

FROM WORKHOUSE TO NHS HOSPITAL IN BRITAIN

1929-1948

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The Poor Law was a central issue in the social history of nineteenth century Britain, but much less so in the twentieth, although it was not abolished until 1948. Few pieces of legislation can have had such a lingering death, in spite of its unpopularity and the thinning ranks of its defenders. It survived a world war, the coming of universal suffrage and a great depression. In spite of various efforts to undermine it, the Poor Law was still a substantial part of social policy when World War II broke out. It added to the problems of evacuation and health care during that war, and it required a major political upheaval to be rid of it.

The Poor Law had become an important part of health care for the working classes during the later nineteenth century. In the larger towns, Poor Law guardians built substantial separate infirmaries, often next to their workhouses. These institutions took a major share in caring for the sick, particularly those labelled 'chronic', though this definition was rather flexible, given changes in medical knowledge. Local voluntary hospitals usually preferred to concentrate on 'acute' cases. Although Poor Law infirmaries were not supposed to accept infectious cases, they usually remained on standby for the tuberculous because public sanatoria often could not cope with demand. The infirmaries were also maternity hospitals, especially for unmarried mothers, and offered asylum to the physically and mentally handicapped. The division of patients between workhouse and infirmary was usually based on administrative need rather than any careful rationale. The elderly, the largest group of workhouse inmates, were in all stages of health and infirmity, and the distinction between infirmary and workhouse was also a shifting one.

The Poor Law survived in spite of several attempts to reduce its stigma, which had long been thought inappropriate to the sick poor.¹ Particular pres-

1 The nineteenth century efforts to move Poor Law medicine on to a more professional footing are described in Ruth G. Hodgkinson, *The origins of the National Health Service. The medical services of the New Poor Law, 1834-1871* (London: Wellcome Trust, 1967).

sure points occurred in 1909, 1918, and 1929. In 1909, both the Majority and the Minority reports of the Poor Law Commission attacked the untidy and overlapping system of health services provided by voluntary effort and the Poor Law: the Fabian-influenced Minority aimed for a state-run medical service with centrally-funded doctors, the Majority for a system of provident dispensaries, retaining the Poor Law only for the very poorest.² Neither report was accepted by Lloyd George, who decided to implement his version of the German model of state insurance, leaving the Poor Law to provide general practitioner treatment for all those not covered by insurance. The new system left out the families of insured men, and did not affect the hospital role of the Poor Law, except that some of the tubercular patients were able to use the local authority sanatoria set up under the Act. The Local Government Board tried various administrative measures to reduce public suspicion of Poor Law hospitals: for example the Poor Law Institutions Order of 1913 led to the term 'workhouse' being replaced by 'Poor Law Institution,' or, more frequently, 'Institution'. Many local boards had pre-empted this trend by resorting to even less identifiable titles for their hospitals, usually named after their location — Hope Hospital at Salford sounded more optimistic than it probably was.

A second movement for change came in 1918, when the Poor Law looked likely to drown in the tide of popular sentiment for the heroes who had won the war. The returning heroes found themselves offered new council housing (though not enough of it), and, for the first time, uninsured men received unemployment benefit, (the 'dole'), separate from the Poor Law. G.D.H. Cole sounded an enthusiastic Socialist note in 1921, looking forward to the end of the Poor Law: 'Indeed, few can be found, except Guardians themselves, to put up at this time of day a case in favour of the retention of the Poor Law ...'.³ But local opposition was enough to prevent the new Ministry of Health from superseding the Poor Law, which was incorporated along with its existing officials. The growing sense of economic crisis, and the government's restrictions on public spending, made the local Guardians seem necessary conservators of public finance.

A more significant change of title came after 1929, when Neville Chamberlain's Local Government Act abolished the English Poor Law guardians and the Scottish parochial boards, and turned poor relief into Public Assistance. The health and assistance functions of the Poor Law were intended to be divided between new Public Health and Public Assistance Committees (PACs) of the local county or borough (burgh) councils. Even the term Public Assist-

2 *Report of the Royal Commission on the Poor Laws and Relief of Distress*, vol. I [Majority Report] (HMSO, 1909), cd 4499, Part V, ch. 3, s 237.

3 G.D.H. Cole, *The future of local government* (London: Cassell, 1921), p. 127.

ance proved too much for some councils, particularly progressive ones, and several, including Glasgow, renamed their PACs 'Welfare' committees. Poor Law officers also preferred to work incognito, as it were: relieving officers were replaced by Public Assistance Officers, workhouse masters began to change slowly into hospital stewards. After 1929 the Poor Law Officers' Association was absorbed into the National Association of Local Government Officers and lost its independent title. Yet all these changes did not shift the Poor Law, or its ancient accompaniment, the durable although much modified Law of Settlement. In order to take account of the changes of several decades, particularly the 1929 Local Government Act, the whole Poor Law was re-enacted in 1930 for England and in 1934 for Scotland, to make plain what had been adjusted, and what still stood.⁴ The system remained in place until the National Assistance Act of 1948 abolished the whole structure in its opening phrase: 'The existing Poor Law shall cease to have effect ...'.

Basic Principles

The twentieth-century Poor Law inherited a number of basic principles from an earlier period. The first was that self-help, or, failing this, family help, should be exhausted before public assistance was given. The mutual legal liability, not only of husbands and wives, but of parents and children (and in Scotland, across three generations and collateral relatives also), was, as I have argued elsewhere, actually extended in the 1930s by the application of household means tests to the whole body of the unemployed, not only those receiving poor relief.⁵ As far as the cost of hospital treatment was concerned, councils could demand payment from liable relatives under the Poor Law. The second principle was that each applicant for assistance paid for by the local rates had a legal place of settlement. The laws governing settlement were not, of course, as harsh or as complex as their seventeenth-century predecessors. Only a tiny number of Poor Law cases were forcibly removed to their place of settlement each year — usually recent arrivals who needed long-term institutional treatment. Although the poor were now virtually irremovable, the cost of their maintenance could still be claimed back from their place of settlement if they had been resident for less than one year in England or three years in Scotland. The system led to a constant trading of services between local authorities: it would sometimes be cheaper for a rural authority to pay for a sick person to be treated in a Poor Law hospital in a nearby town, rather than to provide suitable

4 20 & 21 Geo. 5, c 17: 24 & 25 Geo. 5, c 52 [Scotland].

5 M.A. Crowther, 'Family responsibility and state responsibility in Britain before the welfare state,' *Historical Journal*, 25(1982), 131-45.

accommodation itself. Each local authority still had good financial reasons for checking the background of all applicants, and charging other local authorities if possible.

The third principle was an elaborate updating of the nineteenth century premise that the poor must be totally destitute before they could claim relief, and that the situation of the pauper must be less eligible than the worst paid independent labourer. It was difficult to apply such ideas literally, especially after the extension of the vote even to paupers in 1918. Public assistance had to be fitted in to the newer patterns of relief, such as old age pensions and unemployment insurance, acting as a supplement where these were too low to support a family or provide basic necessities. Nevertheless, the elaborate scrutiny of the public assistance officer, and interrogation by the public assistance committee, maintained the formalities of the old law in the giving of relief. Institutions aimed at more scientific standards of hygiene and nutrition and more professional medical attendance, but still laboured under the reputation of a dreary environment, stultifying regulations, lack of personal freedom and overwhelming monotony.

Poor Law Hospitals

The first major effort to deal with the problem of Poor Law hospitals came in Neville Chamberlain's Local Government Act of 1929. Under the Act, the hospital responsibilities of the guardians were transferred to the local councils, with the intention of providing a local authority service of good quality, charging those who could pay, free to the rest, without the stigma of the Poor Law. Although the Councils now took over all institutions previously run by the guardians, the Poor Law did not cease to operate until the institution was technically stated to be run under the Public Health Acts rather than the Poor Law; this process was known as a 'declaration' under Section 5 of the 1929 Act. Such a 'declaration' could be made only when a hospital reached a standard approved by the Ministry of Health. Given the poor condition of many of the older Poor Law hospitals and institutions, councils would need to spend heavily in order to move their general hospitals closer to the standards of the voluntary sector. In fact, many councils adopted a process known as 'appropriation.' An 'appropriated' hospital was no longer classified as a Poor Law institution, but selected inmates could still be admitted under Poor Law regulations, giving the council the right to reclaim costs from liable relatives, or from other authorities if the patient did not have a local settlement.⁶ Like

6 The complexities of this are explained by Norman Wilson, *Municipal Health Services* (London: Allen & Unwin, 1946), pp. 84-87. For the workings of the system in the LCC, which 'appropriated' the institutions, but did not 'declare,' see MH 57/147, letter from H.P.Glover, 9 March 1936.

the discussions over Poor Law reform in 1918, the 1929 Act came at a particularly bad time. Just at the stage when Councils were supposed to spend on new hospitals, the great slump caused many of them to divert their resources into dealing with the consequences of mass unemployment. Chamberlain had attempted to distribute resources around the country via the block grant, but this was estimated to do no more in the worst-hit regions than allow them barely to keep up with the demand for social expenditure.⁷ In practice, counties with sluggish councils avoided the cost of upgrading their institutions, and often paid for acute patients to be sent to city hospitals, while leaving their institutions for the elderly and chronically sick virtually untouched. Some major cities, including London and Glasgow, although much interested in hospital reform, did not appropriate all the Poor Law hospitals. By 1939, in spite of a considerable effort by many local councils to improve their hospitals, the Poor Law still provided about a quarter of occupied hospital beds in England & Wales.⁸

Yet the official figures used by Robert Pinker are misleading, since they refer to the nominal status of whole institutions, and not to individual patients. It was quite possible for individuals in the appropriated institutions to be dealt with under the Poor Law. The late nineteenth-century Public Health Acts, which permitted councils to provide hospital services outside the Poor Law, did not prevent councils from designating certain patients as paupers.⁹ The situation is illustrated by the tortuous practices in Birkenhead, which is perhaps one of the most extreme examples of an attempt to compromise with the 1929 Act while maintaining the Poor Law whenever convenient. In this borough, Tranmere Poor Law institution was partially appropriated and divided into sections. Poor patients from within the borough were treated without charge, and were not subject to the investigations of the relieving officer. Another section of the institution dealt with contract payment cases from Wallasey corporation and other organizations who could pay for them. These needed a voucher from their own relieving officer, to ensure that the cost of their treatment would be repaid. Another group, suspected of having relatives who could afford the cost of treatment, were also admitted under the Poor Law, that is, via the relieving officer.¹⁰ The hospital superintendent, in cases of emergency, could act as a

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- 7 Joseph Sykes, *A Study in English Local Authority Finance* (London: P.S. King, 1939), pp. 123-25.
- 8 Robert Pinker, *English Hospital Statistics 1861-1938* (London: Heinemann, 1966), p. 102.
- 9 Norman Wilson, *Public Health Services* (London: William Hodge, 1938), pp. 109-11.
- 10 MH 57/27, printed report of committee of representatives of the health committee and PAC, 8 Dec 1932.

relieving officer, making an admission not only on the grounds of the patient's illness, but his ability to pay and his place of settlement. There do not seem to be any national statistics on how many patients were still treated as paupers within the local authority hospitals. We might assume that the great majority became public health cases, especially if they were local residents. But while Poor Law practices continued, the patients' impression that they were receiving a Poor Law service could not be broken down. That this was the case even after the war was confirmed by the hospital survey of the north-western area:¹¹

most of them [the municipal hospitals] are attempting ... to perform a function for which they were not designed and are not suited ... They have the disadvantage of adjoining (in some cases being almost entangled among) rather forbidding and barrack-like Public Assistance Institutions, and the 'Public Assistance atmosphere' (which is difficult to define but easy to recognise) tends to cling to them.

GP services

There is one aspect of Poor Law policy which receives little attention in the textbooks, because the Ministry of Health collected very sparse information about it. This was the district medical officer (DMO) system, under which the Poor Law authorities supplied general practitioner services to the poor. Statistics for 'medical relief' were often disregarded, mainly because this service was so cheap. Under a long-standing practice, local authorities contracted with a general practitioner to give medical treatment to the uninsured poor. Although the doctor could decide to treat emergency cases on his own initiative, it was still the public assistance official who determined eligibility for such free treatment, and the service was, for that reason, not popular. Even under health insurance panels, doctors had little incentive to offer more than a very basic service, since they often had to supply medicines and bandages themselves: Poor Law medicine, with its flat rate payment to the doctor, meant that he was at a disadvantage if his Poor Law clientele swelled. However, this was exactly what did happen during the 1930s. Unlike other aspects of the Poor Law service, outdoor medical relief showed a steady increase. In Manchester, for example, where the DMOs had treated about 5,948 cases in 1919, the numbers of Poor Law patients had risen to 55,000 by 1934.¹² A few large cities, including London and Glasgow, met the problem by employing full-time salaried GPs to meet the demand, though it is probable that the standard of

11 Ernest Rock Carling and T.S.McIntosh, *Hospital Survey: the hospital services of the north-western area* (HMSO, 1945), p. 10.

12 MH 54/44, memoranda on cessation of medical benefit through unemployment; MH 55/442, Note on D.M.O. service.

service was not high.¹³ The statistics are even more inadequate than for other types of relief, since they usually reflect one-day counts which are particularly inappropriate for short-term medical relief, but the figures indicate that this section of the Poor Law was actually becoming more important during the 1930s. In 1929, a one-day count revealed 12,063 people receiving general practitioner treatment: by 1938 there were 23,984.¹⁴

By the end of the 1930s, there were still nearly a million people on Poor Relief in England and Wales, or 29.5 people per thousand. In Scotland the figure was considerably higher: 51 per thousand. The layers of the onion were not being peeled cleanly away. Each left a substantial residue behind.

Why did the Poor Law survive?

In the first place, conventional financial opinions made it difficult to extend the range of social policy outside the Poor Law. The Treasury believed that social policy based on insurance should, as far as possible, be actuarially sound; that is, self-financing, with the state's contribution outweighed by payments from workers and their employers. Although the state made a contribution towards insurance, the expectation was that it would not keep a separate fund for this, but would meet any possible difference between the contribution raised from employers and workers, and the demands made on them. The main areas of pre-1914 social insurance, for unemployment and sickness, were based on this idea: hence the level of contributions had to be a compromise between what a worker's income could stand, and the possible needs of his family. The belief in financial soundness, in getting only what had been paid for, and reducing the liabilities of the state, set severe limitations on the extension of benefits to non-earners. One consequence of this belief was that health insurance did not cover the dependants of workers. As late as 1939, the government Actuary voiced doubts about the possibility of ever offering a free health service for the wives and children of insured workers. The reasons given were less financial than political: he believed that members of the BMA would never accept the status of paid employees of the state. He also saw the health system as part of a larger problem of dealing with the poor, including the elderly. While the government's financial advisers continued to doubt whether insurance could effectively be extended, then the survival of a residual, rate-based Poor Law, was inevitable.

Secondly, the Law of Settlement gave, as it had always done, an incen-

13 Evidence to be submitted to Committee on Scottish Health Services re the Medical Services, p. 62. DTC 6/466, Glasgow City Archives, Corporation of Glasgow.

14 MH 78/259-60. There were no published statistics, but wartime surveys revealed past practices.

tive for local authorities to retain the Poor Law, since they could pass part of the cost on to others. It was estimated that in Liverpool in 1938, about one third of the patients in the voluntary hospitals, and ten per cent of the patients in the municipal hospitals, came from outside Liverpool. Patients from the surrounding counties looked for specialist treatment in the Liverpool voluntary hospitals, in spite of their antiquated facilities — Sir Ernest Rock Carling, and T.S. MacIntosh, who surveyed the hospitals of north-west England after the war, made many criticisms of even the most prestigious teaching hospitals of Liverpool. Those who came from outside Liverpool to the municipal hospitals probably had little choice: most of them were sent from Bootle, which had no municipal general hospital of its own.¹⁵ The use of local facilities by other authorities gave Liverpool Council an incentive during the 1930s to maintain the Poor Law status of many patients, in order to recover the cost from a neighbouring area. There was still a vestigial feeling, which would have been familiar to Edwin Chadwick, that if hospital and other services were made freely available to incomers, there would be a flood of applicants, or a breakdown of family responsibility. Furthermore, the sums obtained by selling Poor Law hospital services to other authorities were often quite considerable. While there was still a financial incentive to retain the Poor Law within the hospitals, they could not be quickly removed from the 'pauper taint.'

Yet other anxieties about the national health, comparable to those in 1913, were beginning to emerge. German propaganda on the fitness of the German race forced a greater interest in the welfare of mothers and children, and more inclination to make local authorities improve their district nursing and midwifery services. As John Stewart has shown, one line of thought via Somerville Hastings and the Socialist Medical Association, asserted that, 'The dictators know that children are all-important. Can the democracies afford to fall behind?'¹⁶ But it would have taken too great a political leap at this point to argue that government should pay the cost of individual health care through national taxation. Individuals must pay if they could: if they could not, then voluntary systems or local government took up the burden. And if local authorities could pass part of the bill on to a neighbour, they would do so. Hence the durability of the Law of Settlement.

In summary, in spite of the expansion of social policy between 1906 and 1939, it is difficult to see any predictable end for the Poor Law before the outbreak of World War II. The new legislation had worked carefully around

15 Rock Carling and McIntosh, pp. 558-59.

16 Quoted in John Stewart, 'Socialist proposals for health reform in inter-war Britain: the case of Somerville Hastings,' *Med.Hist.*, 39(1995), 351.

it, always leaving it as a fall-back where other policies were not enough for subsistence. Although numbers on relief were falling by the end of the 1930s, it is difficult to tell whether this was due to effects of legislation, or simply to the upturn in the economy, which had always produced a reduction in pauperism. The most hopeful sign was the Coalition Government's interest in pushing local authorities into spending more on new hospital services: by 1938 they had been prodded into projecting a five-year expenditure of some £35m on public hospitals and clinics.¹⁷

Part of the responsibility for the survival of the Poor Law lies with Chamberlain himself, who, in spite of his local government reforms, still took a rather positive view of the Poor Law. His family, after all, had played a major part in Birmingham Poor Law administration for many years. He saw the Poor Law, as Sir Keith Feiling remarked, not as 'the code of a depressed order, but a limb of the body of social services.'¹⁸

The Poor Law in World War II

The British entered the Second World War with Poor Law policy virtually intact. The fact that so many people still depended on it at the end of the 1930s, in spite of all efforts to reduce its relevance to unemployment, old age, and illness, shows the limitations of policy at other levels. Even in the national emergency a number of efforts were made to keep the Poor Law in place as a way of preventing the civilian population from taking advantage of the situation in order to avoid their family responsibilities. At first, administrators expected that the Poor Law would operate as usual, and would indeed play a considerable part in dealing with the problems of war. The first signs of this attitude were shown most strongly by the Treasury in the months immediately before the war, and for some time afterwards, in relation to the costs of evacuation. Angus Calder has graphically described the failure of bureaucracy to plan effectively for the mass evacuation of mothers and children which the government regarded as inevitable once war had been declared.¹⁹ The government had originally stated that it would meet the costs of evacuation, but although it did meet certain expenses, the Treasury decided at the last moment to recover part of the costs of billeting from parents, and to pay the rent, but no other living expenses, for mothers who went with their children. After much pressure from the Ministry of Health, the Treasury agreed to set up a fund to assist

17 For the public spending plans, see *Twentieth Report of the Ministry of Health*, PP 1938-9, XI, p. 268.

18 K. Feiling, *The Life of Neville Chamberlain* (London: Macmillan, 1970), p. 146.

19 Angus Calder, *The People's War: Britain 1939-45* (London: Granada, 1971), pp. 48-54.

local authorities with these expenses, while urging that it be kept secret in case families took advantage of it. Hence the Poor Law authorities were to be left with the duty of assessing each family's needs, and reclaiming costs from parents.

The laws of settlement still applied, even for evacuees requiring medical treatment. The government met the costs of treating civilians injured in the blitz, but the rules for evacuees who became ill for reasons other than enemy attack were more complicated. The government agreed to provide GP treatment for any unaccompanied child, but children evacuated with their mothers were another matter, and parents were required to meet the costs directly. If this was impossible, then an application to the local Poor Law doctor would have to be made, and the charge then reclaimed by one local authority from another under normal settlement rules. The effects of these rules, as Titmuss pointed out in his less than favourable account in *Problems of Social Policy*, was that evacuation placed immense pressures on the Poor Law, since it created a large class of people who had left their place of settlement and were often in very difficult personal circumstances. Evacuation made a mockery of the law of settlement, while at the same time that law complicated the relief of needy evacuees by provoking arguments between local authorities. Some were still writing acrimonious letters to each other years after the war ended, over whose responsibility it was to pay for expensive treatment for a former evacuee. Evacuated mothers with children received no help with medical treatment, even though they were often in great need. Some were trying to keep up rent payments on the scarce accommodation they had left behind, while meeting the costs of lodgings in their new billets. Food and other items were more expensive in the countryside, and there was no network of outpatient departments or free clinics, as were available in many towns. The district medical officers became disgruntled as their caseloads grew, and the flat rate they were paid for pauper patients expanded very slowly. The Ministry of Health was unable to impress on local authorities the need for improving their Poor Law GP service; Titmuss concluded that 'the elaborate mechanism for transferring small amounts of money from the pockets of one authority to another represented a disproportionate and wasteful consumption of time and labour'.²⁰

Although Churchill's wartime government considered policies which might have led towards some kind of means-tested National Health Service, by 1944 there was no sign of the major planning necessary for dismantling the Poor Law. The general election, and the arrival of Aneurin Bevin, produced an immediate change, as the Labour government set about erecting the Welfare State. On 27 March 1946, the Cabinet decided that the implementation of the

new Beveridge-type national insurance should be accompanied by a National Assistance bill to break up the Poor Law and deal with all the cases which would not be covered by national insurance. A committee headed by Sir Arthur Rucker was set up specifically to consider how the Poor Law could be abandoned, since a great deal of planning was needed to ensure that the various strands of social policy fell into place simultaneously. The unpublished report was presented to the Cabinet at the end of June.

The lengthy discussions of this inter-departmental committee, bringing together representatives from all the major social service ministries, shows the extreme complexity of dismantling an ancient system which took care of such disparate groups of people.²¹ Local authorities were by this time keen to shed the burden of the Poor Law, possibly because they anticipated a resurgence of pauperism after the war. However, they suspected dire problems would arise from the abolition of the law of settlement, and if they lost the power to impose firm Poor Law discipline in their residential institutions.²² In the end the local authorities lost their hospitals to the NHS, but continued to provide homes for elderly people, often in old Poor Law buildings, with the same staff, and little change in the regime. For this group, the abolition of the Poor Law brought the least dramatic change. Institutional staff were largely kept on, as there was a substantial shortage of nurses after the war.

By 1939, the Poor Law, if not as vigorously as in the nineteenth century, was still a major plank in British social policy. In the case of Poor Law medicine, numbers receiving GP treatment were rising steadily, with no policies in sight to bring the uninsured under a comprehensive health system. The war shot a number of treasured Poor Law policies into pieces, particularly its role in supplementing other kinds of state assistance. Nevertheless, the instinct to preserve the laws of settlement, in spite of the pressures of evacuation, showed how difficult it was to dismantle this ancient regime. The arrival of a government with an almost pathological distaste for the Poor Law was necessary before it could finally be laid to rest. The Poor Law as a legal system was dead, but both its institutions (still incorporated into many hospitals and residential homes), and many of its basic principles, were hard to kill. The need to distinguish between the deserving and the undeserving poor, the relatively low status of geriatric care in relation to other forms of hospital medicine, and, later, the partial revival of the laws of settlement under the NHS trusts, show that it was a form of social policy remarkably hard to kill.

21 Its deliberations are recorded in AST 7/810.

22 AST 7/828, Minute of a meeting with representatives of Scottish Local authority Associations, 4 Oct 1946.