993), 85-118, 88.

Health and Housing

Housing and health were intrinsically linked. Jane Lewis notes that ‘the major public health Acts of the nineteenth century were also characteristically, Housing Acts.’⁷ Housing and health continued to be closely linked at policy level into the twentieth century, as the Minister of Health was also the Minister of Housing. From 1919 onwards, the Ministry of Health was the department of state responsible for formulating and administering housing policy with the power to approve housing schemes, sanction loans and provide subsidies to local authorities for the purposes of slum clearance and the building of council housing.⁸ Labour politicians in Sheffield in the 1920s and 1930s saw health policy and housing policy as two sides of the same coin. For William Asbury it was plain that ‘slum housing breeds disease.’⁹

In the early 1920s the Citizens Alliance accused Labour of ‘grinding an axe’ against the Citizen’s dominated Health Committee by ‘conflating’ the issues of health and housing in every debate.¹⁰ Yet, in the mindset of Asbury and his colleagues, the housing and health link was deeply ingrained. For the Labour leaders in Sheffield there was little point in providing a health service to treat sick people in hospitals if they were then returned to poor living conditions to continue a cycle of ill health. Housing and health were part of a holistic approach to the administration of the Borough. The perceived effects of overcrowding and poor housing shaped ideas about the health of the city expressed in debates during the outbreak of smallpox in Attercliffe in the 1920s and in the development of the TB re-housing scheme. Housing was therefore central to Labour’s health policy and a key part of its municipal socialist agenda.

⁷ J. Lewis, *What Price Community Medicine?* (Brighton, 1986), 5.

⁸ K. Morgan, ‘The Problem of the Epoch? Labour and Housing, 1918-51’, *Twentieth Century British History*, 16, 3, (2005), 227-255.

⁹ W. Asbury, ‘The Future of the Public Health Services’, *Journal of the Royal Sanitary Institute*, 59, (1938), 727-740.

¹⁰ *Sheffield Mail*, 23 October 1923.

Local Authorities, Housing and Politics

A number of local authorities had shown initial interest in municipal housing in the early years of the twentieth century, through the building of show-piece experiments in house building where small numbers of low density, high quality houses, on garden city lines were built, the Wincobank Estate in Sheffield and the Wythenshaw Estate in Manchester are prime examples.¹¹ In general the housing policy pattern for most local authorities between the wars was to move away from building this type of dwelling in order to focus on the construction of cheaper inner city flats and tenements.

Where other towns in time dropped the garden city approach, Sheffield Council resolutely stuck to its policy in the construction of houses on suburban estates rather than inner city flats. Nationally, up until the late 1940s, Labour Party policy on the question of houses versus flats was in harmony with the policy in Sheffield.¹² The anti-Labour alliance in Sheffield, with some justification, argued that the comparatively cheaper rents of flats made them a more suitable housing type as they could be provided at a level of rent that was within the financial range of potential tenants. Yet the Liberal/Conservative alliance managed to build only around 100 flats when they were in office in the 1920s and only 725 of 13,086 of the homes built under the 1930 and 1936 Housing Acts were inner city flats.¹³ The issue of housing dominated the municipal elections of the 1920s, and the record of the anti-Labour Citizens Alliance in addressing the housing issue, provided much political ammunition for the Sheffield Labour Party.¹⁴

¹¹ In 1904 the Council bought 60 acres of land at High Wincobank, to develop its first suburban municipal housing estate which initially constituted 41 houses each with a bath. V.M. Thornes, *The History of the Growth and Location of the Corporation Housing Schemes* (Sheffield, 1959), 3. For Manchester see K. Morgan, 'The Problem of the Epoch? Labour and Housing, 1918-51', *Twentieth Century British History*, 16, 3, (2005), 227-255, 246.

¹² National Labour Party literature into the early 1940s defended the house against the flat, stating: 'Labour knows that most families prefer houses to flats ... a house gives more quiet and privacy than a flat, and it is on the ground level so that you don't have to climb many stairs to reach it.' The Labour Party, *Your Home Planned By Labour* (London, 1943), 3.

¹³ A. Thorpe, 'The Consolidation of a Labour Stronghold 1926-1951', in C. Binfield (ed.), *History of the City of Sheffield* (Sheffield, 1993), 102.

¹⁴ Press coverage of the 1923 municipal election was dominated by the housing issue due to a scandal over Citizen's Alliance City Councillors who sat on the Health Committee being discovered to be the landlords of unfit properties. *Sheffield Mail*, 8-25 October 1923.

The Citizens Alliance exacerbated the situation by ending 'compounding' in 1919, where rates of tenants previously collected as part of the weekly rent by the landlord, were collected in twice yearly lump sums. The *Sheffield Forward*, reported the end of compounding as a way of increasing revenue for landlords at a time when pre-war rent levels were maintained under the Rent Restriction Act of 1919.¹⁵ Tenants found it extremely difficult to save money for the two annual lump sums required under the policy. By April 1927 £693,000 was owed in rates arrears and there had been 289 imprisonments for non-payment of rates.¹⁶

The housing issue in Sheffield, saw a clear split along party political lines and added to the division between the municipalising Labour Party and the free market Liberal/Conservative alliance. There was disagreement over what constituted suitable housing for the working classes. Labour favoured house building by the municipal authority on suburban estates, while the policy preference of the anti-Labour alliance was for the private sector to build flats in central districts of the city.¹⁷ One of the major problems in inter-war housing policy was the difficult balancing act of clearing slums while providing decent housing that was affordable to those in the greatest need. The displacement of people from affordable but poor housing into housing that was unaffordable could lead to overcrowding in new estates as people struggled with high rents or it could mean a return to poor and cheap accommodation.¹⁸ This affordability issue was investigated in Sheffield in the 1930s through social surveys.¹⁹

J.C. Skinner, the Honorary Secretary of the Citizens Alliance stated in 1923 that the main achievement of the Citizens in Sheffield in power had been the reduction of the rates from 14s 11d in the pound in 1920-21 to 10s 7d in the pound.²⁰ This rate reduction had been achieved through the practice of transferring revenue from profits

¹⁵ *Sheffield Forward*, October 1921.

¹⁶ A. Thorpe, 'The Consolidation of a Labour Stronghold 1926-1951', in C. Binfield (ed.), *History of the City of Sheffield* (Sheffield, 1993), 85-118, 88.

¹⁷ A. Thorpe, 'The Consolidation of a Labour Stronghold 1926-1951', in C. Binfield (ed.), *History of the City of Sheffield* (Sheffield, 1993), 102.

¹⁸ F. Berry, *Housing: The Great British Failure* (Knight, London, 1974).

¹⁹ A.D.K. Owen, *A Report on the Housing Problem in Sheffield* (Sheffield Social Survey Committee, 1931). A. D. K. Owen, *A Survey of Unemployment in Sheffield* (Sheffield Social Survey Committee, 1933). A.D.K. Owen. *A Survey of the Standard of Living in Sheffield* (Sheffield Social Survey Committee, 1933).

²⁰ *Sheffield Mail*, 24 October 1924.

made on the municipal tramways.²¹ Ernest Rowlinson for Labour argued that the profits made by running municipal services such as the tramways, should be used for the repayment of the civic debt, the provision of more municipal services and especially for the building of houses by direct labour.²² The record of the Citizens Alliance between 1923 and 1926 in slum clearance opened them up to Labour criticism. The Liberal/Conservative alliance achieved a rate of slum clearance of 65 houses over the three year period, by contrast Labour stepped up the clearance rate in 1927 to 1931 to 301 houses.²³ In the 1926 local election campaign Labour listed its 'Concrete proposals to end the chaos created by the Tory Citizens'.²⁴ Under the heading of 'HEALTH' the priorities were listed as; '1. The abolition of the slums. 2. The greater use of powers for dealing with insanitary property, 3. The conversion of privy middens (4,815 are not yet converted), 4. The abolition of fixed ashpits by substituting mobile bins (9,828 ashpits are yet to be abolished).'²⁵ Sidney Pollard has argued that campaigns like this by the Sheffield Labour Party on 'basic needs' show that socialism in Sheffield was an expression of class solidarity rather than ideology, such that 'in a predominantly industrial community like Sheffield, the Labour Party became an organ for the expression of concrete working-class needs, and was little concerned with the intellectual's search for pure doctrine.'²⁶

Municipal housing policy in Sheffield - The Housing Subsidies

Housing in Sheffield was the responsibility of various sub-committees of the Health Committee until a separate Estates Committee was set up in 1908.²⁷ Medical Officers of Health in their role as sanitary inspectors, had the responsibility for condemning unfit buildings and for the issuing of improvement notices to the

²¹ *Sheffield Mail*, 24 October 1924.

²² *Sheffield Mail*, 23 October 1923.

²³ A.D.K. Owen, *A Report on the Housing Problem in Sheffield* (Sheffield, 1931), 24-25.

²⁴ 'Co-operative Labour Policy of Civic Government: Progressive Charter for Sheffield Ratepayers', *Sheffield Co-operator*, November 1926.

²⁵ 'Co-operative Labour Policy of Civic Government: Progressive Charter for Sheffield Ratepayers', *Sheffield Co-operator*, November 1926.

²⁶ S. Pollard, *A History of Labour in Sheffield* (Liverpool, 1958), 265.

²⁷ The sub-committees of the Health Committee with responsibility for housing were from 1885, the Housing of the Poor Sub-Committee, and from 1901 the Housing of the Working Class Sub-Committee. The Estates Committee from 1906 took on the responsibility of this Committee along with the roles of the Surplus Land Committee and the Improvement Committee. A Housing Committee, separate from the Estates Committee, was established in 1947. Introduction to Listings for Sheffield City Council Estates Committee Minutes, SCA 108.

landlords of unfit properties. In 1914 there were 104,000 dwellings in the city, one quarter of which consisted of the 16,000 back-to-back houses plus 8,000 dwellings which had been declared unfit for human habitation by the MOH.²⁸ In 1917 the Estates Committee was under Tory control. With a stock of 617 council dwellings, the Estates Committee openly declared itself to be a reluctant landlord, and in line with the national Conservative Party attitude throughout the inter-war years believed that, 'working class houses should be provided by private enterprise and the Corporation should only step in when private enterprise has failed, and then only to the extent of the failure.'²⁹ The Estates Committee recommended that 2,500 houses should be built each year from 1917 and that 800 houses available at the market value rent, (not with subsidised rents) should be built by the Council. The strictly limited municipal involvement in the housing market was the main concern of the Liberal/Conservative anti-Labour alliance, 'the object of this limitation is to leave plenty of opportunity to private enterprise to build working class homes.'³⁰ Between 1919 and 1927 67 per cent of dwellings built in the city were constructed by the private sector.³¹

Prompted by the Chamber of Commerce and the Cutlers Company, the anti Labour alliance established a Development Committee in 1917 to promote the city at home and abroad and engaged the services of Patrick Abercrombie in 1919 to draw up a civic plan, which was published in 1924.³² Abercrombie's vision was for the city to be zoned into industrial and residential areas where eventually the industrial east end would be evacuated of housing. Abercrombie suggested that 75,000 people should be moved from the Don Valley, 42,000 from the inner city trades area and 8,000 from the commercial zone.³³ Pollard noted that 'Between 1921 and 1931 over one twelfth, and by 1951 one quarter, of the city's population had moved from the older and the more thickly populated districts to the suburbs, and about four fifths of those who moved appear to have been members of working class families.'³⁴ The process of

²⁸ H.K. Hawson, *Sheffield the Growth of a City* (Sheffield, 1968), 117.

²⁹ Sheffield City Council Estates Committee Minutes 4 July 1917, SCA 108/3.

³⁰ Sheffield City Council Estates Committee Minutes 4 July 1917, SCA 108/3.

³¹ A.D.H. Crook, 'Needs Standards and Affordability After 1914', 79.

³² P. Abercrombie, *Sheffield A Civic Survey and Suggestions Towards a Development Plan* (Liverpool, 1924).

³³ P. Abercrombie, *Sheffield A Civic Survey* (Liverpool, 1924), 55.

³⁴ S. Pollard, *A History of Labour in Sheffield* (Liverpool, 1958), 261.

suburbanisation started in earnest under the four major Housing Acts in the period; the Addison Act of 1919, the Chamberlain and Wheatley Acts of 1923 and 1924 and the Greenwood Slum Clearance Act of 1930. The Addison Act made what had been permissible under the 1890 Housing of the Working Classes Act, compulsory. Local authorities were required to survey housing needs in their area and make and submit plans to the Ministry of Health for approval.³⁵

Under the 1930s Housing Acts Labour were able to take advantage of more generous government subsidies. In 1935 the average rates bill in Sheffield was 15s and 6 ½d. Out of that amount, individual rate payers saw 2s 3 and ¼d go towards the Council's Public Health measures, (including the development of municipal hospitals), whereas only 1s and a ¼d the rates bill raised through the rates went towards the housing budget, incorporating the provision of the new housing estates.³⁶ In 1939 the Government subsidy to the housing schemes in the city was £249,975 and the Council subsidised housing by £91,343.³⁷ The Citizens Alliance, (which became the Progressive Party in 1930), insisted that the private sector should undertake building work. One of Labour's first acts in office in 1926 was to establish a Direct Works Department to carry out building and repair work for the City, the differences between the two parties were clear here, as the department was closed by the Liberal/Conservative Alliance when they were in control of the Council from 1932-1933 only to be re-established by Labour when they were re-elected the following year. During the Citizen's Alliance year in office, rates were cut by a shilling, and despite axing the Direct Labour Department the civic debt increased by a quarter of a million pounds.³⁸

Under the Addison scheme, the Council submitted a plan for the building of 15,000 houses, of which the Ministry approved 10,000.³⁹ Land was purchased at Norwood, Stubbin, Wincobank and Brushes and 2,430 houses were built.⁴⁰ Of these a

³⁵ S. Merret, *State Housing in Britain*, (London, 1979), 308-312.

³⁶ Sheffield City Council Finance Committee, *City Fund Account 1935*, Table 3 Expenditure out of General Rate for 1935. Public Assistance took by far the greatest slice of the rate revenue at 7s and 2d out of the average 15s and 6 and a half pence rate bill.

³⁷ A.D. H. Crook. 'Needs, Standards and Affordability: Housing Policy After 1914' in Binfield (ed.), *History of the City of Sheffield*, vol. 2 *Society* (Sheffield Academic Press, 1993), 76-99.

³⁸ H.R.S. Phillpott, *Where Labour Rules: A Tour Through Towns and Counties*, London, 1934), 6.

³⁹ Sheffield City Council Estates Committee Minutes, 30 December 1919, SCA 108/3.

⁴⁰ S. Pollard, *A History of Labour in Sheffield*, (Liverpool, 1958), 257.

minority, 320 were the large 'parlour type' envisaged by the Tudor Walters Report. Under the terms of the Addison Act both the 'parlour' and 'non-parlour' houses attracted the same subsidy levels, therefore, it cost to the Council the same amount to build the larger and smaller houses.⁴¹ The Addison houses were some of the best Council housing built in the inter-war years and the provisions of the Act were intended to run until 1927. However, during the slump there was a curb on government expenditure accompanied by a sharp rise in the cost of building. The terms of the Act were therefore halted in 1921 resulting in a slow down in the rate of Council building in Sheffield.

In his Annual Report for 1921, the Medical Officer of Health Frederick Wynne typified his willingness to tangle in controversial issues of city governance and drew attention to the problem of overcrowding and the lack of adequate housing in Sheffield. Wynne described how 'the overcrowding issue in the city is still deplorable and I understand from the City Treasurer that there are still some 3000 families on the waiting list for municipal housing. Very numerous applications of a most pathetic description are received at this office.'⁴² Where Labour and William Asbury readily drew a direct correlation between the incidence of ill health, disease and poor housing, Wynne saw the problem of overcrowding more as a social and moral issue, playing down the medical effects. Speaking in 1925, Wynne's conception of overcrowding was a situation where;

a baby may be born in the presence of a whole family and interrupt the cooking of the mid-day meal. Where youths and maidens have no separation, no privacy, where nothing is hidden, where nothing is sacred, where there is no solitude, no decency. Where everything even death itself must happen under the eyes of everybody else as though that human family and their lodgers were a nest of stoats, weasels or rabbits.⁴³

As a scientist Wynne questioned the evidence that overcrowding was a factor in the spread of infectious disease noting that the incidence of infectious disease had

⁴¹ S. Pollard, *A History of Labour in Sheffield*, (Liverpool, 1958), 257.

⁴² Medical Officer of Health for Sheffield, *Annual Report*, 1921.

fallen over the preceding forty years, and arguing that the virulence of disease had over that time weakened and people's resistance had increased. Wynne saw proposals for local authority housing reform as worthwhile but ultimately a long term solution to improving the health of the population and proposed that scientific investigation into the spread and control of disease should be stepped up, stating;

I do not wish to minimise the serious consequences, moral, social and physical of our present overcrowding. I think that it is of great importance that we should seek out and identify the factors that are tending to minimize at all events, the spread of infection in order that we may at least mitigate these evils during the period that must elapse before we see a population adequately and decently housed.⁴⁴

The long term job of sanitary reform through better housing and better sanitation was underway in the 1920s, however in Sheffield in 1920 there were still 40 miles of rubble sewers, 75 miles of unadopted roads, and an injunction of 1907 preventing the pollution of the River Don had never been enforced.⁴⁵ Tinsley sewage plant was converted to bio-aeration in 1920, Blackburn meadows in 1932, and new plants were open at Woodhouse and Coisely Hill in the 1930s. Most yards were paved in the 1920s and a dustless system of refuse collection was started in 1928.⁴⁶

As well as a small number of inner city flats the Citizens Alliance main contribution to municipal housing in the early 1920s were the 2,697 houses built on the Manor Estate. Most of these houses subsequently had to be rebuilt or demolished.⁴⁷ When Labour established the Direct Labour Department in 1926 it was partly justified as a response to the high cost of work done by the private contractors who built and subsequently were called back to repair the houses on the Manor.⁴⁸

⁴³ F.E. Wynne, 'Overcrowding and Epidemic Disease', *Proceedings of the Royal Society of Medicine*, XVIII, (1925), 29-38.

⁴⁴ F.E. Wynne, 'Overcrowding and Epidemic Disease', *Proceedings of the Royal Society of Medicine*, XVIII, (1925), 29-38.

⁴⁵ S. Pollard, *A History of Labour in Sheffield*, (Liverpool, 1958), 256.

⁴⁶ Sheffield Labour Party, *Labour Accomplishes* (Sheffield, 1930).

⁴⁷ The Manor Estate was described by a Council report in 1979 as consisting of 'older housing, built in the 1920s. It is in poor condition with serious structural defaults and extensive dampness. The City Council has resolved to demolish 400 houses by 1982 and survey 600 others.' Sheffield City Council Department of Planning and Design, *Sheffield Inner City Area: Areas of Worst Deprivation*, (Sheffield, 1979).

⁴⁸ Sheffield Labour Party, *Six Years of Labour Rule* (Sheffield, 1932), 12.

Services on the estate were also lacking. In 1926 Labour noted that the estate had 3000 children of school age and 232 school places available in wooden huts, as a result most children were travelling back to their old neighbourhoods in order to attend school.⁴⁹

The Manor Estate was built under the Chamberlain and Wheatley Acts. The former was intended to stimulate private building. The Act allowed Councils to provide grants to private contractors of £100 for houses completed before 1927, either for sale or rent. Local authorities were allowed to build houses on the condition that they could prove to the Ministry that private enterprise was failing.⁵⁰ The Chamberlain Act empowered the Minister of Health to intervene and reduce the size of houses in plans proposed by local authorities. 'Chamberlain houses' were therefore less generous in scale than the previous 'Addison houses.' The Wheatley Act of 1924, devised by the Housing Minister in the first Labour Government, provided an increased Exchequer subsidy for houses completed before 1927. These houses were to be for rent. The longer term basis of the Act provided local authorities a basis with which to plan housing programmes.⁵¹

In Sheffield the Wisewood Estate (completed in 1934) was built under the Wheatley Act and added 946 houses to the Council's housing stock. Wisewood was known locally as the 'Buttons Estate,' as the City Housing Manager explained in 1959, 'this was due to the fact that many of the original tenants followed occupations requiring them to wear some form of "uniform" dress.'⁵² For example employees of the local authority including nurses at the municipal hospitals. This conception concurs with Burnett's statement that the typical council tenant of the 1920s and early 1930s was not the most needy in society, but 'a man in a sheltered manual job which had not been seriously endangered by the depression, who earned slightly more than the average wage and had a family of two young children.'⁵³

⁴⁹ Sheffield Labour Party, *Six Years of Labour Rule* (Sheffield, 1932), 5.

⁵⁰ J. Burnett, *A Social History of Housing* (Routledge, London, 2nd Ed. 1986), 231.

⁵¹ P. Malpass and A. Murrie, *Housing Policy and the State* (London, 1999).

⁵² V. Hughes, *The History of the Growth and Location of the Corporation Housing Schemes*, (Sheffield, 1959), 9.

⁵³ J. Burnett. *A Social History of Housing* (Routledge, London, 2nd Ed. 1986), 238.

The Social Survey of Housing in Sheffield

In 1925 the Citizens Alliance undertook a slum clearance plan to build a housing estate at Wybourn, however this was carried out before the introduction of slum clearance subsidies and although the Wybourn houses had the benefit of gas supply, they did not have hot water or electricity as standard. Tenants had the option of paying two extra shillings extra on their weekly rent if they required hot water and electricity.⁵⁴ The experience of tenants living on the Wybourn Estate was recorded by a social survey published in 1931.⁵⁵ In the same way as the Medical Officer of Health for Stockton-on-Tees in the late 1930s, Dr McGonigle, described the problems of the poorest families on the new council estates of the north-east of England, the report on the housing problem in Sheffield in the early 1930s highlighted the difficulties experienced by those who had been rehoused and as such highlighted the wider problem of developing an effective housing policy.⁵⁶ The Sheffield Social Survey team was headed by A.D.K. Owen, a future General Secretary of the planning and lobby group PEP (Political and Economic Planning) and an instrumental figure in the establishment and work of the United Nations.⁵⁷

The report of 1931 examined the lives of tenants who had moved from the central slum areas to the new suburban Council housing estate at Wybourn. The survey reported that the general sentiment on the estate was that the tenants enjoyed their new homes and felt that their families were healthier as a result of the move. However, the survey found that 35 per cent of those who moved into the new estate had returned to the old industrial and central areas. The new suburban homes being further from the industrial areas incurred greater travel costs, the houses were also

⁵⁴ H. Keeble Hawson, *Sheffield the Growth of a City*, 126.

⁵⁵ A.D.K. Owen, *A Report on the Housing Problem in Sheffield* (Sheffield, 1931).

⁵⁶ G.C.M McGonigle and J. Kirby, *Poverty and Public Health* (London, 1937). A.D.K. Owen, *A Report on the Housing Problem in Sheffield* (Sheffield, 1931).

⁵⁷ Arthur David Kemp Owen, 1904-1969, was an Assistant Lecturer in Economics at Huddersfield Technical College 1926-1929, Director of the Sheffield Social Survey Committee 1929-1933, Secretary of the Civic Division of Political and Economic Planning 1933-36, Co-Director of the Pilgrim Trust Unemployment Enquiry, 1936-37, General Secretary of P.E.P 1940-1941, Personal Assistant to Sir Stafford Cripps 1942-43, Deputy Executive Secretary Preparatory Committee of the United Nations, 1945-46, Executive Chairman United Nations Technical Assistance Board 1951-1965, Co-administrator UN Development Programme 1966-1969. *Dictionary of National Biography, 1961-1970* (Oxford, 1981).

bigger than the inner city back-to backs and therefore more expensive to heat and to furnish. Despite subsidised rents, the houses on the estate were still more expensive to rent than the old houses in the slum areas. Owen found that two thirds of those interviewed paid rents of less than 7s before moving and that a three bedroom house on the Wybourn Estate cost 10s 6d to rent in 1931.⁵⁸ A further report by the Sheffield Social Survey Committee, *A Survey of the Standard of Living* in Sheffield suggested that 7.3 per cent of householders were paying a third of their income out on rent and 20.5 per cent paid more than a fifth.⁵⁹

Other factors such as the camaraderie of the courts and yards of the old terraces were cited by some who moved back, who described feelings of isolation on the windswept hillside housing estate with 'its gardens front and back which some had no desire to tend'.⁶⁰ The garden city houses had been intended to relieve overcrowding. However, to meet the higher rents, some tenants had taken in lodgers, contrary to the tenancy agreement, and some large families were renting the cheaper two bedroom houses. Using the 'Manchester standard' to measure overcrowding, Owen's survey team found that 12.5 per cent of the homes on the Wybourn Estate were overcrowded in 1931, compared to 53.4 per cent the inner city slums being overcrowded.⁶¹ The report recommended that 5000 new houses be built to relieve overcrowding, 20,000 to replace slum property and one thousand to relieve hut and caravan dwellers.⁶²

The issue of the affordability of the new houses was highlighted. The Survey found that of 2,968 working class households surveyed (with an income of less than £5 per week) half were rented at levels that were lower than those set by the Council. The Council charged 10s 9d for a three bedroom house and 12s 11 for a four bedroom house, these were subsidised for those removed from slum clearance areas to 9s and 10s 6d. The median rent for a working class house was 9s.⁶³ The Survey found that the families with an income of less than 40s per week paid between 25% and 33% of

⁵⁸ A.D.K. Owen, *A Report on the Housing Problem in Sheffield* (Sheffield, 1931), 36.

⁵⁹ A.D.K. Owen, *A Report on a Survey of the Standard of Living in Sheffield* (Sheffield, 1933), 31.

⁶⁰ A.D.K. Owen, *A Report on the Housing Problem in Sheffield* (Sheffield, 1931), 39.

⁶¹ The Manchester standard was based on a system of separate bedrooms for both sexes, unless they were a couple and defined overcrowding as over 2.5 people to a bedroom, a child under 10 years of age been counted as half an adult. Owen, *Housing*, 45.

⁶² A.D.K. Owen, *A Report on the Housing Problem in Sheffield* (Sheffield, 1931), 51-53.

their income out in rent, where families with an income of £5 or more paid less than a tenth of their income in rent.⁶⁴

Government subsidy for slum clearance was introduced in 1930 via the Greenwood Act. The process was combined with a grant that favoured the construction of flats that were over three storeys high, and therefore directly shaped the physical nature of inner city life in most British towns and cities.⁶⁵ In Sheffield between the wars, flats continued to be resisted despite the subsidy changes. In order to continue the building programme based on houses, in 1934 the Council dropped the more spacious three bedroom and three downstairs room 'parlour' type houses and built two bedroom houses.⁶⁶ With hot water, bathrooms and gas and electricity, the Council persisted in its policy of building decent houses. The provision of such facilities was questioned by the Ministry of Health. The Estates Committee defended itself against accusations from the Ministry that its policy exceeding minimum standards required of local authority housing, stating that 'only in the provision of both gas *and* electricity' to houses on the estates built in the 1930s, was it going beyond minimum standards.⁶⁷ In 1934 the Estates Committee stated that it 'was not prepared to reduce the specifications [of the houses] even if to do so would result in cheaper homes. We are satisfied that whatever would be the immediate saving would be offset by later cost of repairs'.⁶⁸

The Balance Sheet

The 1930s saw the building of massive suburban council house estates on garden city lines in Sheffield at Parson Cross (5,362 houses), Shiregreen (4,472) Shirecliffe (1,274) and Arbourthorne (2,832).⁶⁹ By 1938 24,374 houses had been demolished under clearance orders, compulsory purchase orders and individual demolition orders. The rate of replacement at 44% of the buildings cleared was the

⁶³ A.D.K. Owen, *A Report on a Survey of the Standard of Living in Sheffield* (Sheffield, 1933), 31.

⁶⁴ A.D.K. Owen, *A Report on a Survey of the Standard of Living in Sheffield* (Sheffield, 1933), 36.

⁶⁵ J. Burnett, *A Social History of Housing* (Routledge, London, 2nd Ed. 1986), 247.

⁶⁶ Sheffield City Council Estates Committee Minutes, 24 April 1934, SCA 108/5.

⁶⁷ Sheffield City Council Estates Committee Minutes, 24 April 1934, SCA 108/4.

⁶⁸ Sheffield City Council Estates Committee Minutes, 24 April 1934, SCA 108/4.

highest in the country.⁷⁰ In total 28,000 council houses were built in Sheffield between 1919 and 1939, an average of 1,250 per year. The private sector built 24,000 houses in the same period meaning that 53.8 per cent of Sheffield's new housing was built by the public sector compared to a national average of 27.6 per cent.⁷¹ At the end of the 1930s the Council was proud of its advances in Housing. As can be seen in table 5.1 below, presented to the Annual Conference of the Royal Sanitary Institute, William Asbury pointed out that Sheffield had built the most Council houses of all the major County Boroughs in 1938:

Table 5.1
Houses provided by Local Authorities during the 12 months ended 30
September 1938 in the largest County Boroughs in England⁷²

County Borough	Population	Houses Provided by LA during 12 months ended 30 Sept 1938
Birmingham	1,043,000	2,506
Liverpool	867,110	2,638
Manchester	751,371	1,911
Sheffield	518,200	2,566
Bristol	415,100	1,074
Leeds	491,860	2,057
Hull	319,400	472
Newcastle	290,400	505
Bradford	289,510	607
Nottingham	278,800	993

⁶⁹ A. Thorpe, 'The Consolidation of a Labour Stronghold 1926-1951', in C. Binfield (ed.), *History of the City of Sheffield* (Sheffield, 1993), 101. V. Hughes, *The History of the Growth and Location of the Corporation Housing Schemes* (Sheffield, 1959), 9.

⁷⁰ M. Bowley, *Housing and the State* (London, 1945), 154.

⁷¹ P. Dickens, S. Duncan, M. Goodwin and F. Gray, *Housing States and Localities* (London, 1985), 166

⁷² W. Asbury, 'The Future of the Public Health Services', *Journal of the Royal Sanitary Institute*, 59, (1938), 727-740.

In public statements Asbury explicitly linked developments in Sheffield's local authority housing policy to health indicators, seeing the reduction of the city's Infant Mortality Rate and the Maternal Mortality Rate as a consequence of both the housing programme and the provision of clinics. Writing in the *Sheffield Forward* in February 1939, Asbury contrasted health results before and after the election of the Labour Council:

In 1924, the total births were 9,712 and 871 infants under one year died. In 1938 the total births were 8,181 and 404 died. The number of women who died during childbirth was 23 compared to 44 in 1924. All this has not been achieved by the waving of a magic wand, but by the steady progress and development of our maternity and child welfare services and by the considerably improved housing conditions. At least 25 per cent of the total population of the city of Sheffield have been re-housed by the local authority.⁷³

For the Labour Council in Sheffield health and housing went hand in hand. This policy formulation was expressed in words as the basis of their election campaign throughout the 1920s and was implemented and defended in deeds in the 1930s.

Conclusion

Analysis of policy statements and the actions of the Council illustrates that a belief in the health benefits of decent living standards was a key driving force behind Labour's distinctive housing policy. Labour politicians in Sheffield in the 1920s and 1930s saw health policy and housing policy as two sides of the same coin. Decent quality living conditions were provided in large numbers and the Council was resolute in its policy of building decent quality houses, rather than inner city flats despite changes to subsidies and despite opposition from the Ministry of Health, the Conservative/Liberal Alliance and its critics in the Communist Party.⁷⁴ Housing dominated the election campaigns of the 1920s and Labour reintroduced

⁷³ *Sheffield Forward*, February 1939.

⁷⁴ In 1938 The Sheffield Branch of the Communist Party agreed with the Liberal/Conservative alliance policy and declared that 'the City Council should direct its attention to the erection of the block type of flats, which can house thousands of families'. CPGB Sheffield Branch, *The Peoples Policy for the City*, (Sheffield, 1938), 8.

compounding in rates collection as one of its first acts after the election of November 1926. Its commitment to public housing and Direct Labour saw the Department in 1938 employ 634 people.⁷⁵ Housing policy was not perfect and there were issues with affordability that were seen nationally. However, the Council made attempts to improve peoples' lives through housing and addressed the issue of isolation that could be a feature of the huge housing estates. When it announced its intention to build community centres on the new estates in 1938, at a cost of £120,000, the Progressive Party member Alderman Jackson described the Council tenants of Sheffield as 'the pampered pets of the corporation'.⁷⁶ There could be some truth to Thorpe's contention that Labour in Sheffield courted a 'clientage' of voters by providing decent housing and jobs for citizens. What is certainly clear, from policy statements, campaign material and Estates Committee minutes is that in the mind of Labour politicians in Sheffield between the wars, health policy and housing policy were one and the same.

⁷⁵ A. Thorpe, 'The Consolidation of a Labour Stronghold 1926-1951', in C. Binfield (ed.), *History of the City of Sheffield* (Sheffield, 1993), 101.

⁷⁶ *Sheffield Telegraph*, 28 June 1938.

The Politics and Ideology of Local Authority Health Care in Sheffield: 1918-1948.

Conclusion

This thesis has attempted to provide a more detailed and more nuanced picture of local authority health care in Sheffield in the 1918-1948 period than has previously been available. The Sheffield example illustrates how local actors and groups sought to address problems of finance and access in health care using the policy instruments available at the time. The methodology adopted has shown that unpacking the specific local, social and political processes that shaped health service provision in a locality is necessary if we are to arrive a better understanding of the history of health and social policy in Britain before the NHS.

Can the Sheffield Labour Party be said to have anticipated the Welfare State as we know it today by taking advantage of all the permissive legislation available, some of which only became compulsory later? To a qualified degree, it can. Events in Sheffield illustrate that a progressive local authority elected on a platform of municipal socialism achieved great steps towards dealing with the general problems of access and finance, problems that prevailed nationwide and that were ultimately responsible for the nationalisation and centralisation of health services in Britain in 1948. Some pioneering steps were taken in Sheffield *before* Labour was elected to office in 1926. For example the early introduction of a compulsory TB notification scheme in 1903 well before national legislation and arguably the open air school policy developed in the Edwardian era. These policies serve to remind us of the importance of local Medical Officers of Health in any assessment of local authority health care.

How does the charge that Medical Officers of Health failed to develop a distinct medical philosophy in the pre-NHS period hold for Sheffield? The work has shown that in the 1920s Frederick Wynne asserted a significant strength of character and distinctive public health leadership. His Annual Reports did not shy away from drawing attention to the less positive aspects of health in Sheffield in the period. His difference of opinion with William Asbury over smallpox vaccination, illustrated a

willingness to defend medical science in a high profile debate that directly pitched a Council employee against an elected politician, the Labour Chairman of the Committee that he and his Department answered to. The fact that Wynne managed to persuade 100,000 Sheffielders to seek smallpox vaccination between 1925 and 1927 suggests that he possessed eloquent skills as a promoter and communicator of public health. Frederick Wynne was a colourful and opinionated character. His willingness to stand up to the vested interests in the milk trade and push for compliance to local regulations, that strictly, went beyond the letter of law, showed leadership qualities and the strength to take a stand against commerce in the pursuit of a better food supply and better health for the City.

Wynne's refutation of the claim that MOsH in the 1920s did little more than go around 'smelling drains' indicates that the job of MOH in Sheffield was a medical and a scientific one. The close links to the University of Sheffield Medical School regarding all the laboratory work of the Public Health Department and the conferment of the Sheffield MOsH as Honorary Professors of Public Health until 1947, supports this view, as does the joint research work Wynne completed with Arthur Hall on encephalitis in 1924 and his numerous professional publications. As well as being an environmental and scientific role, the job of MOH was also a human relations role where an understanding of how people thought, worked and actually lived their lives was important and meant that Sheffield was fortunate to have a playwright, novelist, scientist and former soldier as its head of public health and social medicine for the 1920s.

The main charge against MOsH - that they were weak and ineffectual public health administrators in the first half of the 20th century rests on the claim that their energies were spread too thinly in the 1930s when the remit of public health expanded to take in hospitals and curative services, as well as the traditional environmental watch-dog role. With the death of Wynne in 1930, John Rennie stepped up to the role of MOH and though he ran an effective TB service that ensured access to treatment for many more patients, young and old, than the Ministry felt was appropriate, his involvement in the wider sphere as the chief public health Medical Officer for the Borough was limited. It was James Clark the Deputy MOH, Rennie's former tutor and Medical Superintendent of the Municipal Hospital service whose dynamism and

dedication so impressed the Ministry of Health in the LGA (1929) Survey of 1934 and the Wartime Hospitals Survey. Clark was a highly effective public health administrator and surgeon who transformed the Firvale Union Infirmary into the fully functioning City General (today the Northern General) Hospital in the north of the city. His plan for the joint municipal and voluntary hospital service for Sheffield that operated in the 1930s, co-designed in association with Professor Arthur Hall, was a significant development. The diplomatic skills of the Town Clerk, Sir William Hart should also be recognised here in brokering the deal that brought the two sides of the hospital divide together in order that a functioning hospital service for Sheffield could be provided. One that utilised spare capacity at the municipal hospitals, reduced the waiting lists at the voluntary hospitals and ensured that a former Poor Law infirmary became a fully functioning municipal general teaching hospital in the years before nationalisation.

The primary aim of this investigation has been to look into local authority health care in Sheffield in 1918-1948, however, as has been seen, joint working was important to the Sheffield example and it has also been necessary to examine important aspects of the voluntary sector. The creation of the Joint Hospitals Council in 1919, produced an unusual situation where the four independent voluntary hospitals of the city united under a single advisory body in order to address the serious financial difficulties faced by all voluntary hospitals after the First World War. This voluntary hospital join-up did not happen in other places. Cities like Birmingham and Bristol also had multiple teaching hospital facing financial problems and a situation of overlapping services, however the long tradition of the voluntaries as independent entities and free standing charitable organisations militated against voluntary hospital co-ordination in other towns. The creation of the Penny in the Pound workers hospital contributory scheme by the Sheffield Joint Hospitals Council was another significant and distinctive development.

Sheffield was not unique in having a hospital contributory scheme, Liverpool also had a 'Penny in the Pound' scheme and it is estimated that nationally the contributory schemes had 10 million members by the end of the era. Sheffield was however unique in having a scheme that included a pro rata employers' contribution of one third of the amount raised by the workers through pay roll deduction and

collections - an employers' contribution that was actually paid. The efforts taken by the Joint Hospitals Council to win the support of the Labour movement illustrate that Fred Osborn and the scheme organisers considered the concessions called for by the Trades Council representatives a price worth paying for the effective operation of a scheme that could save the voluntary hospitals of the city. There was no doubt from all sides involved, including Sidney Lamb the professional contributory schemes administrator who set it up, the medical staffs of the hospitals who worked in hospitals financed by the scheme, by Labour representatives and the contributors themselves that membership of the Sheffield Penny in the Pound scheme was effectively hospital insurance ensuring access to hospital treatment for the 350,000 contributors and their dependents in Sheffield and its District.

So, how important was politics and ideology? The Labour Council provided the finance for improvements at the City General Hospital, it made attempts to take over the Middlewood Mental Hospital and provided support for birth control clinics where it legally could. The years following the First World War were a period of adjustment to democracy. The extension of the franchise increased the size of the electorate at the same time that local government powers expanded, particularly in the provision of health services by those local authorities that wished to take up powers in permissive legislation. The era was one where the engagement of the electorate in local politics reached its peak. The average turnout in municipal elections in Sheffield in the 1920s, 1930s and 1940s was around 50 per cent.¹ After the 1926 local election the Labour Council in Sheffield received a mandate for reform for most of the rest of the twentieth century and Labour consolidated its position through a programme of municipal service provision, in health, housing, transport, education and in the better management of the Borough in terms of finance and modern administration than had previously seen under the Liberals and Conservatives.

Analysis has shown that municipal hospital provision was extended in Sheffield and that the local authority service operated within a complex policy landscape – but one that mutually beneficial. The extent of partnership working in a mixed economy of health care has been seen and a pragmatic approach was taken in order that the

various elements in health and hospital care could be brought together and operate as a system. The existence of partnership working and joined up provision does not necessarily mean that politics and ideology were not relevant. Research shows that the individual responsible as the broker of the Hall/Clark municipal and voluntary hospital plan was prominent in the national voluntary hospitals organisation. The Sheffield Town Clerk, Sir William Hart was a leading light in the British Hospitals Association. It was Hart that moved the motion that established the BHA's Sankey Commission on regionalisation of the hospital service that partly added to the development of the argument in the 1930s and 1940s for a national health service based on regional structures deliberately designed to be independent of local government.

On the other side of the hospital divide, William Asbury Labour Chairman of the Health Committee maintained his commitment to a national health service based on local government throughout. There is no doubt that elements within the Sheffield Labour movement achieved a great deal of satisfaction from their involvement in the Joint Hospitals Council, the role of Moses Humberstone as the President of the of Contributors' Association and Vice President of the Sheffield Trades and Labour Council being the prime example. Despite winning the case for the employers' contribution and for greater representation on the JHC and on the Boards of the hospitals and despite the attendance of huge numbers of contributors at quarterly meetings in the 1920s, 30s and 40s - there is scant evidence that the contributory scheme and the S&DAHC wielded any real power or reversed any decisions made by the hospital leadership. Asbury's brief membership of the JHC is telling, and unlike Moses Humberstone, he was not afraid to express his less than fraternal views. Speaking in 1938, Asbury plainly put the case against contributory schemes and for local democratic control:

The idea that admission to a hospital should be determined solely by medical or surgical needs finds little favour in those areas where voluntary hospital contributory schemes are in existence. The plain blunt fact is that the majority of the real poor must find their way to the municipal hospital. We cannot avoid much longer a thorough

¹ Average turnout at local elections in Sheffield in the 1920s was 50.4 %, 49.2% in the 1930s and 47.3% in the 1940s. W. Hampton, *Democracy and Community* (Oxford, 1970), 313.

overhauling of our general hospital system. In what sense does the care of the sick differ from these other social services that it should continue to be dependent on private charity, whatever form such charity should take? It is immaterial whether it be in the form of weekly collections from the wages of the workers, so called provident associations, or bequests from those that have had a fair share of this world's goods and are well disposed to the voluntary system. It depends entirely on individual goodwill, ignoring collective responsibility.²

For Asbury, as for the Labour Party leadership in general until very late in the day, the only sensible response to the hospital and health problem was for collective action and the creation of a national health service based on local government.

As with any case study the question remains of the usefulness of local studies such as this one. Studies of particular places are self evidently locally specific and atypical of the country in general. The approach adopted however, can be applied elsewhere and the challenge set by Webster and Freedon to analyse the contribution of politics and ideology to the development of social policy in Britain though detailed analysis of a wide range of source material has been seen to be a useful one. As John Welshman notes in his study of public health in 20th century Leicester, the degree of local autonomy and the influence of local factors in the pre-NHS era means that it is only through detailed archival work in the localities using a wide range of sources that the development of local authority health care in twentieth century Britain will be more fully understood.³

Analysis of events in health and hospital history in Sheffield have shown that far from being the passive recipients of Ministry of Health dictats, Sheffield Council was dynamic and pro-active in its goals for health service provision. The desire to act as a fully functioning health authority was such that Sheffield politicians and Council officers informed the Ministry of Health that in Sheffield the development of the municipal hospital service in the city would not be under the national legislation used

² W. Asbury, 'The Future of the Public Health Services', *Journal of the Royal Sanitary Institute*, 59, (1938), 734.

elsewhere, the Local Government Act of 1929, but under Section 249 of the Sheffield Corporation (Consolidation) Act 1918 and Section 131 of the Public Health Act 1875. Sheffield was not alone in this expression of independence and local agency. When Bradford Council set up its municipal hospital in 1921 it also cited Section 131 of the 1875 Public Health Act – intended by the LGB to allow for the provision of infectious disease hospitals via local authorities, but drafted vaguely enough to be interpreted by those who wanted to, that permission was available on the statute for local authorities to provide fully functioning municipal general hospitals.

Taking a cue from the work of Pickstone and Sturdy this thesis has attempted to contextualise events in the history of health care in Sheffield. It has made an assessment of the local social, cultural, and political characteristics prevalent in the period and assessed the possible reasons for choices and actions taken by individuals and groups in the formation of health policy. Taking a cue from Webster and Freedon regarding the relevance of ideology to all historical eras, this thesis has investigated and presented research information drawn from newspapers, journals, committee minutes, and the records of local and national archives to argue that contrary to Tanya McIntosh's statement that 'in Sheffield 'both the Council and voluntary groups pursued policies that were not based on ideology but depended on pragmatism and consensus ... the tone of all groups was pragmatic rather than ideological,'⁴ ideology, politics and structured ways of thinking remained important to decision making in health care in the period from 1918-1948.

The Labour Council was elected on a programme of municipal socialism and developed a distinctive health and housing policy in the 1920s and 1930s. Clear differences between the Labour Party and its Conservative/Liberal opponents have been discussed, particularly over the issue of housing, which it is argued was an integral part of the Council's health policy. The relevance of politics and ideology goes beyond party politics however, and the work has also examined the development of health care provision and health policy in Sheffield through an analysis of the

³ J. Welshman, *Municipal Medicine: Public Health in Twentieth Century Britain* (Peter Lang, Oxford, 2000), 299.

⁴ T. McIntosh, 'A Price Must Be Paid For Motherhood: The Experience of Maternity In Sheffield, 1879-1939' (University of Sheffield PhD. thesis, 1997), 220.

voluntary sector including the Joint Hospitals Council and the professional politics of the medical staffs of the voluntary hospitals.

The limitations of the thesis stem mainly from its case study approach. Some comparisons with other areas have been made throughout the work but a comparative analysis of a similar sized city or other Yorkshire town not under a Labour Council would potentially have strengthened the findings and the argument. As the thesis has discussed, Sheffield is an unusual city in terms of its size, class structure, geography, landscape, politics and industry, therefore finding a suitable comparator for Sheffield is no easy task. The lack of a counterfactual can also be seen in the analysis of the Labour Party in Sheffield. The Party dominated local politics for three quarters of the twentieth century. The actions of the Liberal/Conservative alliance can be assessed for the first 26 years of the century and in 1932-33. In that year the anti-Labour alliance abolished the Direct Labour Department, and in the pre-1926 era the issue of the housing record of the Alliance in terms of ending compounding and constructing poorly built council accommodation meant that the appeal of the 'economising' anti Labour parties was not felt in Sheffield. The study is also purely qualitative and not an economic history. Financial data has not been extensively utilised and the analysis has been one of policy statements and actions rather than fiscal analysis. The study has also focussed on events in health and politics in Sheffield in the 1920s and 1930s, arguably there is more to the history of health services in Sheffield and its region that could be analysed through an investigation of events during the era of the Second World War. The Emergency Hospital Service brought in degrees of central control and uniformity previously unseen, therefore in order to develop our understanding of the specific local, social, cultural and political factors – the focus on the years before the EHS and the NHS can be justified.

In 1992 Jose Harris pointed out that:

Legislation after the Second World War created in Britain one of the most uniform, centralised, bureaucratic and "public" welfare systems in Europe, and indeed in the modern world. Yet a social analyst of a hundred years ago would have observed and predicted the exact opposite:

that the provision of social welfare in Britain was and would continue to be highly localised, amateur, voluntaristic and intimate in scale.⁵

A social analyst of 70 years ago may well have observed that the future of health services in Britain would be characterised by ‘a unified hospital system controlled by the local authorities’.⁶ Maintaining the Labour Party’s long standing plans for democratic control of hospitals and health services by local government would have given the national health service an element of democracy that it has lacked since its inception.

This examination of health and politics in Sheffield in the era between 1918 and 1948 has illustrated that one local authority was capable of operating as a health authority as part of a health care system in concert with a well co-ordinated and unified voluntary sector, making use of a virtually universal quasi-insurance system for hospital admission as well as services provided by the rates. The research has also shown that the particular social, cultural, industrial and political circumstances in Sheffield were unique and therefore the system developed in Sheffield was unlikely to be able to be replicated elsewhere, or indeed *everywhere* in the UK in 1948. The work has attempted to make a contribution towards assisting our understanding of the challenges and choices facing policy makers in Sheffield before the NHS.

⁵ J. Harris, ‘Political Thought and the Welfare State, 1870-1940: An Intellectual Framework for British Social Policy’, *Past and Present*, 135, (May 1992), 116.

⁶ W. Asbury, ‘The Future of the Public Health Services’, *Journal of the Royal Sanitary Institute*, 59, (1938), 734.

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	National Events	Sheffield Events
1918	<p>First World War ends.</p> <p>Representation of the People Act, universal male suffrage, and women over 30. Those in receipt of poor relief no longer dis-enfranchised. Constituency boundaries redrawn. Local government vote given to all house holders. Conscientious objectors disenfranchised for five years.</p> <p>Maternity and Child Welfare Act, allows Local Authorities to set up grant aided clinics.</p> <p>Midwives Act, makes training rigorous.</p> <p>Labour Party constitution adopts socialism.</p> <p>Worldwide flu epidemic.</p>	<p>Representation of the people Act increases local electorate. Prior to Act 59% of adult males had vote in Sheffield.</p> <p>Act created two new seats all 7 won by Lloyd George Coalition.</p>
1919	<p>Ministry of Health established, with powers over health, housing, and local government.</p> <p>Scope of National Health Insurance extended.</p> <p>Nurses Registration Act.</p> <p>Addison Housing Act, requires local authorities to survey housing needs and report to Ministry of Health. Provides state subsidy for council house building.</p> <p>First local elections under new franchise. Labour makes huge advances in north and midlands.</p>	<p>Anti-Socialist Citizen's Alliance wins control of Council. Labour contends every municipal seat for first time and wins 11 of 64 council seats.</p> <p>Municipal milk supply established.</p> <p>Governing bodies of Sheffield's four voluntary hospitals address financial crisis by forming Sheffield Consultative and Advisory Hospitals Council.</p>
1920	<p>Dawson Report on Medicine and Allied Services calls for greater co-ordination in health care.</p>	<p>The two Sheffield Trades Councils divided since 1908 combine.</p> <p>Dr Fred Wynne appointed MOH for Sheffield. Trained in Dublin and Manchester, previously MOH for Leigh, and for Wigan, playwright, novelist, columnist for Manchester</p>

		<p>Guardian.</p> <p>Council votes against building elementary schools.</p> <p>Sheffield Corporation Act includes Handsworth and Wadlsey in Sheffield County Borough.</p> <p>Edward Mellanby appointed Professor of Pharmacology, University of Sheffield.</p>
1921	<p>Public Health (Tuberculosis) Act, responsibility of Local Authorities to treat sufferers.</p> <p>Dismissal of Medical Officer of Health made subject to approval of Minister.</p> <p>End of Addison housing scheme.</p> <p>Geddes Committee recommends sweeping cuts to government expenditure.</p> <p>The Mayor and 21 councillors are imprisoned in the London borough of Poplar for increasing benefit payments to the unemployed.</p>	<p>Municipal election sees Labour Group increase to 16 Councillors, including Ernest Rowlinson, future Leader of Sheffield City Council</p> <p>Workers contributory hospital scheme, 'Penny in the Pound Scheme' launched jointly by Sheffield's four voluntary hospitals. Labour movement represented on the Hospitals Council.</p> <p>Sir Henry Hadow (Vice Chancellor of Sheffield University) becomes Chairman of Sheffield Hospitals Council.</p> <p>Moses Humberstone (Labour Councillor) becomes President of the Sheffield and District Association of Hospital Contributors.</p> <p>City Council under the Citizen's Alliance ends practice of compounding where rates are collected as part of rent, replaced with twice yearly lump sum paid directly by tenant. Leads to massive arrears, and 289 imprisoned for non-payment.</p> <p>Unemployment reaches 69,300.</p> <p>Riots outside Town Hall.</p> <p>Infant mortality rate stands at 99/1000 live births.</p>

1922		<p>Municipal milk supply ended.</p> <p>A.V. Alexander elected as Co-op Party MP for Hillsborough. Labour take Attercliffe and Brightside, and hold them in 1923 and 1924.</p> <p>Sheffield Chamber of Commerce presents Sir Eric Geddes with a stainless steel axe.</p> <p>100 Deaths from Respiratory TB</p>
1923	<p>Chamberlain Housing Act provides subsidy to private house builders or local authority if they can do work cheaper.</p>	<p>Municipal election sees Labour Group increase to 20 councillors.</p> <p><i>Sheffield Mail</i> reveals slum landlord scandal of 147 notices served by MOH on City Councillors regarding poor state of properties, including members of Health Committee and the Chairman, Citizens Alliance Councillor Kaye. Kaye loses seat in November election.</p>
1924	<p>First minority Labour Government, lasts 9 months.</p> <p>Wheatley Housing Act introduces 15 year scheme of subsidy to encourage local authorities to build houses to let.</p>	<p>Publication of Patrick Abercrombie's <i>Sheffield a Civic Survey</i>. Recommends 75,000 people be rehoused away from industrial zone.</p> <p>Work begins on Manor Housing Estate, criticised by Labour for low quality and housing shortage of school places.</p>
1925		<p>The Ecclesall Poor Law Union and Sheffield Poor Law Union combine into one city wide body.</p> <p>Labour Group on Council increases to 24.</p> <p>Communist Councillors no longer entitled to Labour whip.</p>
1926	<p>General Strike.</p> <p>Smoke Abatement Act lays down more stringent regulations regarding pollution.</p> <p>Boards of Guardians (Default) Act gives Minister of Health power to</p>	<p>Labour win overall majority on Sheffield Borough Council, taking six seats from the Citizens.</p> <p>William Asbury becomes Chairman of the Health Committee.</p> <p>Number of contributors to '1d in £'</p>

	appoint a replacement board for Guardians deemed to be abusing office.	<p>scheme reaches 220,000 individuals and 3,500 firms.</p> <p>Smallpox cases notified in October.</p>
1927		<p>Smallpox epidemic in industrial East End, 667 cases notified.</p> <p>100, 000 Vaccinated against smallpox between 1925 and 1927.</p> <p>Health Committee reorganised. Increased from 15 to 21 members, incorporates weights and measures and care of the mentally defective.</p> <p>Municipal Printing Department established.</p> <p>Council reintroduced compounding for rate collection.</p> <p>Direct Labour Department set up to repair houses, schools, and public buildings.</p> <p>Tram building department established.</p> <p>Infant mortality rate stands at 91, Leeds at 81, Bradford, 94.</p>
1928		<p>Council house waiting list closed for one year, stands at 7000.</p> <p>Tuberculosis rehousing scheme introduced, includes rent subsidy.</p> <p>Last year of policy introduced by Citizens to use profits from municipal trading to reduce rates.</p>
1929	<p>Local Government Act, Poor Law Guardians abolished, responsibility for poor relief transferred to local authorities. Block Grant introduced, removal of limits on borrowing and Local Authorities permitted to appropriate former Poor Law Infirmaries as Municipal General Hospitals.</p> <p>Labour forms its second minority government.</p>	<p>Single municipal abattoir replaces 166 private slaughterhouses.</p> <p>Number of electoral wards increased from 17 to 24, Council increased to 96 members. Labour wins 47 councillors and 16 aldermen.</p> <p>Labour wins Park and Central constituencies, for the first time retains Attercliffe, Brightside and Hillsborough.</p>

		Council launches Peace Day for Sheffield Schools.
1930	<p>National Health Insurance (Prolongation of Insurance) Act extends entitlement of unemployed workers.</p> <p>Greenwood Housing Act allows local authorities to declare slum clearance areas, for redevelopment and provides subsidies for rehousing.</p>	<p>Former Poor Law Infirmaries become City General Hospital and Nether Edge Hospital, to be run as general hospitals under Health Committee.</p> <p>Asbury becomes chairman of Public Assistance Committee.</p> <p>Dr John Rennie appointed MOH for Sheffield, previously employed as Tuberculosis Officer.</p> <p>Under Greenwood Act Council demolished 9,570 houses in clearance areas.</p> <p>Upperthorpe Public Wash House Opens, 8 washing machines, 16 hand washing stalls. 5 Public Wash houses by 1937, Wincobank, Heeley, Brightside, Oakes.</p> <p>Ambulance Service for all Sheffield Hospitals co-ordinated.</p> <p>Co-op affiliates to Trades Council.</p> <p>Citizen's Alliance 'united front' of Liberal and Conservative Partys, rebrands as The Progressive Party.</p> <p>Superannuation introduced for council employees.</p> <p>Sheffield, Rotherham and District Smoke Abatement Committee established, first regional committee in Britain. Chairman, William Asbury.</p>
1931	National Government economy package reduces benefits by 10 per cent.	<p>Conservatives take all seven Sheffield constituencies in general election.</p> <p>Howard Florey takes up Joseph Hunter Chair of Pathology, University of Sheffield.</p>

		<p>Unemployment stands at 34 per cent of insured workers. The highest in British cities for that year.</p> <p>53 cases of smallpox notified.</p> <p>Hall/Clark Plan for Sheffield Hospitals.</p>
1932	Town and Country Planning Act, extends planning power of local authorities to encourage major schemes.	<p>Maternity and Child Welfare clinics opened at Nether Edge and City General municipal hospitals.</p> <p>Infant mortality rate 73.</p> <p>Unemployment at 60,000.</p> <p>Sheffield City Hall opens for entertainment and public meetings.</p> <p>Progressive Party win majority on Council</p> <p>Direct Labour Department closed. Its contract for the extension to City General Hospital given to private building firm.</p>
1933	Wheatley housing subsidies abolished early.	<p>Labour regains overall control of Council. 50 seats, majority of four.</p> <p>Direct Labour Department re-established.</p> <p>Sheffield Extension Act, incorporates Norton Rural District.</p>
1934	Labour wins control of London County Council.	<p>City General Hospital treats 334 abortion cases.</p> <p>Maternal Mortality at 6.1 per 1000 live births.</p>
1935	<p>Housing Act obliges local authorities to survey overcrowding, and provides grants.</p> <p>Home Office Air Raid Precaution plans require local authorities to prepare plans.</p>	<p>Riot by unemployed outside Town Hall. Sheffield becomes first Local Authority to reinstate unemployment benefit cut.</p> <p>General Election; Labour regains constituencies of Attercliffe, Brightside, Hillsborough and Park.</p> <p>Council majority increases to 14.</p>

		<p>Large scale suburban council housing estates started at Parson Cross (5, 362) houses, Arbourthorpe, (2, 832), Shirecliffe,(1,274).</p> <p>National Conference of Labour Women, held in Sheffield.</p> <p>Annual Conference of British Contributory Schemes Association held in Sheffield.</p> <p>Council introduces subsidised milk scheme to schools.</p> <p>Work starts on Ladybower reservoir, opens 1944.</p>
1936	<p>Voluntary Hospitals (Paying Patients) Act allows voluntary hospitals to accept private patients.</p> <p>Midwives Act creates full-time salaried service, barring of unqualified midwives from attending births.</p>	<p>Referendum held by Council to gauge public opinion allowing Public Houses on municipal housing estates. Agrees to provide restrictive licence for one pub on each estate.</p> <p>2000 cases of diphtheria notified, 86 deaths.</p>
1937	<p>National Health Insurance scheme extended to 14 and 15 year olds at lower rate of contribution and benefit.</p>	<p>Municipal Domicilliary Midwifery Scheme introduced.</p> <p>Sheffield Corporation Bill attempts to take control of Middlewood Mental Hospital from the West Riding County Council.</p> <p>Asbury becomes Chair of ARP Committee.</p>
1938		<p>Local Authority Maternity and Child Welfare Clinic opens at Firth Park.</p> <p>Public Health Laboratory built at City General Hospital.</p> <p>Hospitals Council launches Million Pound Appeal Fund, to build new general hospital near to University. Raises £500,000 by 1948.</p> <p>Housing Department established, separate from Estates Department.</p>

		<p>Plans announced to build community centres on housing estates.</p> <p>Maternal Mortality at 2.7.</p>
1939	<p>Second World War Declared.</p> <p>Housing (Emergency Powers) Act, allows local authorities to use any building as housing.</p> <p>Cancer Act increases provision for treatment allows for state loans to the National Radium Trust.</p> <p>Government suspends municipal elections for the duration.</p> <p>Whooping cough and measles become notifiable diseases.</p>	<p>ARP Committee replaced by Emergency Committee.</p> <p>Amalgamation of two voluntary hospitals, Sheffield General Infirmary and Sheffield Royal Infirmary</p> <p>Rebuilding of Lodge Moor Isolation Hospital Complete.</p> <p>O.B Steward (Clerk and Solicitor to Derwent Valley Water Board) elected President of Sheffield and District Association of Hospital Contributors.</p> <p>Infant mortality rate 48.</p> <p>Maternal mortality rate 2.37.</p> <p>Central bus station planned for Pond Street.</p>
1940	<p>Churchill replaces Chamberlain as Prime Minister.</p>	<p>German Aerial bombardment, 'Blitz', raids target Sheffield City Centre and the industrial East End. 589 killed, 488 seriously injured. 134 people buried together in mass municipal grave.</p> <p>Nether Edge, Jessops and Commonsides Hospitals suffer damage.</p> <p>Information Bureau set up at Central Library, co-ordinates information between local authority and people.</p> <p>11,000 notifications of measles, 8 deaths.</p>
1941	<p>National Health Insurance Contributory Pensions and Workmen's Compensation Act, increases rate of contribution and benefit, and extends scope of</p>	<p>Ernest Rowlinson dies.</p> <p>Asbury appointed Council Leader.</p> <p>Infant mortality rate 67.</p>

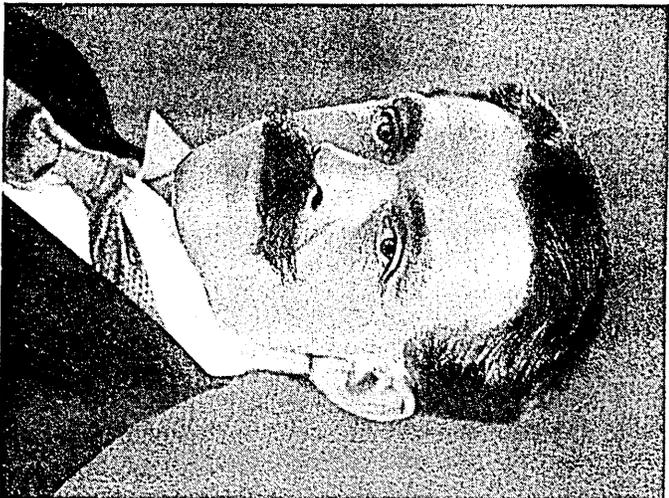
	scheme to those earning higher wages.	Diphtheria immunisation campaign launched. 1,472 cases of diphtheria notified.
1942	Beveridge Report on Social and Allied Services published.	Asbury leaves Council to become Deputy Regional Commissioner for Civil Defence, Southern Region then, Land Commissioner for North Rhine Westphalia, 1946-1948, and Land Commissioner for Schleswig-Holstein, 1948-1950. Frank Thraves becomes Leader of Council. 1,147 cases of diphtheria notified.
1943	Defence Regulation 3b introduced, identifies sexual contacts spreading disease.	783 cases of diphtheria notified.
1944	Town and Country Planning Act gives local authorities increased powers to acquire land. Government announces plans to issue pre-fabricated housing. NHS White Paper proposes local government lead in health service.	<i>Sheffield Replanned</i> published as part of reconstruction plans. Ministry of Health allocates 2,000 prefabricated houses to alleviate housing shortage.
1945	End of Second World War. First majority Labour Government. Local government vote given to all adults, rather than householders.	Ministry of Health <i>Hospital Survey of Sheffield and the East Midlands</i> published. Parsons, Clayton Fryers, and Godber, critical of the buildings and situation of every Sheffield hospital. Praise local authority municipal hospital, The City General for its role as a general hospital with resident staff, specialists, laboratory and treatment of acute cases, rather than merely chronic cases. Labour increases majority on council. Labour 59, progressives 39, Independents 1, Communists, 1. General Election; Labour hold Attercliffe, Brightside, Hillsborough and Park, and gain Central. Conservatives hold Ecclesall and Hallam. Mass radiography unit opened at Ellin Street. Encouraged early

		<p>detection of TB through periodic x-ray.</p> <p>VD clinic opened at City General Hospital, previously VD clinics were based in the four voluntary hospitals.</p> <p>James Clark Medical Superintendent at City General Hospital (appointed 1915), defers retirement to oversee transfer to National Health Service.</p>
1946	<p>NHS Act. Legislates for comprehensive, free at the point of use, universal health service funded through taxation.</p> <p>Sheffield named as a Regional Hospital Board.</p>	<p>J.H. Bingham becomes Leader of Council.</p> <p>Labour gain three seats from the Progressive Party, and one from Communist Party.</p> <p>Public Health laboratory opens at City General Hospital.</p> <p>127 cases of diphtheria notified.</p>
1947		<p>Dr Llwyn Roberts becomes MOH.</p> <p>Labour majority increases to 36.</p> <p>Plans for College of Technology established.</p> <p>41 cases of diphtheria notified.</p>
1948	<p>5 July 'Appointed Day' for the introduction of the NHS.</p> <p>Electricity nationalised.</p> <p>Gas Nationalised.</p>	<p>Voluntary hospitals and Municipal control of health services including hospitals passes to NHS Regional Hospital Board.</p> <p>Municipal payroll reduced by 2,778 employees or by 16 per cent.</p> <p>Progressive Party, replaced by Sheffield Conservative and Liberal Federation.</p> <p>Work starts on Royal Hallamshire Hospital.</p> <p>2,156 temporary and 2,056 permanent houses completed since 1945.</p>

	<p>Infant mortality rate 32.</p> <p>Maternal Mortality 0.64.</p> <p>Municipal elections suspended as polling moves from November to May.</p> <p>Building work begins on Nether Edge Maternity Unit, 40 lying in beds.</p> <p>Death rate from respiratory TB 44/100,000</p> <p>Population 514,000</p> <p>Death Rate 5,797</p> <p>26 deaths from whooping cough, 7 deaths from measles.</p>
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COUNCILOR W. ASBURY
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